

OWCP Case Management



Purpose

The Federal Employees' Compensation Act (FECA) was created in 1916. It is designed to provide monetary compensation, medical care and assistance (attendant's allowances), vocational rehabilitation, and Office of Personnel Management (OPM) retention rights to civilian Federal employees who sustain injuries including occupational disease as a result of their employment with the Federal Government. The FECA also provides for the payment of funeral expenses and for compensation benefits to qualified survivors of the decedent in case of employment-related death. The FECA is intended to be remedial in nature, and proceedings under it are non-adversarial.



OWCP Structure and Jurisdiction

The Division of Federal Employees' Compensation (DFEC) administers the FECA. The Director for DFEC and the various OWCP Regional Directors have authority over the operations of the 12 district offices. Each of these offices is headed by a District Director, who is responsible for office functions. In each district office there are two or more Supervisory Claims Examiners, or Claims Managers, who are responsible for the operation of individual claims units. The claims units, staffed with Senior Claims Examiners and Claims Examiners, have primary responsibility for issuing decisions and managing the individual claims.

The jurisdictions of the 12 district offices are as follows:

- District 1 – Boston, MA (covers claims for CT, ME, MA, NH, RI and VT)
- District 2 – New York, NY (claims for NJ, NY, PR and the VI)
- District 3 – Philadelphia, PA (claims for DE, PA, WV and parts of MD)
- District 6 – Jacksonville, FL (claims for AL, FL, GA, KY, MS, NC, SC and TN)
- District 9 – Cleveland, OH (claims for IN, MI and OH)
- District 10 – Chicago, IL (claims for IL, MN and WI)
- District 11 – Kansas City, MO (claims for IA, KS, MO, NE and DOL employees)
- District 12 – Denver, CO (claims for CO, MT, ND, SD, UT and WY)
- District 13 – San Francisco, CA (claims for AZ, CA, HI and NV)
- District 14 – Seattle, WA (claims for AK, ID, OR and WA)
- District 16 – Dallas, TX (claims for AR, LA, NM, OK and TX)
- District 25 – Washington, DC (claims for parts of MD, VA and DC)

Financing

The FECA program is financed by the Employees' Compensation Fund, which consists of funds appropriated by Congress through a charge back system to the various agencies. Each year the Secretary of Labor furnishes each agency with a statement of payments made from the fund with respect to its employees. The agencies include these amounts in their budget requests and the resulting sums appropriated are deposited in the fund.



Information and Records

Individual case files are protected under the Privacy Act of 1974, and only the employee, his or her designated representative, and designated agency personnel may routinely have access to a given file. Any of these parties may inspect the file at the district office, which has custody of it; an appointment should be requested ahead of time.

The protection, release, inspection and copying of records covered by OWCP, shall be accomplished in accordance with the rules, guidelines and provisions set forth in 20 CFR §10.11 of OWCP's regulations, as well as those contained in 29 CFR parts 70 and 71. As stated in OWCP's regulations, while an employer may establish procedures for an injured employee or beneficiary to obtain documents, any decision issued in response to such a request must comply with OWCP's regulations, and no employer may correct or amend records pertaining to OWCP claims.

Exclusiveness of Remedy

Except for third-party rights, the Act is the sole legal avenue by which a Federal employee (or survivors) may recover damages in consideration of an injury or death that is causally related to Federal employment. A federal employee or surviving dependent is not entitled to sue the United States or recover damages for such injury or death under any other law; the Act is the exclusive remedy (5 U.S.C. 8116[b]).



Penalties

The regulations set forth in 20 CFR §10.15 address waiver of compensation. 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 shall be valid.

The regulations set forth in 20 CFR §10.16 address criminal penalties in connection with a claim under the FECA. 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.

Penalties Continued

The regulations set forth in 20 CFR §10.17 address the effects to a beneficiary who defrauds the government in connection with a claim for benefits. When a beneficiary either pleads guilty 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.



Program Benefits

FECA provides for four basic types of benefits to civilian Federal employees who sustain injuries including occupational disease as a result of their employment with the Federal Government and monetary benefits to qualified survivors of the decedent in case of employment-related death. The four types of benefits are as follows:

1. Medical Benefits

- OWCP Fee Schedule
- Travel Reimbursement for medical treatment

2. Compensation Benefits

- Continuation of Pay
- Total Disability Compensation
- Partial Disability Compensation
- Schedule award

3. Death benefits

- Survivors' compensation
- Funeral expenses
- Transportation of body
- Administration fees

4. Other Benefits

- Attendant allowance
 - Vocational rehabilitation
 - Nurse Services
- 

Medical Benefits

The FECA provides for any medical service needed to treat, counteract, or minimize the effects of any injury, condition, or disease judged to be causally related to employment with the Federal Government. No time or monetary limitations will be imposed on medical care for the employee as long as there is substantiated need for treatment of the work-related injury or illness. However, no bill will be paid if the bill is submitted beyond the end of the calendar year following the year of the date of service or by the end of the calendar following the year in which the claim was first accepted, whichever is latest.

All medical, pharmacy, and hospital reimbursements are subject to OWCP's fee schedule which limits the dollar amount of the reimbursement based on the type of medical service provided and the geographical area (zip code) that it was provided. The providers must accept this payment as payment in full. NOTE: The employee may not be billed for any difference.

The only limitations to medical care are that OWCP does not pay for preventative treatment unless there is a physical injury as set forth in 20 C.F.R. 10.313(b). The payment of chiropractic treatment consisting of manual manipulation of the spine is limited to claims accepted for spinal subluxations only.

Compensation Benefits

Federal employees that suffer disabilities that are casually related to employment are eligible for one or more of types of wage loss compensation. Disability benefits are classified by the nature and extent of disability incurred, and is defined as temporary total, or permanent partial.

List below are the types of monetary benefits provided by the FECA:

1. Continuation of Pay
2. Compensation for Loss of Wages
3. Schedule Award
4. Death Benefits



Continuation of Pay

If an employee suffers a job related “traumatic” injury, the employee is entitled to continuation of regular pay for the period not to exceed 45 calendar days. After that time, the employee is entitled to file for compensation for wage loss (disability benefits). Entitlement to continuation of pay is limited to traumatic injuries only. Employees who file claims for employment related “occupational disease” are not entitled to continuation of pay, but can file a claim for compensation for any related wage loss.



Compensation for Loss of Wages

The Act provides that compensation for wage loss be paid at one of two rates; $66 \frac{2}{3}$ percent of the employee's regular pay for those who do not have dependants and 75 percent for those who do have dependants. All compensation payments are subject to a three day waiting period if the disability is less than 14 calendar days. Once the disability has exceeded 14 calendar days, the employee will be compensated for the first three days.

When establishing the wage rate for compensation purposes, the regulations recognize certain additional pay elements which may be included in the salary, such as night and Sunday differential, dirty work pay, hazardous duty pay, administrative uncontrollable overtime, and law enforcement availability pay. Regularly earned overtime pay, however, can not be included.

It should be noted that for a single parents who have dependants, when the dependant reaches age 18, and is not pursuing higher education on a full time basis (generally 12 semester hours), compensation will be reduced to $66 \frac{2}{3}$ percent of the employee's regular pay. Once the dependant enrolls in a full-time course of study and is unmarried, compensation will be increased to 75 percent. Compensation will continue that this rate until the dependant has completed four years of education beyond high school level or reaches age 23.



Compensation Continued

The Act, 5 U.S.C.8112, subjects compensation payments to a minimum and maximum dollar amount. Compensation may not exceed a dollar amount equal to 75 percent of the current base GS-15 step 10 pay rate. The minimum compensation for total disability may not be less than 75 percent of a current base GS-2 step 1 pay rate. The minimum and maximum pay rates do not include locality pay.

If a beneficiary is still in receipt of disability benefits for more than one year, they become eligible for cost-of-living increases. Cost-of-living increases are awarded to FECA beneficiaries effective March 1 of each year. The amount of the increase is based on the Consumer Price Index (CPI) for the calendar year prior to March 1, and is added to the compensation payable. The CPI is computed by OWCP, and the increase is sent directly to the employee with notification.

Schedule Award

The Act provides for limited term payments in cases where an employee suffers anatomical loss or loss of use of parts of the body listed in the schedule found in Section 8107 of the Act and in the program's regulations at 20 C.F.R. 10.404. Benefits under these provisions are paid in the same manner as disability compensation; however it is payment for a specified period of time which is proportional to the severity of loss. The severity of loss is derived through the use of the American Medical Association's Guides to the Evaluation of Permanent Partial Impairments, 5th Edition. In cases where the employee suffers disfigurement of the face, neck or head, the Act provides that an employee will be paid an award of compensation not to exceed \$3500.00.

The Act precludes employees from receiving wage loss compensation and schedule award benefits concurrently for the same injury. If an employee sustains a period of temporary total disability during the course of an award, the award may be interrupted to pay the period of disability; payment for the remainder of the award will resume afterwards.

Death Benefits

The basic requirements to qualify for death benefits are the same as those to qualify for disability benefits (see previous section).

The Act provides for a full range of benefits for the survivors of a Federal employee who dies as a result of a job-related injury. Widows and widowers of the decedent are eligible for wage loss compensation equal to 50 percent of the deceased employee's regular pay. A widows and widowers with an eligible child is eligible for compensation equal to 45 percent of the deceased employee's pay plus an additional 15 percent for each eligible child, to a maximum not to exceed 75 percent of the deceased employee's pay. The minimum and maximum pay rates apply as well as the entitlement to cost-of-living increases (see previous section).

If the deceased employee leaves no spouse, or the spouse is no longer entitled to survivor benefits, dependant children are eligible for compensation equal to 40 percent of the deceased employee's regular pay, plus 15 percent for each additional dependant, to a maximum of 75 percent of the employee's regular pay. Funeral expanses are also provided to survivors under the provisions of the Act.

Up to \$800.00 will be paid for funeral expenses. If the employee dies away from his or her home, the cost of transporting the remains to the place of burial will be paid in full. In addition, a \$200.00 allowance will be paid in consideration of the expenses of terminating the Federal employment status of the deceased.

Other Benefits

Attendant Allowance

Under the provisions set forth in 20 C.F.R. 10.312, the payment for services of an attendant may be granted in cases where it is medically documented that the injured worker requires assistance to care for personal needs such as bathing, dressing, or feeding. Such services must be provided by a licensed health care provider and are paid as a medical expense under 5 U.S.C. 8103. The services are limited to maximum amount of \$1500 per month under 5 U.S.C. 8111 and are paid directly to the provider of the services. The payment is no longer made directly to the injured worker.

Vocational Rehabilitation

The Act provides for OWCP-directed vocational rehabilitation services necessary to counteract the disabling compensable effects of any permanent illness or injury casually related to Federal employment. The cost of rehabilitation is paid from the Compensation Fund, and is usually administered through private vocational rehabilitation agencies under the direction of OWCP.

Other Benefits Continued

Nurse Services

OWCP provides the services of registered nurses working under its direction. The nurses provide services that include visiting the worksite, ensuring that duties of the position do not exceed the medical limitations, and addressing any problems the employee may have in adjusting to the work setting. The nurse acts as a liaison between the injured employee, the attending physician, the agency and OWCP.



Federal Workers Compensation Claims Processing



Traumatic Injury vs. Occupational Disease

- **Traumatic:** Happened within one work shift (can have multiple incidents in one shift)
 - File CA-1, agency should consider issuing CA-16 authorizing medical care
- **Occupational:** work factors or injuries over more than one shift
 - File CA-2

What's the difference?

- No COP or CA-16's for Occupational Diseases

Special Note:

- Diagnosed condition does not determine whether traumatic or occupational, the way the injury happened does



Traumatic Injuries (CA-1)

- **Back strains**
- **Knee, ankle strains**
- **Exposure to fumes, dust, smoke (within one shift)**
- **Acoustic trauma (explosion, noise)**
- **Traumatic stress**
 - **Angry customer/co-worker/supervisor**



Form CA-1 Traumatic Injury Claim

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

[Reset](#) [Print](#)

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.

Witness: Complete bottom section 16.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

| | |
|---|---|
| Employee Data | |
| 1. Name of employee (Last, First, Middle) | |
| 2. Social Security Number | |
| 3. Date of birth Mo. Day Yr. | 4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 5. Home telephone | 6. Grade as of date of injury Level <input type="checkbox"/> Step <input type="checkbox"/> |
| 7. Employee's home mailing address (Include city, state, and ZIP code) | |
| 8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other | |
| Description of Injury | |
| 9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine) | |
| 10. Date injury occurred Mo. Day Yr. | Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| 11. Date of this notice Mo. Day Yr. | 12. Employee's occupation |
| 13. Cause of injury (Describe what happened and why) | |
| 14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg) | |
| a. Occupation code | |
| b. Type code | |
| c. Source code | |
| OWCP Use - NOI Code | |

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- b. Sick and/or Annual Leave

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Witness Statement

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of witness _____ Signature of witness _____ Date signed _____
Address _____ City _____ State _____ ZIP Code _____

Form CA-1
Rev. Apr. 1999

Official Supervisor's Report: Please complete information requested below:

| | | |
|--|---|--|
| Supervisor's Report | | |
| 17. Agency name and address of reporting office (include city, state, and zip code) | | |
| OWCP Agency Code | | |
| OSHA Site Code | | |
| ZIP Code | | |
| 18. Employee's duty station (Street address and ZIP code) | | |
| 19. Employee's retirement coverage <input type="checkbox"/> CSRS <input type="checkbox"/> FERS <input type="checkbox"/> Other, (identify) | | |
| 20. Regular work hours From: _____ a.m. To: _____ a.m. / _____ p.m. To: _____ p.m. | 21. Regular work schedule Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. <input type="checkbox"/> | |
| 22. Date of injury Mo. Day Yr. | 23. Date notice received Mo. Day Yr. | 24. Date stopped work Mo. Day Yr. Time: _____ a.m. / _____ p.m. |
| 25. Date pay stopped Mo. Day Yr. | 26. Date 45 day period began Mo. Day Yr. | 27. Date returned to work Mo. Day Yr. Time: _____ a.m. / _____ p.m. |
| 28. Was employee injured in performance of duty? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain) | | |
| 29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? <input type="checkbox"/> Yes (If "Yes," explain) <input type="checkbox"/> No | | |
| 30. Was injury caused by third party? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.) | 31. Name and address of third party (include city, state, and ZIP code) | |
| 32. Name and address of physician first providing medical care (include city, state, ZIP code) | | |
| 33. First date medical care received Mo. Day Yr. | | 34. Do medical reports show employee is disabled for work? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain) | | |
| 36. If the employing agency controverts continuation of pay, state the reason in detail. | | |
| 37. Pay rate when employee stopped work \$ _____ Per _____ | | |

Signature of Supervisor and Filing Instructions

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of supervisor (Type or print) _____
Signature of supervisor _____ Date _____
Supervisor's Title _____ Office phone _____

39. Filing instructions
- No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
 - No lost time, medical expense incurred or expected: forward this form to OWCP
 - Lost time covered by leave, LWOP, or COP: forward this form to OWCP
 - First Aid Injury

Form CA-1
Rev. Apr. 1999

Agency Processing of Traumatic Injury Claims

- The agency must ensure that the completed CA-1 is submitted to OWCP within 10 working days.
- The agency should not wait for the submission of supporting evidence before sending the CA-1 to OWCP.
- If an employee requires medical treatment, a form CA-16 should be issued.
- Inform the employee of the right to elect continuation of pay (COP) or sick/annual leave if time is loss will occur.
- Advise the employee whether COP will be controverted, and if so, whether pay will be terminated.
- Advise employee of his/ her responsibility to submit prima facie medical evidence of disability within 10 calendar days or risk termination of COP



Tips for CA-1 Form Completion

- Employee Portion -

- The front page is to be completed by the employee, but if the employee is incapacitated, the supervisor can complete it for them.
- Check to make sure that the employee uses their home address in Block 7 and not the agency address.
- The employee must put a specific date for the date of injury and date of notice. If the employee puts a date range down for the date of injury, it is likely an occupational claim.
- Check to make sure the employee signs and dates the form



Tips for CA-1 Form Completion

- Agency Portion -

- OWCP Agency Code must be entered.
- The date of injury in Block 22 should match the date on the employee portion (Block 10).
- If you answer “No” to the question regarding your knowledge of the injury in Block 35, you must submit evidence to refute the claimed injury. Lack of direct knowledge of the injury does not constitute probative evidence.
- If you are controverting Continuation of Pay (COP) in Block 36, you must state the reason. Controverting COP is different from challenging the claim.
- The Supervisor must sign and date the claim and submit it to the local District Office (not the mail room address in London, KY)
- The Federal Regulations, §10.110, require a Federal employer to complete and transmit Forms CA-1 and CA-2 to OWCP within 10 working days after receipt of notice from the employee



Form CA-16

Authorization for Examination And/Or Treatment

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



The following request for information is required under (5 USC 8101 et. seq.). Benefits and/or medical services expenses may not be paid or may be subject to suspension under this program unless this report is completed and filed as requested. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and OMB Cir. No. A-108.

OMB No.: 1215-0103
Expires: 10-31-99

Person are not required to respond to this collection of information unless it displays a currently valid OMB control number.

PART A - AUTHORIZATION

| | | |
|---|--|---------------|
| 1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service: | | |
| 2. Employee's Name (last, first, middle) | 3. Date of Injury (mo., day, yr.) | 4. Occupation |
| 5. Description of Injury or Disease: | | |
| 6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 11, subject to the condition stated in item A, and to the condition indicated either 1 or 2, in item B. | | |
| A. Your signature in item 35 of Part B certifies your agreement that all fees for services shall not exceed the maximum allowable fee established by OWCP and that payment by OWCP will be accepted as payment in full for said services. | | |
| B. <input type="checkbox"/> 1. Furnish office and/or hospital treatment as medically necessary for the effects of this injury. Any surgery other than emergency must have prior OWCP approval. | | |
| <input type="checkbox"/> 2. There is doubt whether the employee's condition is caused by an injury sustained in the performance of duty, or is otherwise related to the employment. You are authorized to examine the employee using indicated non-surgical diagnostic studies, and promptly advise the undersigned whether you believe the condition is due to the alleged injury or to any circumstances of the employment. Pending further advice you may provide necessary conservative treatment if you believe the condition may be to the injury or to the employment. | | |
| 7. If a disease or illness is involved, OWCP Approval for issuing Authorization was obtained from: (Type Name and Title of OWCP Official) | 8. Signature of Authorizing Official: | |
| | 9. Name and Title of Authorizing Official: (Type or print clearly) | |
| 10. Local Employing Agency Telephone Number. | 11. Date (mo., day, year) | |
| 12. Send one copy of your report: (Fill in remainder of address) | 13. Name and Address of Employee's Place of Employment: | |
| | Department of Agency | |
| | Bureau or Office | |
| | Local Address (including ZIP Code) | |

Public Burden Statement

We estimate that it will take an average of 5 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Form CA-16
Rev. Jan. 1997

PART B - ATTENDING PHYSICIAN'S REPORT

| | | |
|---|--|--|
| 14. Employee's Name (last, first, middle) | | |
| 15. What History of Injury or Disease Did Employee Give You? | | |
| 16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe) | | 16a. IDC-9 Code |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | _____ |
| 17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.) | 18. What is Your Diagnosis? | 18a. IDC-9 Code |
| | | _____ |
| 19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt). | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 20. Did Injury Require Hospitalization? (If yes, date of admission (mo., day, year) Date of discharge (mo., day, year)) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Is Additional Hospitalization Required? |
| 22. Surgery (if any, describe type) | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Date Surgery Performed (mo., day, year) | | |
| 24. What (Other) Type of Treatment Did You Provide? | 25. What Permanent Effects, If Any, Do You Anticipate? | |
| 26. Date of First Examination (mo., day, year) | 27. Date(s) of Treatment (mo., day, year) | 28. Date of Discharge from Treatment (mo., day, year) |
| 29. Period of Disability (mo., day, year)(If termination date unknown, so indicate) | Total Disability: From _____ To _____ Partial Disability: From _____ To _____ | 30. Is Employee Able to Resume |
| | | <input type="checkbox"/> Light Work Date: _____ <input type="checkbox"/> Regular Work Date: _____ |
| 31. If Employee is Able to Resume Work, Has He/She Been Advised? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, Furnish Date Advised |
| 32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations. | | |
| 33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address. | | |
| 34. Do You Specialize? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state speciality) | | |
| 35. SIGNATURE OF PHYSICIAN I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution. | | 36. Address (No., Street, City, State, ZIP Code) |
| | | 37. Tax Identification Number |
| | | 39. Date of Report |
| | | 38. National Provider System Number |

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402

Form CA-16

- Only used in Traumatic Claims (CA-1)
- Should be issued immediately, but may be issued later
- Guarantees payment of all medical expenses for 60 days after date of issuance
- Does not cover non-emergency surgery
- The claimant does have their choice of initial attending physician (ER physician or EA physician do not count)



Form CA-16 Instructions

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 to either a United States medical officer/hospital or any duly qualified physician/hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

- Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

- U.S. medical facilities include Public Health Service, Military or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

- The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM)

Information for Physician – See Reverse Side

Form CA-16 Instructions cont.

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

- Please read Part A of Form CA-16. You are authorized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

This form covers office visits and consultations, laboratory work, hospital services (including inpatient), x-rays, MRIs, CT scans, physical therapy, emergency services (including surgery) and chiropractic services. Chiropractic services are limited to charges for physical examinations and x-rays to diagnose a subluxation of the spine and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

This form does not cover elective and non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym membership and work hardening programs.

USE OF CONSULTANTS AND HOSPITALS

- You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accommodations unless a private room is medically necessary. Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

- After examination, complete items 14 through 39, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

- Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

- OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified. In Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

- Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

- The provider's Tax Identification Number (TIN) is an important identified in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN – either corporate or personal – which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.

Form CA-16 and Chiropractic Care

- **Chiropractors are only considered “physicians” under the Act if they treat a subluxation (dislocation) of the spine as demonstrated on x-ray. The x-ray may be taken by the chiropractor**
- **If this is diagnosed, only manipulation of the spine is payable**



Occupational Diseases (Form CA-2)

OWCP classifies occupational disease claims into two types:

Basic Occupational Disease Claims:

- **Orthopedic strains caused by repetitive trauma**
- **Carpal Tunnel Syndrome**
- **Tarsal Tunnel and Plantar Fasciitis**
- **Eye Strain**
- **Exposure to fumes, dust, smoke (over more than one shift)**

Extended Occupational Disease Claims:

- **Hearing loss**
- **Asbestosis**
- **Emotional stress**
- **Sick building syndrome**

***Special note: almost always require a second opinion to be set up by our office and exposure data from agency is also needed.**



Form CA-2 Occupational Disease Claim

Notice of Occupational Disease and Claim for Compensation

Reset **Print**

U. S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.

Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

| Employee Data | | | | | |
|--|-----|-----|--|--------|-------------------|
| 1. Name of Employee (Last, First, Middle) | | | 2. Social Security Number | | |
| 3. Date of birth | Mo. | Day | Yr. | 4. Sex | 5. Home telephone |
| | | | | M | |
| 7. Employee's home mailing address (include city, state, and ZIP code) | | | 8. Dependents | | |
| | | | <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other | | |

| Claim Information | |
|--|---|
| 9. Employee's occupation | a. Occupation code |
| | |
| 10. Location (address) where you worked when disease or illness occurred (include City, state, and ZIP code) | 11. Date you first became aware of disease or illness |
| | Mo. Day Yr. |
| 12. Date you first realized the disease or illness was caused or aggravated by your employment | 13. Explain the relationship to your employment, and why you came to this realization |
| Mo. Day Yr. | |

| | |
|---|-----------------------------|
| 14. Nature of disease or illness | OWCP Use - NOI Code |
| | b. Type code c. Source code |
| | |
| 15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay. | |
| | |
| 16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay. | |
| | |
| 17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay. | |
| | |

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government, agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date _____

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Official Supervisor's Report of Occupational Disease: Please complete information requested below

| Supervisor's Report | |
|--|---|
| 19. Agency name and address of reporting office (include city, state, and ZIP Code) | |
| | |
| OWCP Agency Code | |
| | |
| OSHA Site Code | |
| | |
| ZIP Code | |
| | |
| 20. Employee's duty station (Street address and ZIP Code) | |
| | |
| ZIP Code | |
| | |
| 21. Regular work hours | 22. Regular work schedule |
| From: _____ To: _____ | <input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat |
| | |
| 23. Name and address of physician first providing medical care (include city, state, ZIP code) | |
| | |
| 24. First date medical care received | |
| Mo. Day Yr. | |
| | |
| 25. Do medical reports show employee is disabled for work? | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | |
| 26. Date employee first reported condition to supervisor | 27. Date and hour employee stopped work |
| Mo. Day Yr. | Mo. Day Yr. Time _____ |
| | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| 28. Date and hour employee's pay stopped | |
| Mo. Day Yr. Time _____ | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| 29. Date employee was last exposed to conditions alleged to have caused disease or illness | |
| Mo. Day Yr. | |
| | |
| 30. Date returned to work | Time _____ |
| Mo. Day Yr. | <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| | |

31. If employee has returned to work and work assignment has changed, describe new duties

32. Employee's Retirement Coverage CSRS FERS Other, (Specify) _____

| | |
|--|---|
| 33. Was injury caused by third party? | 34. Name and address of third party (include city, state, and ZIP code) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If "No," go to Item 34. | |
| | |

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Name of Supervisor (Type or print) _____

Signature of Supervisor _____ Date _____

Supervisor's Title _____ Office phone _____

Agency Processing of an Occupational Disease Claim

- The agency must ensure that the completed CA-2 is submitted to OWCP within 10 working days, in accordance with 20 C.F.R. 10.110(b).
- The agency should not wait for the submission of supporting evidence before sending the CA-2 to OWCP.
- Narrative statements are required from both the employee and supervisor. All statements should relate the occupational disease to the employee's work or otherwise.
- The agency should issue to the employee two copies of the appropriate checklist, Form CA-35a-h, for the disease claimed.
 - CA-35a Occupational Disease in General
 - CA-35b Hearing Loss
 - CA-35c Asbestos-Related Illness
 - CA-35d Coronary/Vascular Condition
 - CA-35e Skin Disease
 - CA-35f Pulmonary Illness (not Asbestosis)
 - CA-35g Psychiatric Illness
 - CA-35h Carpal Tunnel Syndrome

Tips for CA-2 Form Completion

- Employee Portion -

- The front page is to be completed and signed by employee.
- Check to make sure that the employee enters a specific date into Block 11 and 12. This is the number on reason that delays the creation of the claim.
- The employee must put a specific date for the date of injury and date of notice. This is important for determination of timely filing.
- Check to make sure that the employee clearly indicates the type or nature of injury in Block 14.
- Check to make sure the employee signs and dates the form.



Tips for CA-2 Form Completion

- Agency Portion -

- OWCP Agency Code must be entered in Block 19.
- If the employee is retired or separate, please indicate the last date of employment in Block 31.
- If the employee is retired, you may want to retrieve his/her Official Personnel File (OPF) to verify last date of employment and effective pay rates.
- The Supervisor must sign and date the claim and submit it to the local District Office (not the mail room address in London, KY)
- The Federal Regulations, §10.110, require a Federal employer to complete and transmit Forms CA-1 and CA-2 to OWCP within 10 working days after receipt of notice from the employee



Recurrence of Disability

Recurrence of Disability: This term includes certain kinds of work stoppages which occur after an employee has returned to work after a period of disability.

It includes a work stoppage caused by:

- (a) A spontaneous material change, demonstrated by objective findings, in the medical condition which resulted from a previous injury or occupational illness without an intervening injury or new exposure to factors causing the original illness;
- (b) A return or increase of disability due to an accepted consequential injury; or
- (c) Withdrawal of a light duty assignment made specifically to accommodate the claimant's condition due to the work-related injury. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.



Recurrence of Disability Cont.

It does not include a work stoppage caused by the following factors:

- (a) Termination of a temporary appointment, if the claimant was a temporary employee at the time of the injury;
- (b) Cessation of special funding for a particular position or project (e.g., "pipeline" grants);
- (c) True reductions in force (RIFs), where employees performing full duty as well as those performing light duty are affected;
- (d) Closure of a base or other facility; or
- (e) A condition which results from a new injury, even if it involves the same part of the body previously injured, or by renewed exposure to the causative agent of a previously suffered occupational disease. If a new work-related injury or exposure occurs, Form CA-1 or CA-2 should be completed accordingly.



Form CA-2a Notice of Recurrence

Reset Print

Notice of Recurrence

U.S. Department of Labor
 Employment Standards Administration
 Office of Workers' Compensation Programs



Employee: Complete Part A below.

Employing Agency (Supervisor or Compensation Specialist): Complete Part B.

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0167
 Expires: 05-31-2011

Part A - Employee

| | | | | | |
|---|--|---|--|---|--|
| 1. Name of employee (Last, First, Middle) | | 2. Social Security Number | | 3. OWCP file number for original injury | |
| 4. Date of birth Mo. Day Yr. | | 5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | | 6. Home telephone | |
| 7. Home mailing address (include city, state, and ZIP code) | | | 8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other | | |
| 9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code) | | | 10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also. | | |
| 11. Date and Hour of original injury (mo., day, year) | 12. Date and Hour of recurrence (mo., day, year) | 13. Date and Hour stopped work after recurrence (mo., day, year) | 14. Date and Hour pay stopped after recurrence (mo., day, year) | 15. Date and Hour returned to work (mo., day, year) | |
| <input type="checkbox"/> Medical Treatment Only <input type="checkbox"/> Time Loss From Work | | 17. Date of first medical treatment following recurrence (mo., day, year) | 18. Name and address of treating physician | | |
| 19. After returning to work following the original injury, were you in any way limited in performing your usual duties? (If so, explain. Also state how long these limitations continued.) <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received. | | | | | |
| 21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury. | | | | | |
| 22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence. Arrange for the submission of all relevant medical records. | | | | | |

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the Federal Employees' Compensation Act (FECA), or who knowingly accepts compensation to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

| | |
|---------------------------|---------------------------|
| 23. Signature of employee | 24. Date (mo., day, year) |
|---------------------------|---------------------------|

Form CA-2a
 Rev. Sept. 1996

Part B - Federal Employing Agency

| | | | |
|--|---|--|---|
| 25. Name and address of reporting office (include city, state, and ZIP Code) | | OWCP Agency Code | |
| ZIP Code | | OSHA Site Code | |
| 26. Employee's duty station (street address and ZIP Code) | | 27. Date of first return to FULL-TIME REGULAR duty following original injury | |
| ZIP Code | | Mo. Day Yr. | |
| 28. Regular work hours From: <input type="checkbox"/> a.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> p.m. | | 29. Regular work days <input type="checkbox"/> Sun. <input type="checkbox"/> Tues. <input type="checkbox"/> Thurs. <input type="checkbox"/> Mon. <input type="checkbox"/> Wed. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat. | |
| 30. Date of injury Mo. Day Yr. | 31. Date of recurrence Mo. Day Yr. | 32. Date stopped work after recurrence Mo. Day Yr. Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | |
| 33. Date pay stopped after recurrence Mo. Day Yr. | 34. Dates COP paid for recurrence From Mo. Day Yr. To | | 35. Date returned to work after recurrence Mo. Day Yr. Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |
| 36. Did the employee receive medical care at an agency facility if so, please attach all relevant medical records. <input type="checkbox"/> Yes <input type="checkbox"/> No | | 37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, provide full details. | | | |
| 39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details. | | | |
| 40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information. | | | |
| 41. Signature of Supervisor or Compensation Specialist (at time of recurrence) | | | |
| 42. Title | 43. Work phone | 44. Date (mo., day, year) | |

A supervisor or compensation specialist who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

Form CA-2a Notice of Recurrence

Part C - Employee

(To be completed by the employee if not employed with the Federal Government at the time of the claimed recurrence)

1. For all jobs held since you left the job held when the initial injury occurred, list the full name and address of your employers, and the inclusive dates of employment. Include any self-employment.

[Redacted area for item 1]

2. For all jobs listed in item 1 above, provide your job title, nature of duties performed, number of hours worked per week and rate of pay.

[Redacted area for item 2]

3. Describe all educational and/or vocational training received since your original injury. Include any licenses or certificates earned.

[Redacted area for item 3]

4. What was your rate of pay if you stopped work due to this recurrence?

\$ [Redacted] per [Redacted]

5. Do you claim compensation for lost wages? Yes No

If so, for what period? [Redacted] through [Redacted]

6. Have you received any pay during the period claimed? Yes No

If so, how much and from what source? [Redacted]

NOTE: The following statement is made in accordance with the Privacy Act of 1974 (5 USC §552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is Section 8101, et seq., Title 5 to the U.S. Code. Furnishing the requested information is required to obtain and retain benefits in order to ensure the timely filing of a notice of recurrence of disability and claim for benefits under the Federal Employees' Compensation Act (FECA). The information will be used to initiate and assist in the adjudication of the claim and failure to provide the information may prevent or delay claim processing. Additional disclosures of this information may be to: third parties in litigation; employing agencies; various individuals and organizations providing related medical rehabilitation and other services; insurance plans which may have paid related bills; labor unions; various law enforcement officials; other federal, state and local agencies (including the GAO and IRS) as appropriate; data processing contractors to the Department of Labor; debt collection agencies and credit bureaus.

7. Signature of Employee

8. Date (mo., day, year)

INSTRUCTIONS FOR COMPLETING FORM CA-2a NOTICE OF RECURRENCE

DEFINITION OF RECURRENCE

A **Recurrence of the Medical Condition** is the documented need for additional medical treatment after release from treatment for the work-related injury. Continuing treatment for the original condition is not considered a recurrence.

A **Recurrence of Disability** is a work stoppage caused by:

- A spontaneous return of the symptoms of a previous injury or occupational disease without intervening cause;
- A return or increase of disability due to a consequential injury (defined as one which occurs due to weakness or impairment caused by a work-related injury); or
- Withdrawal of a specific light duty assignment when the employee cannot perform the full duties of the regular position. This withdrawal must have occurred for reasons other than misconduct or non-performance of job duties.

IF A NEW INJURY OR EXPOSURE TO THE CAUSE OF AN OCCUPATIONAL ILLNESS OCCURS, AND DISABILITY OR THE NEED FOR MEDICAL CARE RESULTS, A NEW FORM CA-1 OR CA-2 SHOULD BE FILED. This is true even if the new incident involves the same part of the body as previously affected.

INSTRUCTIONS FOR EMPLOYEE

- Review the definition of "recurrence" given above. If you believe that you have sustained a recurrence, complete Part A of this form. Attach a separate sheet of paper if needed to provide full details.
- If you worked for the Federal Government at the time of the recurrence, submit Form CA-2a to your employing agency. If you no longer work for the Federal Government, complete Parts A and C of this form and submit all materials directly to the Office of Workers' Compensation Programs (OWCP).
- If you are claiming a recurrence of disability for an occupational illness, or if all 45 days of continuation of pay (COP) have been used, you may claim wage loss on Form CA-7. The OWCP will pay compensation if the claim is approved.
- Arrange for your attending physician to submit a detailed medical report. The report should include: dates of examination and treatment; history as given by you; findings; results of x-ray and laboratory tests; diagnosis; course of treatment; and the treatment plan. The physician must also provide an opinion, with medical reasons, regarding causal relationship between your condition and the original injury. Finally, the physician should describe your ability to perform your regular duties. If you are disabled for your regular work, the physician should identify the dates of disability and provide work tolerance limitations.
- If other physicians treated you after you returned to work following the original injury, obtain similar medical reports from each of them.

INSTRUCTIONS FOR EMPLOYING AGENCY

- After the employee has completed Part A, promptly complete Part B and submit the form to OWCP, unless the claimant is still receiving continuation of pay (COP); the recurrence is for medical care only and the claim is still open; or the claimant is currently requesting neither wage-loss compensation nor payment of medical expenses. In these instances, file the form in the Employee Medical Folder.
- If COP is being paid, obtain medical evidence using Form CA-17, "Duty Status Report", as often as circumstances indicate.
- For a recurrence less than 90 days after the employee's return to work following the original injury, you may authorize required medical care using Form CA-16. For a recurrence more than 90 days after the employee's return to work, OWCP must authorize further medical care.
- For recurrences of disability which continue after the 45 days of COP have expired or which involve occupational illness, instruct the employee to file Form CA-7.

Public Burden Statement

Completion of this collection of information is estimated to vary from 15 to 45 minutes per response with an average of 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room 5-3225, 200 Constitution Avenue, N.W., Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE OFFICE SHOWN ABOVE.

Agency Processing of Claims for Recurrence

- The agency must ensure that the injured worker completes Section 1 through 24 on Part A along with sections 1 through 7 on Part C. Failure to ensure that the form is properly completed may delay the processing of the form.
- The agency is responsible for the completion of Part B of the form and submission to the OWCP District Office.
- The agency should not wait for the submission of supporting medical evidence before sending the CA-2a to the OWCP District Office.
- If you are unable to immediately provide narrative statements as requested in Part B, Section 38 through 40, please do not delay the filing of the claim and submit the form indicating that comments/ statements will follow.
- The complete form should be forwarded to the appropriate OWCP District Office and not the Central Mail Room in London, KY.



What if the wrong form is submitted?

- A CA-1 which describes an occupational disease can be created as a new CA-2 and COP will be denied
- A CA-2a which describes a new injury can be created as a new case
- Encourage injured worker to file the correct one but ultimately DOL will make decision



Claiming Compensation for Loss of Wages

- In order to claim loss of wages, leave repurchase, loss of premium pay or Schedule Award for an accepted work injury, the injured worker will need to complete a Form CA-7 and submit it to the agency for completion and submission to the OWCP District Office.
- The form should be submitted to OWCP within 7 calendar days following completion by injured employee.
- For Schedule Awards, the CA-7 may also be submitted when the employee reaches maximum medical improvement and has sustained a permanent partial impairment as a result of the work injury.



Form CA-7 Claim for Compensation

Claim for Compensation

Reset Print

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



SECTION 1 EMPLOYEE PORTION

a. Name of Employee Last First Middle OMB No. 1215-0103 Expires: 09/30/2011

b. Mailing Address (Including City, State, ZIP Code) c. OWCP File Number

d. Date of Injury Month Day Year e. Social Security Number

E-Mail Address (Optional) f. Telephone No./FAX No.

SECTION 2 Compensation is claimed for:

a. Leave without pay Inclusive Date Range From To Intermittent? Yes No Go to Section 3

b. Leave buy back Yes No Go to Section 3, and Complete Form CA-7b

c. Other wage loss; specify type, such as downgrade, loss of night differential, etc. Yes No Go to Section 3 Type: Intermittent, complete Form CA-7a, Time Analysis Sheet

d. Schedule Award (Go to Section 4)

SECTION 3 You must report all earnings from employment (outside your federal job); include any employment for which you received a salary, wages, income, sales commissions, piecework, or payment of any kind during the period(s) claimed in Section 2. Include self-employment, involvement in business enterprises, as well as service with the military forces. Fraudulent concealment of employment or failure to report income may result in forfeiture of compensation benefits and/or criminal prosecution. **Have you worked outside your federal job for the period(s) claimed in Section 2?**

Yes Name and Address of Business: Name Address City State ZIP Code

No Go to Section 4 Name Address City State ZIP Code

Dates Worked: Type of Work:

SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury? Yes No

Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"

Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim? Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s) No - Complete Section 7

SECTION 5 List your dependents (including spouse):

| Name | Social Security # | Date of Birth | Relationship | Living with you? |
|------|-------------------|---------------|--------------|---|
| | | | | Yes No |
| | | | | <input type="checkbox"/> <input type="checkbox"/> |
| | | | | <input type="checkbox"/> <input type="checkbox"/> |

For dependents not living with you, complete items a and b below.

a. Are you making support payments for a dependent shown above? Yes No If Yes, support payments are made to: Name Address City State ZIP Code

b. Were support payments ordered by a court? Yes No If Yes, attach copy of court order.

SECTION 6 a. Was/Will there be a claim made against a 3rd party? Yes No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

Yes Claim Number Full Address of VA Office Where Claim Filed Nature of Disability and Monthly Payment

No

c. Have you applied for or received payment under any Federal Retirement or Disability law?

Yes Claim Number Date Annuity Began Amount of Monthly Payment Retirement System (CSRS, FERS, SSA, Other) CSRS FERS SSA Other

No

SECTION 7 I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain compensation as provided by the FECA, or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature Date (Mo., day, year)

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

SECTION 8 Show Pay Rate as of Date of Injury: Base Pay \$ per Additional Pay Type \$ per Additional Pay Type \$ per Additional Pay Type \$ per

Grade: Step: Date Employee Stopped Work: Type \$ per Type \$ per Type \$ per

Grade: Step: Date Employee Stopped Work: Type \$ per Type \$ per Type \$ per

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarter (QTR), etc. (List each separately)

SECTION 8 a. Does employee work a fixed 40-hour per week schedule? Yes No

1. If Yes, circle scheduled days: S M T W TH F S

2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.

FOR EXAMPLE ONLY

| | S | M | T | W | TH | F | S |
|--------------------------|---|---|---|---|----|---|---|
| WEEK 1 From 5/14 to 5/20 | 8 | 4 | 8 | 6 | 6 | | |
| WEEK 2 From 5/21 to 5/27 | 8 | | 6 | 6 | 4 | | |

WEEK 1 From to S M T W TH F S

WEEK 2 From to S M T W TH F S

b. Did employee work in position for 11 months prior to injury? Yes No

If No, would position have afforded employment for 11 months but for the injury? Yes No

SECTION 10 On date pay stopped, was employee enrolled in:

a. Health Benefits under the FEHBP? No Yes Code c. Optional Use Insurance? No Yes Class

b. Basic Life Insurance? No Yes d. A Retirement System? No Yes Plan (Specify CSRS, FERS, Other)

SECTION 11 Continuation of Pay (COP) Received (Show inclusive dates): From To Intermittent? Yes - Complete Time Analysis Sheet, Form CA-7a No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:

Sick Leave From To Intermittent? Yes No If intermittent, complete Form CA-7a, Time Analysis Sheet.

Annual Leave From To Yes No

Leave without Pay From To Yes No If leave buy back, also submit completed Form CA-7a.

Work From To Yes No

SECTION 13 Did employee return to work? Yes No

If Yes, date: If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties? Yes No If No, explain:

SECTION 14 Remarks:

SECTION 16 An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.

Signature Title Date / / (Agency Official)

Name of Agency Date Claim Form Received from Employee / /

If OWCP needs specific pay information, the person who should be contacted is: Name Title Telephone No. Fax No. E-Mail Address

Form CA-7 Claim for Compensation

INSTRUCTIONS FOR COMPLETING FORM CA-7

If the employee does not qualify for continuation of pay (for 45 days), the form should be completed and filed with the OWCP as soon as pay stops. The form should also be submitted when the employee reaches maximum improvement and claims a schedule award. If the employee is receiving continuation of pay and will continue to be disabled after 45 days, the form should be filed with OWCP 5 working days prior to the end of the 45-day period.

The CA-7 also should be used to claim continuing compensation, when a previous CA-7 claim has been made.

Collection of this information is required to obtain a benefit and is authorized by 20 C.F.R. 10.105.

EMPLOYEE (or person acting on the employee's behalf) - Complete sections 1 through 7 as directed and submit the form to the employee's supervisor.

SUPERVISOR (or appropriate official in the employing agency) - Complete sections 8 through 15 as directed and promptly forward the form OWCP.

EXPLANATIONS - Some of the items on the form which may require further clarification are explained below:

| Section Number | Explanation |
|---|---|
| 2d. Schedule Award | Schedule awards are paid for permanent impairment to a member or function of the body. |
| 5. List your dependents | Your wife or husband is a dependent if he or she is living with you. A child is a dependent if he, or she either lives with you or receives support payments from you, and he or she: 1) is under 18, or 2) is between 18 and 23 and is a full-time student, or 3) is incapable of self-support due to physical or mental disability. |
| 6a. Was/will there be a claim made against 3rd party? | A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer who gave improper instructions for the use of a chemical to which an employee is exposed, could all be considered third parties to the injury. |
| 8. Additional Pay | "Additional Pay" includes night differential, Sunday premium, holiday premium, and any other type (such as hazardous duty or "dirty work" pay) regularly received by the employee, but does not include pay for overtime. If the amount of such pay varies from pay period to pay period (as in the case of holiday premium or a rotating shift), then the total amount of such pay earned during the year immediately prior to the date of injury or the date the employee stopped work (whichever is greater) should be reported. |
| 11. Continuation of pay (COP) received | If the injury was not a traumatic injury reported on Form CA-1, this item does not apply. |
| 14. Remarks | This space is used to provide relevant information which is not present else- where on the form. |

The authority for requesting this information is 5 U.S.C. 8101 et seq. The information will be used to determine entitlement to benefits. Furnishing the requested information is required for the claimant to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974, as amended (5 U.S.C. 552a). Failure to furnish the requested information may delay the process, or result in an unfavorable decision or a reduced benefit.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 13 minutes per response including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, please send them to the Department of Labor, Office of Workers' Compensation Programs, Room 9-3229, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U. S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other healthcare providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax identifying number (TIN) on this form is mandatory. The SSN and/or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Tips for CA-7 Form Completion

- Agency Portion -

- Be sure to correctly enter the pay rate information in Section 8. It is important to include any premium pays that the injured employee was earning at the time of injury and/or disability.
- Premium pays include, but are not limited to: night and Sunday differential, dirty work pay, holiday pay, administratively uncontrollable overtime (AUO), quarters allowance, National Guard Service, locality and hazardous duty pay
- Regular overtime should not be included in the payrate
- Be sure to accurately represent the employees work schedule in Section 9.
- Report any health benefits, life insurance, or optional life insurance deduction and retirement system of the employee in Section 10. Please include last date of deduction.
- Please provide a contact name and phone number in Section 16 in case the claims examiner needs additional information.

Leave Repurchase

- When an employee elects to use sick or annual leave during the period of disability, he or she may later, with the concurrence of the employing agency, claim compensation for the period of disability and "buy back" the leave used. Form CA-7b is required as an attachment to Form CA-7 to request Leave Buy Back (LBB). CA-7a is an optional form for use when leave is used intermittently.
- The employee is responsible for making payment to the agency for the difference between the amount paid by OWCP to the agency and the amount paid for the leave.



Form CA-7b Leave Buy Back

Leave Buy Back (LBB) Worksheet/ Certification and Election

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee Statement - Please carefully read instructions on pages 3 and 4 before filling out this form.

| | |
|--|----------------------|
| A. Name of Employee: (Last, First, Middle) | B. OWCP File Number: |
| C. Social Security Number: | |

D. Period for Which Compensation is Claimed to Repurchase Leave
From: ____ / ____ / ____ To: ____ / ____ / ____

I. Agency Estimate of FECA Entitlement:

A. Weekly Base Payrate (excluding overtime)

- Date of Injury ____ / ____ / ____ \$ _____
- Date Stopped Work ____ / ____ / ____ \$ _____
- Date of Recurrence ____ / ____ / ____ \$ _____

Enter the greatest amount and the effective date of that amount on line 1. 1. _____
____ / ____ / ____
(effective date)

B. Additions to Base Pay:

If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 * by 52.

- Night Differential 2. _____
- Sunday Premium 3. _____
- Subsistence/Quarters 4. _____
- Other (Specify) 5. _____

C. Total Weekly Payrate (Add lines 1 through 5) 6. _____

D. Compensation Rate (Circle either 2/3 or 3/4) 7. 2/3 3/4

E. Total Hours Claimed on CA-7a 8. _____

F. Total Hours Worked per Week 9. _____

G. Formula (for FECA Entitlement)

$$\$ \frac{\text{Weekly Payrate (See Line 6)}}{\text{Hours (See Line 9)}} \times \frac{\text{Compensation Rate (See Line 7)}}{\text{Hours (See Line 9)}} \times \text{Hours (See Line 8)} + \text{Hours (See Line 9)} = 10. \$ \underline{\hspace{2cm}}$$

II. Agency Certification:

H. Total Amount Due Agency to Repurchase Leave 11. \$ _____

I. Estimate of FECA Entitlement (See Line 10) 12. \$ _____

J. Balance Due Agency from Employee (Line H minus Line I) 13. \$ _____

I hereby certify that the above is consistent with agency payroll records.
The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

(Signature of Agency Official) (Title/Position)

Phone No. _____ Date Signed: _____

Employing Agency Address for Check: _____

III. Employee Claim:

_____ K. I hereby elect not to repurchase the leave used at this time.

_____ L. I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my Job-related Injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above, OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

(Signature of Claimant) (Date Signed)

Form CA-7b Leave Buy Back

Instructions Form CA-7B Leave Buy Back Worksheet

This form is intended to accompany Form CA-7, *Claim for Compensation*, when the employee is claiming leave buy back.

Things to Know About Leave Buy Back:

When an employee uses their sick or annual leave to cover an injury-related absence from work, they may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 3/4 with 1 or more dependents. The agency pays leave at 100% of salary. In order for leave to be reinstated, the employee must refund to the agency the difference between the compensation entitlement and the total amount of leave paid by the agency.

The employee's pay status must be changed to LWOP in order for compensation to be paid. Leave is not earned while in LWOP. Also, contributions to the Thrift Savings Plan (TSP) are not made during LWOP. Therefore, the repurchase of leave may result in a reduction in an employee's leave and/or TSP balance. Consult your personnel office to learn how the change to LWOP would effect you.

When a Leave Buy Back (LBB) payment is made during the same year that leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. Where leave repurchase is not completed during the same year in which leave is used, the employee may not adjust their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Further questions regarding tax implications of LBB should be addressed to the IRS.

A claimant may not repurchase leave used during a period they were eligible for COP.

When disability does not exceed 14 days beyond the COP period, 3 day LWOP must be charged before compensation can be paid. If leave was used for this period, compensation can not be paid for the 3 days, but the claimant will have to pay back leave paid during the 3 days to repurchase the leave.

Instructions to the Employee:

Please submit a claim for a minimum of 10 hours unless no further claim is anticipated. Medical documentation must be provided for all dates claimed.

1. Complete the Form CA-7 for the dates claimed. Where more than one continuous period of leave is claimed, complete Form CA-7a following the instructions for completing that form.
2. Submit the completed CA-7, CA-7a, if appropriate, and medical documentation for all dates claimed, to your agency official. If there are discrepancies, try to reconcile the difference with your agency official prior to submission of the claim.
3. The agency official will provide you with an estimate of worker's compensation benefits due, the total amount owed the agency in order for the leave to be restored, and the amount you must pay the agency. Using this information, determine whether you wish to repurchase your leave, and check the appropriate block. If you choose to repurchase the leave, you will be required to pay to the agency the difference between the compensation due and the amount owed to the agency.
 - a. If the total amount of FECA benefits estimated by the agency is not more than 10% above the amount determined by OWCP to be accurate, OWCP will process a payment for all hours supported by medical evidence. If medical evidence supports some, but not all of the hours claimed, payment will be made for the approved hours. You may submit a new claim with medical support for the additional hours.
 - b. If the total amount of FECA benefits estimated by the agency is more than 10% above the correct amount, OWCP will not process the payment. Instead, the Office will offer you a new election with the correct amount of FECA benefits payable.

Instructions to the Agency:

Items A through D (top of form) are self-explanatory.

Section I. Agency Estimate of FECA Entitlement:

Item A: Enter all three pay rate types and effective dates if applicable. Choose the greatest amount of the three and enter the amount and effective date in Line 1. A recurrent pay rate should only be used if: (1) the employee stops work more than 6 months following their first return to regular, full time duty and (2) the loss of time is due to disability rather than medical examinations or treatment.

For unusual situations, please refer to Payrate Desk Aid.

Item B: If the employee works a regular schedule, enter the differentials earned weekly. If an irregular schedule, give the total amount earned for the year prior to the date in Line 1 divided by the number of weeks worked in that year.

Please refer to Payrate Desk Aid for guidance on inclusions and exclusions. If in doubt, consult a Claims Examiner.

Item C: Add lines 1 through 5 and enter the total in Line 6.

Item D: Circle the appropriate rate: 2/3 for employees without dependents; 3/4 with dependents. Dependents include: spouse; children under 18 living with or supported by the employee; children under 23 in school full time; children over 18 incapable of self support; and parents wholly supported by the employee.

Item E: Enter the total hours claimed, from Form CA-7a.

Item F: Enter the total hours in the employee's normal work week.

Item G: Formula for FECA Entitlement. Use this formula to calculate estimate of FECA entitlement and enter the result in Line 10.

Example of computation: The weekly pay from line 6 is \$574.00. The employee is married, works 40 hours a week, and is claiming 82 hours of leave. FECA entitlement is calculated as follows:

$$\$574.00 \times 3/4 \times 82 \text{ hours} \div 40 \text{ hours} = \$682.52$$

Section II. Agency Certification:

Item H & I are self-explanatory. For Line J, subtract Line I from Line H.

Sign and date, and advise the employee of the amount they owe to the agency.

Section III. Employee Claim:

If the employee elects not to repurchase the leave, retain the form in the agency files. If the employee elects to repurchase the leave, submit all claim documents (CA-7, CA-7a & CA-7b) plus any medical documentation to OWCP for processing.

The Basic Elements of a Claim



The 5 Basic Elements

- **1. Time To Submit Claim**
 - Continuation of Pay.....30 Days
 - Compensation (inc. medical)...3 Years
- **2. Civil Employee**
- **3. Fact Of Injury**
- **4. Performance Of Duty**
- **5. Causal Relationship**



Five Requirements of Every Claim

- **Time**
 - Must file within three years of injury or awareness of the injury being work-related, OR:
 - If agency has actual knowledge of injury within thirty days, then claim may be filed anytime
 - **Civil Employee**
 - Does not cover active military
 - Does cover volunteers for U.S. Government
 - **Fact of Injury**
 - Injury must be substantiated but not necessarily witnessed
 - Medical Diagnosis from physician must be present
- 

Statements/Comments

- In cases involving exposure or specific incidents of employment, the agency may be asked to comment on the injured workers' statements
- They must provide accurate and complete responses, even if just to say that the agency agrees with the allegations
- The claimant must also provide this, if they do not, they have not established that an injury occurred.



Five Basics continued:

- **Performance of duty**
 - **Injury arose “in the course of employment”**
 - **Generally, happened at work**
 - **“Incidental to Employment” is covered: falls in bathroom, wet floors, coffee burns, falls on stairs**
 - **Injury also must arise “out of the employment”**
 - **Related to actual duties, not administrative matters**
- **Causal Relationship**
 - **Medical evidence must state that diagnosis is causally related to employment. Rationale required in complex cases**



A note about property vs. premises (Performance of Duty)

- **Generally workers are covered once they are in the office, including the break room and bathroom**
- **Parking lot injuries are generally not covered if the U.S. Government does not own or control the lot**
- **DFEC will ask for this information if not on file**
- **Conferences**



Diversions from Duty and TDY

- Generally workers are covered while traveling, while at the hotel, and while going to eat or to meetings/training
- Workers who drive as part of their work are covered as long as they do not deviate from their route for personal reasons
- Rural Postal Carriers who use their own vehicle are covered as soon as they enter their vehicle until they return home



Pre-existing Conditions

- If a worker's injury is an aggravation of a pre-existing condition, benefits are the same as for a brand new injury
- However, once the aggravation resolves, benefits are no longer payable
- Can be traumatic or occupational
- Physician should be clear about what aspects of the patient's condition is pre-existing and what has been aggravated
- History of prior conditions and pertinent medical records are required
- The burden to establish the claim is greater as the injured worker has to show that the preexisting condition materially worsened.



Three Statutory Exclusions

Where the questions of “fact of injury” and “performance of duty” are decided affirmatively, consideration must also be given to the question of whether the injury or death was caused by (1) the willful misconduct of the employee, (2) by the employee’s intention to bring about the injury or death of self or of another, or (3) if intoxication of the injured employee was the proximate cause of the injury or death.

Each of the exclusions will be discussed individually.



Three Statutory Exclusions

Willful Misconduct

- The question of deliberate willful misconduct arises when at the time of the injury the employee was violating a safety rule, regulation, order, or law. Because safety rules have been established for the protection of the worker rather than the employer, simple negligent disregard of such rules is not sufficient to deprive an employee or beneficiary of entitlement to compensation.
- Disobedience of such orders may destroy the right to compensation, only if the disobedience is deliberate and intentional as distinguished from careless and heedless.
- Willful misconduct is a statutory exclusion to compensation benefits and appears in the FECA at 5 U.S.C. 8102(a) (1). However, the employee enjoys an affirmative defense to such a finding. This means that the burden is on the office to establish that there was misconduct, that it was will full, and that the willful misconduct resulted in injury.

Three Statutory Exclusions

Employee's intention to bring about injury or death to self or another

- Where it appears that the employee brought about his/her own injury or death, or that of another, the intent must be established. If the factual and medical evidence show that the employee was not in full possession of his/her faculties, the injury may be compensable. Thus, suicide may be compensable if the job-related injury (or disease) and its consequences directly caused a mental disturbance or physical condition which produced a compulsion to commit suicide and prevent an employee from exercising sound discretion or judgment so as to control that compulsion.



Three Statutory Exclusions

Intoxication

- In any case involving intoxication (whether by alcohol or illegal drugs) the record must establish the following: (a) the extent to which the employee was intoxicated at the time of the injury, and (b) the particular manner in which the intoxication caused the injury.
- It is not enough merely to show that the employee was intoxicated. It is OWCP's burden to show that the intoxication caused the injury. An intoxicant may be alcohol or any other drug.
- It must be shown that the intoxication proximately caused the injury.
- This requirement does not, however, provide agency personnel with any additional authority to test employees for drug use beyond that which may exist under other statutes or regulations.



Can an agency challenge a claim?

- Yes, but they cannot refuse to complete and process any paperwork
- Agency has only fourteen calendar days to submit CA-1's and CA-2's to DFEC
- Agency has only seven calendar days to submit CA-7's to DFEC
- Claimant and agency should keep a copy of everything sent to DFEC
- Challenging a claim and “Controverting” a claim are not the same thing. You challenge the merits of the claim and “controvert” payment of continuation of pay.

Withdrawal of a Claim



Withdrawal of a Claim

- Added in the January 4, 1999 Regulation changes.
- The injured worker has the right to withdraw claims for both traumatic and occupational disease injuries providing that the claim has not been formally adjudicated.
- The same right and rules are extended to survivors who have filed a claim for benefits.
- All requests for withdrawal of a claim must be in writing.



Continuation of Play



TOPICS TO BE COVERED

- COP DEFINED
- REQUIREMENTS FOR COP
- CONTROVERTING COP - THE 9 VALID REASONS
- CONTROVERTING COP - OTHER REASONS
 - Investigating Entitlement to COP
 - Submitting Statements
- TERMINATING COP
- COUNTING COP DAYS
- DETERMINING THE COP PERIOD
- THE FINAL WORD...



Continuation of Pay (COP)

The 1974 amendments to the FECA program introduced the concept of Continuation of Pay (COP).

COP is simply defined as a continuation of regular pay for up to 45 calendar days of wage loss due to disability and/or medical treatment after a **traumatic injury**.

The intent of COP is to avoid interruption of pay while the claim is adjudicated. It is subject to usual deductions from pay, such as income tax, retirement, allotments, etc.

An employee's decision to use leave over COP is **not** irrevocable. Employee who uses leave can later elect COP within one year of the leave usage or date the case is accepted by OWCP, whichever is later.



COP Eligibility and Entitlement

Eligibility

- Must be a traumatic injury
- Must file the CA-1 (or notice of injury) within 30 days of the date of injury
- Must begin losing time from work within 45 days of the injury.

Entitlement

- The 45 days during which pay may be continued are calendar days, not work days, 20 C.F.R. 10.215.



CONTROVERTING COP



Controverting COP vs. Challenging the Claim

- These are two completely different issues
- Unless one of the nine valid reasons to not pay COP exists, EA must pay it
- Agency may pay COP but challenge the claim itself
- Agency may controvert COP but not the claim itself
- Agency may controvert COP for one of the nine reasons AND challenge the claim itself



CONTROVERTING COP

- *20 C.F.R. 10.221* states that an employing agency may controvert a claim. Controvert means to challenge or deny the validity of the claim.

There are the nine (9) reasons for controverting (not paying) COP. Do not pay COP if one of these reasons applies in the case.

Agency should indicate “controversion” on the CA-1 claim form and specify which reason(s) applies.



9 Reasons an Agency May Controvert COP

The agency may terminate or not begin COP only if the controversion is clearly based on one of the nine categories listed below. It should be remembered that OWCP makes all final determinations and can overturn the agency controversion and require that COP be paid. The nine mandatory categories for controversion are listed below with an explanation following each:

1. Disability results from an occupational disease or illness.
2. The employee is excluded by 5 USC 8101 (1) B or E. This section of the law deals mostly with volunteers (unpaid) to the federal government.
3. The employee is neither a citizen nor a resident of the United States or Canada.
4. The injury occurred off the employing agency's premises and the employee was not involved in official "off premises duties".

9 Reasons an Agency May Controvert COP

5. The injury was caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or was proximately caused by employee's intoxication.
6. The injury was not reported within 30 days following the injury.
7. Work stoppage first occurred more than 45 days following the injury.
8. The employee initially reports the injury after his or her employment has been terminated.
9. The employee is enrolled in the Civil Air Patrol, Peace Corps, Job Corps, Youth Conservation Corps, Work Study Programs or other similar group.



CONTROVERTING COP (CONT'D)

OTHER REASONS

- If you believe the employee is not entitled to COP for any other reason, you should advise OWCP on the CA-1 claim form that your agency is “controverting” paying COP. You should also include a narrative statement and evidence to support your controversion. You must continue to pay COP until advised otherwise by OWCP.
- You will probably encounter situations that may raise questions about an employee’s entitlement to COP.



CONTROVERTING COP (CONT'D)

Examples of Situations That May Require Further Investigation

- 1) Employee did not report injury immediately (several days pass after the injury) nor did he or she mention it to anyone.
- 2) Employee did not seek medical treatment within several days of the injury.
- 3) Employee could not describe how injury occurred; or when injury occurred; or how injury occurred.
- 4) Employee's statement is not consistent with surrounding facts.
- 5) Employee told co-worker injury occurred at home or on another job.
- 6) First medical history given by employee is not consistent with what employee reported on the CA-1 claim form



INVESTIGATING ENTITLEMENT TO COP



INVESTIGATIONS

- If you believe the employee does not meet the requirements for COP, you should “controvert” COP. This puts the “burden” on the agency to explain why the employee is not entitled to COP and to submit sufficient evidence to support the agency’s controversion.

INVESTIGATIONS (CONT'D)

SUBMIT OBJECTIVE EVIDENCE: FACTUAL AND MEDICAL

FACTUAL:

- *Time sheets or time cards*
- *Agency's accident investigation report*
- *Credible Witness statements*
- *Counseling reports - **This is particularly important if willful misconduct is the basis of the controversy.***
- *Air quality test reports*
- *Photographs*
- *Police report*

MEDICAL:

- *First medical history given by employee*
- *Other medical reports*

FACTUAL EVIDENCE

1. **Witness statements:** Witness Statements, Reports of Investigation, Incident Reports, etc..
2. **Written explanations:** Explanations of specific equipment, machines, operations, etc...



INVESTIGATIONS (CONT'D)

CREDIBLE WITNESS STATEMENTS:

In order for a witness statement to be considered credible, the person submitting the statement must have direct knowledge of the claimed work injury. Hearsay does not have any evidentiary value.

The statement must clearly report what the person “witnessed”, including any oral statements made by the injured worker. If the witness statement contradicts the injured worker’s claim, the statement provided should be as clear and concise as possible.

The Office of Worker’s Compensation Program will evaluate all statements that are submitted in reference to a specific claim. Please remember that any statement submitted is available to the injured worker or his or her authorized representative.



INVESTIGATIONS (CONT'D)

LACK OF WITNESS STATEMENTS:

An agency's statement such as "injury not witnessed" is not sufficient for OWCP to advise you to stop paying COP. *Under the FECA, an injury does not have to be witnessed.* Unless the agency submits evidence demonstrating that injury could not have occurred where employee claimed injury occurred, or when it occurred, or how it occurred, OWCP accepts what the employee reported as true.

INVESTIGATIONS (CONT'D)

Providing Written Explanations:

- Be brief and concise. (Try to keep it to no more than one page. If more than one page, ask yourself if you are trying to adjudicate the claim.)
- First sentence should be a statement that agency does not believe employee is entitled to COP. Then, go on to
 - explain reasons why (e.g., why injury could not have occurred at time employee stated it happened)
 - attach evidence to support controversion
- Date and sign it.
- Provide a telephone number where claims examiner can call you if s/he has questions or needs clarification.



Importance of Submitting Statements

Although the claims examiner will probably allow your employee to receive COP while the claim is under development at OWCP, your statement and evidence will be used to properly adjudicate the claim.

If a CA-1 claim for benefits is denied, the COP is also denied. The employee can have the COP changed to sick/annual leave or have it declared an overpayment by the agency.



NO TIME LOST CASES AND CONTROLLING COP



“NO TIME LOST” (NTL) CASES AND CONTROVERTING COP

Traumatic Injury cases that meet the following four requirements remain in a “unadjudicated status” at OWCP and medical bills will be paid until they exceed **\$1500.00** or a CA-7, Claim for Compensation, is filed by the employee.

- 4 Requirements:
- 1) Traumatic Injury
 - 2) Claim not controverted by agency
 - 3) Medical expenses under \$1500.00
 - 4) No CA-7, Claim for Compensation, filed

If you think a claim should be controverted say so, or medical bills will automatically be paid on the case.



TERMINATING COP



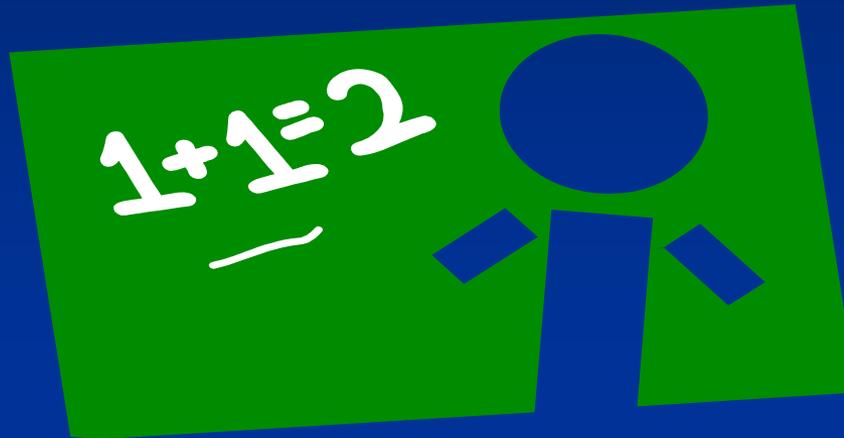
Termination of COP

Where the employer has paid COP, it may be stopped only when at least one of the following occurs:

- Medical evidence is not received within 10 calendar days after the claim is submitted
- Medical evidence shows that the employee is not disabled from his/her regular position
- Medical evidence shows that the employee is capable of performing light duty, and the employee has refused a suitable written job offer
- Employee returns to work with no loss of pay
- Employee's period of employment expires
- OWCP directs the employer to stop
- COP has been paid for 45 days



COUNTING COP DAYS



Beginning of COP Period

If the employee has stopped work due to the disabling effects of a traumatic injury, the period begins with the first full day or shift of the disability, provided that it begins within 45 days of the injury.

The employing agency will keep the employee in a pay status or grant administrative leave for any fraction of a day or shift lost on the date of injury, with no charge to the 45-day period. Only if the injury occurs before the beginning of the work day may the date of injury be charged to COP.



Portion of Day

If the employee stops work for a portion of a day or shift other than the day of injury, such day or shift will be counted as one calendar (full) day for purposes of tolling the 45 days. The employee, however, is not entitled to COP for the entire day or shift if work is available for the remaining partial shift. For instance, an employee who is scheduled to work an eight-hour day and who must lose three hours in order to receive physical therapy for the effects of the injury will be charged COP as follows:

If work is available for the rest of the day, the employee is entitled to three hours of COP for that day or shift even though one full calendar day will be charged against the 45-day limit. If the employee is absent for all or any portion of the remaining five hours, the absence would be covered by leave, LWOP, AWOL, etc., as appropriate, since absence beyond the time needed to obtain the physical therapy cannot be charged to COP.

If the employing agency does not allow the employee to work a partial shift, the employee is entitled to COP for the entire shift. For example, rural letter carriers are often not allowed to work partial shifts due to the nature of their work. Therefore, if they obtain medical care for employment-related injuries during work hours, they will likely be absent for the entire shift, and will therefore be entitled to COP.

Leave Use During COP Period

- If an employee uses sick or annual leave immediately after the injury, these days are counted as part of the 45 day eligibility period. An employee cannot use sick or annual leave plus 45 COP days.
- The employee's decision to use leave over COP can be changed within one year of the leave usage or date case was accepted, whichever is later.



End of Period

The claimant's entitlement to COP must begin within 45 days of the date of injury, whether its use results from disability due to the original injury or the need for medical care.

However, where continuing days of COP bridge the 45th day, pay may be continued until entitlement is exhausted or the claimant returns to work. This situation arises when the claimant experiences a recurrence of disability during the COP period (within 45 days of the first return to work following the injury).



Counting COP Entitlement - Example

- Worker is injured on 6/1
- Disability starts on 6/2
- Worker returns to full time limited duty on 6/14.
- Disability returns on 6/22 and is continual

June

| | | | | | | |
|----|-----------|----------------------|----|----|----|----|
| | | 1 DOI | 2 | 3 | 4 | 5 |
| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 RTW | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 Disabled Again | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | | | |

Counting COP Entitlement - Example Cont

July

| | | | | | | |
|----|----|----|----|----|----|-----------------------|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 Last day of COP |
| 25 | 26 | 27 | 28 | 29 | 30 | 31 |

Counting Days

- Used 12 days COP for 6/2 – 6/13
- 6/14 is first RTW date
- 6/22 – disability resumes and is continuous
- Can use balance of 33 days of COP because continual disability is within 45 days of first RTW. The 45th of COP is 7/24

THE FINAL WORD...

OWCOP is the final arbiter on COP issues.





RETURNING INJURED EMPLOYEES TO MODIFIED DUTY JOBS



Medical Evidence – Burden of Proof

- (1) The employee has the burden to provide prima facie evidence to establish the initial claim of a job related injury and disability. The cases in our discussion of reemployment have been accepted as having an injury sustained during federal employment and resulted in a period of total disability with continued medical restrictions. In these cases the burden of proof has shifted to the Federal Employees Compensation Program. There is no prima facie evidence accepted to establish the employee's ability to work. **The program must establish by weight of medical evidence the injured employee's current work tolerance level. Medical evidence must be conclusive and not speculative.**
- (2) The employees over all physical and mental condition must be considered. Conditions developed after the injury, conditions that pre-existed and the injury it's self must be taken into consideration. Another way to say this is the whole person must be considered when making job offers.
- (3) Keeping all this in mind **a medical report whether from the treating physician, second opinion, or referee physician must be comprehensive, non-equivocal, and based on a complete factual and medical background.** The physician should examine the injured employee and assign specific work tolerance limitations.



Requesting Medical Reports

A. **The first effort is to secure a current medical report from the treating physician.**

This report should contain all the information as described above. The treating physician's opinion carries great weight as the physician has the knowledge of medical and treatment history. The work tolerance limitations assigned by the treating physician not only carries a lot of evidentiary weight but there is less likelihood that the physician will change his opinion once a job is modified and offered to the employee.

1. **In securing work tolerance limitations from the treating physician we recommend using form CA-17.** Complete section (A) describing the physical requirements of the employees regular job. Have the treating physician complete the remainder of the form. If the treating physician gives the opinion that the employee cannot return to the regular position then see if your agency can modify the position by using the physician's opinion of the employees work tolerance limitations as given in section number 13 of the form CA-17. Once the job is modified send the treating physician a description of the physical requirements of the modified position asking for final approval. This last step is not required but will strengthen the final job offer. When our office request works tolerance limitations from any physician we use a standard form (OWCP-5) asking for specific information on physical ability much like the CA-17.



Requesting Medical Reports Cont.

2. **If the treating physician does not reply or his report is equivocal or the objective findings do not support the restrictions assigned by the physician our office (only our office) may request a second opinion.** The agency should never contact the second opinion physician. This action could compromise our offices effort to secure an independent opinion.
 3. The second opinion report must meet the same standard as any other medical report. The second opinion physician will be instructed to perform an examination. This will include authorization for any non-invasive test and if requested the functional capacity evaluation. Our office will evaluate the quality of the report and determine if the opinion carries the weight of medical evidence. **If the weight of medical evidence is with the second opinion, these work tolerance limitations will be forwarded to the employer asking if a position can be modified and offered for the employees reemployment.**
 4. **If the second opinion does not carry the weight but is adequate to establish a conflict medical opinion with the treating physician, our office will set up a referee examination.** Again the agency must not contact the physician and all reports must be evaluated by our office before any action is taken to reemploy the injured worker.
- B. If our office determines the referee examination meets our requirements the physicians opinion carries the weight of evidence and the agency must use these work tolerance limitations in designing modified job for the employee.**



Weight of Medical Evidence

When OWCP determines the weight of medical evidence, only OWCP can consider new medical evidence and determine when the weight of medical evidence changes.



Job Offers

Our office will take immediate action to reduce or terminate benefits based on actual earnings whenever we receive notification that the claimant has either accepted a job offer or has actually returned to work.

We will set a computer reminder for 60 days from the return to work date to issue a formal LWEC decision. No further action needs to be taken until the reminder date, unless the employee stops work or the job is withdrawn.

Generally speaking, the fact that the claimant has performed the job for at least 60 days and is working the number of hours he/she is capable of working establishes that the job fairly and reasonably represents his/her wage earning capacity. Although we will require a copy of the job offer, we will not make a determination concerning validity or suitability in these situations.



Preparing the Job Offer

However, if we receive a copy of a job offer and there is no evidence that the employee has accepted the job or has returned to work, we will review the offer and determine whether it is **(a) a valid offer** and **(b) a suitable offer**. We will consider first the criteria for a valid offer...

Valid Offers

To be considered valid, the offer must

1. be in writing
2. describe the duties to be performed
3. describe the physical requirements of the job
4. state the location of the job
5. state the date of the job is available
6. state the date by which employee must respond to job offer
7. in some cases must indicate moving expenses will be paid



Don't Use Vague Terms

The physical requirements of the job should be described in concrete terms, even in psychiatric cases. The description should state specifically what the incumbent would be required to do.

For example, a valid offer would state the claimant is required to lift up to 10 lb. Reach above shoulder level intermittently up to hours per day, etc.

An offer that uses **vague terms** such as “**no heavy lifting,**” “**some reaching above the shoulder,**” **etc.**, will **not be considered valid**, since this type of description explains what the employee will not be required to do and does not clearly explain what the employee will be required to do.

Additionally, offers that state the **job is sedentary, with no physical requirements**, are **not** considered **valid**. Every job has some physical requirements.

Remember, if the job offer does not clearly show what the employee will be required to do, it is not possible to arrive at a conclusion as to whether the employee could do the job.

The second decision that must be made when reviewing an offer of employment is whether the offer is suitable for the claimant...



Suitable Offers

To find an offer of employment suitable:

- (1) We will compare the duties and physical requirements of the job offer to the medical limitations in file.** We will take the physical requirements of the job and compare them directly with the completed OWCP-5, work limitation evaluation form which OWCP has determined has the weight of medical evidence. Although we can rely on the expert opinion of the RS/RC, it is the responsibility of the Climes Examiner in our office to assure that the opinions and findings of the RS/RC are consistent with the fact of the case.

In psychiatric cases this process of comparison may be more complex. The work limitations may not be described as clearly as needed. Since the limitations are not physical, we will use a special form designed for psychiatric/psychological limitations. If we do not have work limitations on the current form (OWCP-5a), we will consult the narrative sections of current medical reports for descriptions of work limitations.

The examiner will list all work limitations mentioned using the language in the reports. Then will list all requirements of the proposed job and look for any conflicts. If the examiner is not certain whether the job demands are within the employee's emotional abilities, the examiner will request the attending physicians (if an appropriate specialist) to review the job offer before making a final determination on suitability.

Suitable Offers Cont.

- (2) **Determine whether the claimant is vocationally capable of performing the job.** The CE will decide, for example, whether the claimant has appropriate education and experience for the job – unless the RS/RC has already done so. If the RS/RC has made the determination already, the claims examiner will rely on it.

Information about the employee's skills and experience will usually be sufficiently detailed in an SF-171 (or other job application form) which is often a part of the file.

If such a form is not in file, there are other ways to arrive at a reasonable conclusion regarding suitability. Often we have enough information from the employee and/or agency as to the type of jobs held prior to the work injury to determine suitability.

Even if that type of information is not contained in the file, often the job being offered is very much in line with the kind of work the employee was doing when injured. This is, of course, true when the agency is offering a modified job. It's basically the same job with greater restrictions.

If another job is offered, we will consider whether the type of work the employee was doing at the time of the injury would have given the employee the skills and knowledge necessary to do the job offered. For example, it is reasonable that a mail carrier has the skills to work in mark-up section which repairs damaged mail.

Disqualifying Factors

Verify that none of these four disqualifying situations apply. The job must be judged unsuitable.

- If the employee can work four or more hours per day, yet the job is for less than four hour per day.
- If the job is temporary, unless the employee was a temporary employee when injured **and** the job reasonably represents the claimants WEC. However, a temporary job will not be considered suitable if it will end in fewer than 90 days.
- If the job is for permanent seasonal employment (unless the employee was a seasonal or temporary employee when injured, or resides in an area where jobs are scarce)
- If the employee is disabled from the offered job due to a condition which has arisen since the injury, even if this later condition is not work-related.



What to do when a job offer is neither valid nor suitable

If the offer does not meet the necessary requirements **WE WILL WRITE OR CALL THE EMPLOYING AGENCY** and advise them of the problems.

If they can modify and/or make corrections to the offer so it can be ruled valid and suitable, ask the agency to do so and submit a corrected copy to our office.



What to do when a job offer is valid and suitable

When the claims examiner determines that the offer is valid and suitable and the employee has neither accepted the job nor returned to work, we will take these steps.

(1) Phone the agency and confirm that the job is still available. Document our conversation in the file.

(2) Write to the employee. The letter will contain the following information:

- a. The job has been determined to be suitable.
- b. The job remains open for the employee.
- c. The employee will be paid compensation for the difference (if any) between the pay of the offered job and the pay of the date of injury job.
- d. The employee has 30 days from the date of the claims examiner's letter to either accept the job or provide an explanation of the reason(s) for refusal. Otherwise the employee will penalized with loss of compensation. To satisfy the requirement of due process, our office must quote 5 USC 8106 c (2) in our letter to the employee.
- e. The employee can accept the job without penalty within the 30 day period.



Acceptable Reasons For Refusal

1. A medically documented worsening of the employee's condition to the point of disabling him/her for the offered position.
2. The employee finds other work which fairly and reasonably represents his/her wage earning capacity.
3. The offered position is withdrawn.
4. The treating physician advises the employee not to take the position and provides medical rationale by the physician. (requires further development)
5. Medical evidence establishes the employee is unable to travel to the job because of residuals of the work injury.

The following are additional reasons for employees that are no longer on the agency employment roll.

- a. The employee has moved and medical condition of either the employee or family member prevents the employee from moving back to the area.
- b. The position is temporary and will not afford health insurance coverage for the employee.
- c. The employee is already working, and the job fairly and reasonably represents his or her WEC, whether or not a formal rating is in place.

If the reasons for refusal are not valid:

1. We will contact the agency to make sure the job is still available.
2. We will write the employee and advise him/her that the reason for refusal is not acceptable.
3. We will advise the employee he/she has 15 days in which to accept the offer without the penalty of compensation loss.
4. We will advise the employee that no further arguments/evidence will be considered during the 15 day period.

If the employee continues to decline the offer, we will issue the final decision finding that the employee is not entitled to further compensation benefits. (Compensation includes compensation for wage loss and schedule award of compensation.) This does not affect payment of related medical expenses, so entitlement to medical benefits for the accepted condition will continue. In this situation (i.e. the employee has refused an acceptable job) we are terminating benefits under the provision of 5 U.S.C. 8106, and we do not need to provide pre-termination notice. Our letters concerning suitability and our response to any interim submission of evidence satisfies the due process requirement

Recognizing and Handling Issues of Wage Earning Capacity

- (1) When there will be a wage-earning capacity issue:

Employee's who are able to perform some work, even though it is not the date of injury job, are considered partially disabled. If a claimant returns to work earning less than the current pay rate for the date of injury grade and step, our office pays the difference. This is called a loss of wage-earning capacity (LWEC) determination.

The object of an LWEC is to estimate an injured employee's earning capacity as close as possible to parity with current pay for the grade and step held on date of injury. There are no provisions to compensate injured employees for grade or step increases they might have received had they not been injured.

If the employee has some work limitations and is disabled from the date-of-injury job, an LWEC determination must be made even if the employee is re-employed at the same grade and step level as when the accepted injury/illness occurred. (The compensation can be reduced to zero).

- (2) Actions required to determine a employee's wage earning capacity:

The mathematical determination of a employee's wage earning capacity is made with the Shadrack formula.



Moving Expenses and OPM Elections

Moving Expenses

Anytime an employee has been removed from the agency employment roll and the employee has moved away from the area the employee may be reimbursed for moving expenses. This information must be given to the employee in the job offer. If not OWCP will so advise the employee. While the expenses may be disbursed by OWCP, the agency must handle the required paper work and expenses must be authorized using the agency's normal procedures for any relocation of an employee. The final paper work and amount authorized must be submitted for payment by OWCP if the agency would like the money to be disbursed from the compensation fund.

Election of OPM Benefits

Election of O.P.M. is not a suitable reason to refuse a job offer. For this reason the agency should never give this as an option in lieu of accepting the offered job.



Request for Medical Authorization and Medical Bill Processing



AUTHORIZATION LEVELS

- LEVEL 1: Procedures do not require authorization (for example, Office Visits, MRIs, Routine Diagnostic Tests). No response will be sent on Fax requests, Please check Web or call 1-866-335-8319
- LEVEL 2: Procedures can be authorized by ACS – often over the phone with ACS. Hospital Admission must be called in. Currently the Web does not accept facility authorizations
- LEVEL 3/4: Procedures require authorization by a Claims Examiner. Requests for procedures can be initiated via fax from Provider to ACS. Fax request could take up to 7 work days, Web request should be monitored via the web.



Overview

- Services that require authorization
- Submitting an authorization request
- Information required in order to process authorization
- Timeframes for Completion



What requires authorization?

- Whenever there is a question about treating an injured worker, verify on the website if procedure requires authorization
- Or if you don't have web access call 1-866-335-8319 for the IVR or the call center for services at 850-558-1818.
- Certain procedures require authorization prior to services being rendered
- Examples include surgery, physical therapy, occupational therapy, and some DME.



How to Submit an Auth Request

- **Website:** <http://owcp.dol.acs-inc.com>
- **Fax** to 1-800-215-4901
- **Mail** to: P.O. Box 8300
London, KY 40742-8300



Info Required for Auth Requests: Routine Medical Requests



- Claimant name
- Claimant case number
- CPT or HCPCS code(s)
- Specific body part to be treated
- Requested date of service
- Appropriate supporting documentation
- Provider name
- Provider number

Info Required for Physical Therapy and Occupational Therapy

- Claimant name
- Claimant Case number
- Requested CPT code(s)
- Specific body part to be treated
- Prescription from attending physician
- Treatment Plan
- Frequency and Duration of Services
- Provider name and number



Info Required for DME Auth

- Claimant name and case number
- CPT or HCPCS code(s)
- Prescription from attending physician
- Duration of services
- Rental or purchase price for each item
- Appropriate supporting documentation
- Provider name and number



Auth Requests will be returned if:

- The case is closed
- The claimant's case number is missing or invalid
- Procedures codes are missing or invalid
- Any of the following are missing:
 - Prescription, when required
 - Rental or Purchase Price, when required
 - Frequency and Duration



No Authorization

- **Certain procedures require prior authorization**
- **ACS requires specific information in order to correctly process auth requests**
- **Examples: claimant case #, provider #, CPT code and date range if available**
- **If auth was not previously requested, a retro-authorization may be requested**
- **Provider will need to request that the denied bill reprocessed by ACS**
- **This is also the case if an authorization has previously been denied. Once the authorization is approved you may call the call center to have the bill adjusted or resubmit the bill**



Authorization EOB Codes

- Claims lacking proper authorizations will deny payment
- EOB codes are 529, 530, 531, 532, 533



Authorization EOB Code

- Your claims may deny for:
 - EOB code 529
 - Case is denied
- EOB code 530
- “No authorization on file”
- EOB Code 531
- “Authorization for claimant, not for provider”



Authorization EOB Code

- EOB Code 532
- “Authorization for claimant and provider, not for dates of service”

- EOB Code 533
- “Authorization for claimant, provider, and dates of service; not for procedure”



Authorization Approval

- If a request for authorization is approved, the requesting provider will receive a letter in the mail.
- Some authorizations must be approved by the District Office – the District Office has 3 business days to respond to that request.



FURTHER DEVELOPMENT



Fiscal Agent Services
PO Box 8300
London, KY 40742



U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

LETTER DATE

PROVIDER NAME
ADDRESS
CITY, STATE, ZIP

Your recent request for authorization cannot be approved at this time. The Office of Workers' Compensation Programs (OWCP) has determined that further medical development is needed before the request can be approved or denied. This development will be done by OWCP, and the claimant will be contacted with further details. When accessing the web portal for the status of your request, you will see these authorizations coded in an "F" status.

Claimant Name:
Claimant ID:

PROVIDER NUMBER:
Confirmation Number:
Procedure Code(s):

| CODE | SHORT DESCRIPTION FROM ACHIEVE | 1 UNIT(S) |
|------|--------------------------------|-----------|
|------|--------------------------------|-----------|

To monitor the ongoing status of your request, please use:

ACS Web Bill Processing Portal: <http://owcp.dol.acs-inc.com/portal/main.do>

Or

Interactive Voice Response system: 1-866-335-8319 (Toll Free)

Sincerely,
ACS Prior Authorization Department

AUTHORIZATION LETTER



Fiscal Agent Services
PO Box 8300
London, KY 40742



U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

LETTER DATE

PROVIDER NAME
ADDRESS
CITY, STATE, ZIP

Claimant Name:
Claimant ID:
Authorization Number:
Provider Number:
System Auth Number:

The request for authorization for **FIRST DOS to LAST DOS** has been reviewed and authorized as follows:

| CODE | SHORT DESCRIPTION FROM ACHIEVE | 1 UNIT(S) |
|------|--------------------------------|-----------|
|------|--------------------------------|-----------|

This service requested is authorized for the condition(s) accepted by OWCP. It is your responsibility to ensure you have the correct ICD9 code from the claimant for their accepted condition when you bill for this service. This authorization does not guarantee payment as billed. Billings are subject to systematic review for propriety. Additionally, the OWCP Fee Schedule applies to billed amounts.

In the event that you wish to change the procedure authorized (i.e. date of service, provider, or procedure), please submit your change request via facsimile to 800-215-4901 using the prior authorization template, which can be found on our website.

For faster service, you are now able to seek, and, for routine care, receive medical authorizations online. Please begin using our website at <http://owcp.dol.acs-inc.com/portal/main.do> to submit your authorization requests. If you do not have access to the website, you may continue to submit your prior authorization requests to us via our toll free facsimile line at 800-215-4901 using the prior authorization templates provided to you in your welcome packet.

Sincerely,
ACS Prior Authorization Department

Timelines for Prior Medical Authorizations

- Level 2 procedures that ACS can authorize take an average of 3 days
- All spinal surgery and many other surgery authorizations require District Medical Advisor (DMA) approval and could take about 30 days or less
- In some instances, additional development of the claim by the Claims Examiner is needed to approve or deny an authorization request. Case complexity, claimant responsiveness, Employing Agency responsiveness, and other factors impact the timeline for authorization.



Medical Bill Processing



Why will some bills deny?

- Claimant is ineligible
- Disagreements with accepted condition
- No authorization
- Improper CPT codes



Claimant Eligibility

- Each claimant must be currently eligible in order to receive services
- Claimant case status is determined by DOL



Claimant Eligibility

- Claimants are responsible for providing their treating physicians with the accepted condition
- Claimants are responsible for contacting the district office if there are questions regarding case status
- Providers may acquire this information directly from the claimant or via our website at <http://owcp.dol.acs-inc.com>



Treatment Suite

- Services that greatly differ from expected services to treat an injury will deny
- For example: Billing for a hand x-ray when the claimant has a cut lip will trigger this denial code



Treatment Suite Related EOB Codes

- EOB Code 863 - Diagnosis Mismatch
- In this case the diagnosis being treated is not related to the accepted work injury. This usually involves a basic service and can be due to the use of a “non specific” ICD-9 code.
- EOB Code 865 – Treatment Suite Mismatch
- The requested procedure is not in the treatment suite. This is an uncommon edit.



Claimant Query System (CQS)

Universal Access through ACS at:

<http://owcp.dol.acs-inc.com/portal/main.do>



CQS - Claimant Query System

CQS will allow an injured employee to access information regarding:

- Benefits payments
- Benefits tracking
- Medical Bill status
- Case status history
- Accepted conditions
- Employing agency information
- CA-16 information

To get started log in to the ACS-DOL Web Portal

<http://owcp.dol.acs-inc.com>

ACS Web Bill Processing Portal Office of Workers' Compensation Programs

Please enter the portal by selecting a user type associated with one of the following programs:

FECA → [Provider](#)
[Claimant](#)
[Agency](#)

DCMWC → [Provider](#)
[Claimant](#)

DEEOIC → [Provider](#)
[Claimant](#)

[Home](#) | [ACS Contact Info](#) | [Portal FAQ](#) | [Forms & Links](#) | [FECA & DEEOIC Fee Schedule](#) | [Quit Application](#) | [HELP](#)

Welcome to the DOL OWCP Web Bill Processing Portal

Latest Developments
[Submit Bills and Attachments](#)

Click on the CQS link on the left hand side of the screen

ACS Web Bill Processing Portal Office of Workers' Compensation Programs

[Home](#) | [ACS Contact Info](#) | [Portal FAQ](#) | [Forms & Links](#) | [FECA & DEEOIC Fee Schedule](#) | [Logout](#)

Inquiries
[Eligibility & Accepted Conditions](#)
Bill Status
[Medical Authorization](#)
[CQS](#)

Bill Status Inquiry

Please enter the information below and click 'Submit.'

Case File #:

* **View Option:** Resolved Bills (Paid and Denied)
 Bills In Process

Date of Service From: / / - **To:** / /

ACS Provider ID:

Enter FECA case number and click "Submit Query"

 U.S. Department of Labor

www.dol.gov



Enter Case Number:

CQS case summary and status will display. Links are available to search for compensation payments, compensation tracking, and search for information under a different case



CQS Injured Worker Case Query ★ ★ ★

| | | | | |
|------------------------------|---|---------------------|--|--------|
| CASE#: | [REDACTED] | SSN: | | SEX: F |
| NAME: | [REDACTED] | DOB/Age: | | |
| Address: | [REDACTED] | DOI: | | |
| City State Zip: | [REDACTED] | | | |
| Reported Condition: | 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE | Condition Accepted: | 3540 R - CARPAL TUNNEL SYNDROME 72703 R - TRIGGER FINGER (ACQUIRED) | |
| Form Rev'd: CA2 - 04/19/2000 | Location: Kansas City | CEID: CBF | | |

★ ★ ★ CASE STATUS

| | | |
|---------------------|------------|--------------------------------|
| Current Case Status | [REDACTED] | Medical Benefits Only |
| Current Location | [REDACTED] | OTHER LOCATIONS - IMAGED CASES |

| | |
|-------------------------------------|--------------------------|
| Continuation of Pay was not elected | Case Created: 04/19/2000 |
| Lost Time Began: | Closed: |
| Last Updated On: 12/10/2007 | Reopened: |
| | Retired: |

★ AUTHORIZATION FOR MEDICAL TREATMENT ★

CA-16 Authorized Medical Treatment Period
From Date - To Date

[NEW CASE](#) [Compensation Payments](#) [Compensation Tracking](#)

Bonus Material



E-filing via AQS

Division of Federal Employees' Compensation



Overview

- Forms to be filed via AQS
 - Benefits of e-filing
 - Ground Rules
 - How it Works
- Major Differences Between e-forms and Paper Forms
 - Screen Shots



Forms You Will be Able to e-file through AQS

- CA-7, Claims for Compensation
(Used for claiming compensation and schedule awards)
- CA-7a, Time Analysis Form
- CA-7b, Leave Buy Back Worksheet
Certification and Election
- CA-3, Report of Work Status (only e-filed forms will be accepted)



Benefits of E-filing

- Early receipt of CA-7s enables OWCP to promptly adjudicate wage loss claims and reduce financial hardship on claimants
- Agency (AQS) and claimants (CQS) will know within 24 hours whether OWCP has received a filed CA-7
- CA-3s will reduce the possibility and/or severity of overpayments
- The CA-3 will reduce the number of false positives in early nurse case management if we speed input of RTW info

Better customer service!

Ground Rules

- Just like CA-1s and CA-2s, the EA must retain the original version of the form (signed)
- AQS Users will have to complete a Non-Disclosure Form requesting e-filing access.
- Non-disclosure form will need to be signed by the AQS user and countersigned by IAC (authorizing e-filing privileges).



How Will the ICS E-file forms?

- The ICS will login to AQS
- Pull up the case for which a form will be filed
- There will be a link at the bottom of the AQS page: "E-File CA-Form"

Case Management - Microsoft Internet Explorer provided by US Department of Labor - ESA

Address: <https://aqsweb.dol-esa.gov/AQS/resources/list.do>

Current Location ● XIN - 10/31/2008 - CASE TRANSFER IN TRANSIT

Previous Location ● OLI - 10/31/2008 - SECURITY

● *Continuation of Pay was not elected* ● *Case Created:* 05/16/2005

● *Pay was not Terminated* ● *Reviewed:* 05/16/2005

● *Case has not been controverted* ● *Closed:*

● *Lost Time Began:* ● *Reopened:* 10/28/2008

● *Last Updated On:* 10/31/2008 ● *Retired:*

Cause of Injury ● 99 - CAUSE UNKNOWN

Nature of Injury ● TS - SPRAIN/STRAIN OF LIGAMENT, MUSCLE, TENDON, NOT BACK

Anatomical Location ● 99 - OTHER

Extent of Injury ● 2 - First Aid

★ **AUTHORIZATION FOR MEDICAL TREATMENT** ★

CA-16 Authorized Medical Treatment Period
From Date - To Date

● [NEW CASE](#) ● [Compensation Payments](#) ● [Compensation Tracking](#)
● [Bill Inquiry](#) ★ [E-File CA Form](#)

Done Internet

How Will the ICS E-file forms?

- The ICS will have the various Form options
- The ICS will click on the desired form and begin completing the form

9999 - OTH/UNS COMPLICATIONS MEDICAL CARE 9999 - OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE

Form Rcv'd: CA1 - 05/16/2005 **Location:** Hearings and Review **CEID:** CC1 **Injury ZIP:** 20260

★ ★ ★ **CASE STATUS**

Adjudication Status ● AM - 10/28/2008 - Accepted - Medical Payments Only

Current Case Status ● MC - 10/28/2008 - Medical Benefits Only

Current Location ● XIN - 10/31/2008 - CASE TRANSFER IN TRANSIT

• [CA7 Form](#)

• [CA7A Form](#)

• [CA7B Form](#)

• [CA3 Form](#)

The E-File CA Forms application requires Microsoft Internet Explorer browser, Version 6.0 or higher.

What the ICS will see

ICS will complete the form and click "Submit"

CA7 Form - Microsoft Internet Explorer provided by US Department of Labor - ESA

File Edit View Favorites Tools Help

Back Forward Stop Refresh Home Search Favorites

Address https://aqsweb.dol-esa.gov/AQS/resources/CAForm_7.do Go

Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



SECTION 1 **EMPLOYEE PORTION**

a. Name of Employee

| | | | |
|----------|----------|--------|-----------|
| Last | First | Middle | OMB No: |
| TESTCASE | TESTCASE | | 1215-0103 |

Expires: 09/30/2011

b. Mailing Address (Including City, State, ZIP Code)

123 UNION

BOSTON MA 01752

c. OWCP File Number

502500000

d. Date of Injury

05/01/2005

e. Social Security Number

999-99-9991

E-Mail Address (Optional)

SECTION 2 Compensation is claimed for:

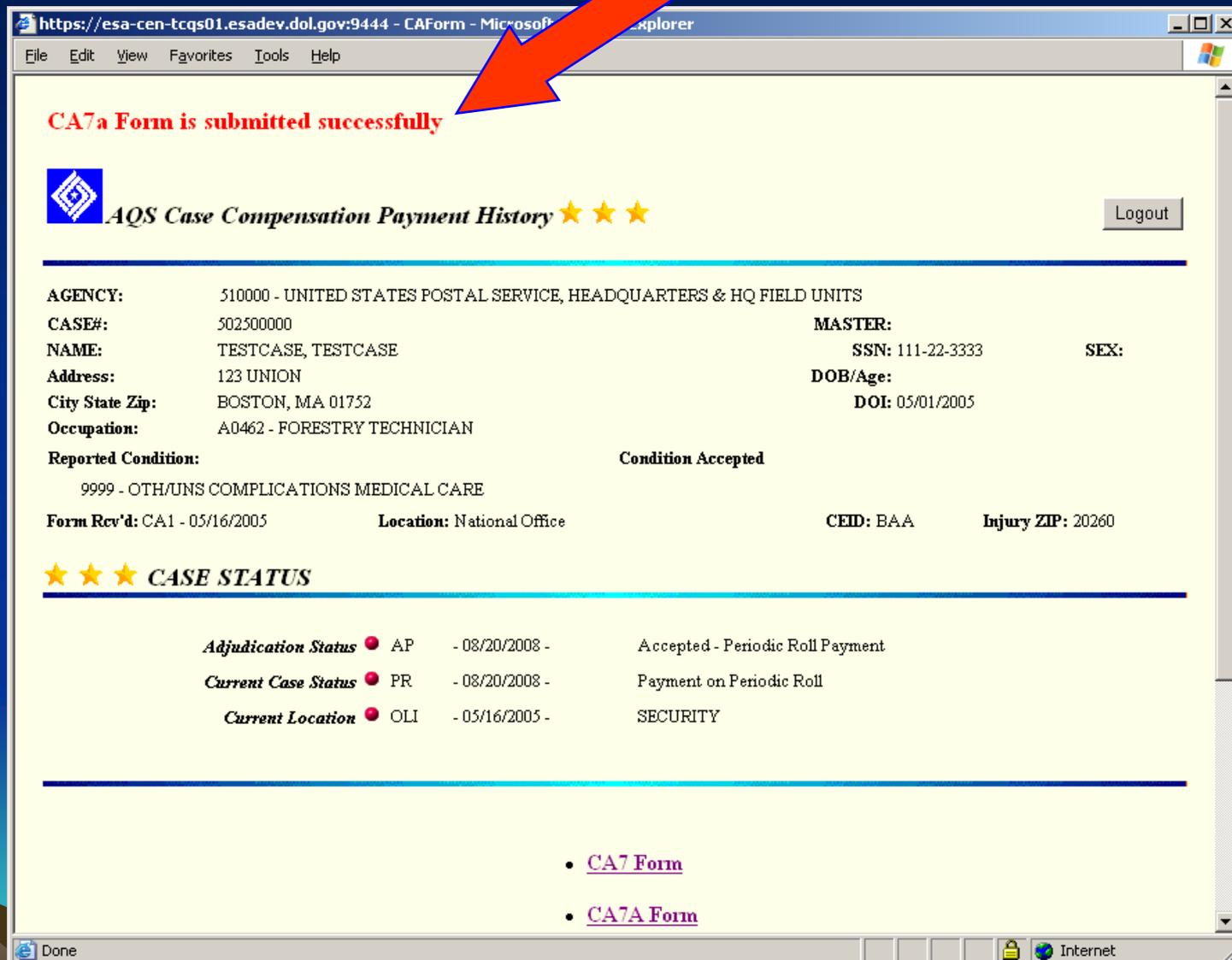
| | | |
|----------------------|---------------|--------------------------|
| Inclusive Date Range | Intermittent? | f. Telephone No./FAX No. |
| From To | | |

a. Leave without pay Yes No

Go to Section 3

Done Internet

What the ICS will see



https://esa-cen-tcqs01.esadev.dol.gov:9444 - CAForm - Microsoft Internet Explorer

File Edit View Favorites Tools Help

CA7a Form is submitted successfully

 **AQS Case Compensation Payment History** ★ ★ ★ [Logout](#)

AGENCY: 510000 - UNITED STATES POSTAL SERVICE, HEADQUARTERS & HQ FIELD UNITS
CASE#: 502500000
NAME: TESTCASE, TESTCASE
Address: 123 UNION
City State Zip: BOSTON, MA 01752
Occupation: A0462 - FORESTRY TECHNICIAN

MASTER: SSN: 111-22-3333
DOB/Age: DOI: 05/01/2005
SEX:

Reported Condition: 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE
Condition Accepted:

Form Rev'd: CA1 - 05/16/2005
Location: National Office
CEID: BAA
Injury ZIP: 20260

★ ★ ★ **CASE STATUS**

Adjudication Status ● AP - 08/20/2008 - Accepted - Periodic Roll Payment
Current Case Status ● PR - 08/20/2008 - Payment on Periodic Roll
Current Location ● OLI - 05/16/2005 - SECURITY

• [CA7 Form](#)
• [CA7A Form](#)

Done Internet

Pop-Up will appear denoting that

Form Submission was Successful

How will the ICS know it worked?

In addition to the immediate pop-up alerting the ICS that the submission was successful, AQS will update the Payment Tracking page within 24 hours



Case Compensation Tracking - Microsoft Internet Explorer provided by US Department of Labor - ESA

Address: https://aqsweb.dol-esa.gov/AQS/resources/tracking.do

AQS Case Compensation Tracking

Logout

AGENCY: 141000 - OTHER ESTABLISHMENTS, BICENTENNIAL COMMISSION
CASE#: 069000099
NAME: DOE, JOHN
Address: 1234 MAIN STREET
City State Zip: JACKSONVILLE, FL 32204
Occupation: -

MASTER: SSN: 111-22-4444 SEX: M
DOB/Age: 01/01/1930 - 78
DOI: 03/23/2008

Reported Condition: 9999 - OTH/UNS COMPLICATIONS MEDICAL CARE
Condition Accepted: 9999 - OTHER AND UNSPECIFIED COMPLICATIONS OF MEDICAL CARE

Form Rev'd: CA1 - 04/23/2008
Location: Jacksonville
CEID: ADD
Injury ZIP: 32204

CASE STATUS

Adjudication Status ● AC - 07/24/2008 - Accepted - COP Elected
Current Case Status ● MC - 07/24/2008 - Medical Benefits Only
Current Location ● OLI - 07/24/2008 - DESC MISSING

COMPENSATION PAYMENT TRACKING

| Comp Payment Period: From - To | Date CA-7 Received by OWCP | Decision Code, Date, & Description | Date IW Signed |
|-----------------------------------|----------------------------|--|-------------------|
| 05/12/2008 - 05/30/2008 | 2008-07-23 | - Undecided | 2008-04-20 |

[NEW CASE](#) ● [Compensation Payments](#) ● [Compensation Tracking](#)
● [Bill Inquiry](#)

Done Internet

Major Differences Web form vs. Paper

Section 5 (Dependents). On the web form, the AQS user is asked to enter the dependent's Last Name, First Name and Middle Initial, in that particular order. This is different than the paper form, which only asks for the dependent name(s). Since there is no format to follow on the paper form, most people usually handwrite the first name followed by the last name, but on the web form we ask that your users please follow the format described above and depicted in the screen shot below.

Address https://aqsweb.dol-esa.gov/AQS/resources/CAForm_7.do Go

Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?
 Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s) No - Complete Section 7

SECTION 5 List your dependents (including spouse):

| Last | First | Middle | Social Security | Date of Birth | Relationship | Living with you? |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For dependents not living with you, complete items a and b below.

a. Are you making support payments for a dependent shown above? Yes No If Yes, support payments are made to:

Major Differences Web form vs. Paper

Above Section 8. At the top of the second page on the paper form, filers are advised that they need not complete Sections 8 through 15 if the CA-7 is a subsequent submission. For ease of electronic filing, the web form asks the AQS users to check a box indicating whether the submission is for an initial form *or* a subsequent form. If the AQS user checks the "Initial" box, Sections 8 through 15 are required fields. If the AQS user checks the "Subsequent" box, only Sections 12 through 15 are required.

Address https://aqswb.dol-esa.gov/AQS/resources/CAForm_7.do Go

Form CA-7
Rev. June 2005

Employing Agency Portion
For first CA-7 claim sent, complete sections 8 through 15.
For subsequent claims, complete sections 12 through 15 only.

Is this the initial or a subsequent CA-7 ? Initial Subsequent

| SECTION 8 | Show Pay Rate as of | Additional Pay | Additional Pay | Additional Pay |
|------------------|---------------------|----------------|----------------|----------------|
| Date of Injury: | Base Pay | Type | Type | Type |
| Date: 05/01/2005 | \$ per | \$ per | \$ per | \$ |
| Grade: | Step: | | | |

Fields on CA-7b

Pre-Populated Sections:

- A. Name of Employee
- B. SSN
- C. OWCP File No.

| Leave Buy Back (LBB) Worksheet/ Certification and Election | | U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs | |
|--|--|---|--|
| Employee Statement - Please carefully read instructions on pages 3 and 4 before filling out this form. | | | |
| A. Name of Employee: <i>(Last, First, Middle)</i> | | B. OWCP File Number: | |
| C. Social Security Number: | | | |

Required Sections:

Dates and Signatures

Required Fields on CA-3

Pre-Populated Sections:

- A. OWCP Case No.
- B. Claimant's Name
- C. DOI

Required Sections:

- "Agency"
- "Injury Compensation Specialist/Date"
- "Phone"

REPORT OF WORK STATUS

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

To the Employing Agency: This form should be completed and submitted to OWCP each time a claimant stops work, reduces their work hours or returns to work following a work-related injury. The form should be completed even if the claimant has not yet filed form CA-7 or CA-2a. **This form does not replace form CA-7 or CA-2a.**

OWCP CASE# _____ CLAIMANT'S NAME: _____ DOI _____

COP WORK STATUS INFORMATION

1. DATE STOPPED WORK (during COP): _____ (Include reductions in work schedule)
 Stopped Work After CA-1 FILED but During COP Eligibility Period

2. RETURN TO WORK DATE (during COP): _____ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS:

___ Full Time Regular Duty: No Restrictions
___ Full Time Modified Duty: With Restrictions
___ Part Time Regular Duty: No Restrictions for ___ Hours per Day
___ Part Time Modified Duty: With Restrictions for ___ Hours per Day

POST COP INFORMATION

1. DATE EMPLOYEE STOPPED WORK: _____ (Include reductions in work schedule)

2. REASON FOR WORK STOPPAGE:

___ WITHDRAWAL OF LD
___ RECURRENCE of Temporary Total Disability (TTD)
___ ADMINISTRATIVE (explain) _____
___ OTHER (explain) _____
___ SURGERY ___Y___N SURGERY DATE _____
CA-7 FILED? ___YES___NO CA-2a FILED ___Yes___NO

3. RETURN TO WORK DATE: _____ (Must complete RTW Section below)

THE CLAIMANT RETURNED TO WORK WITH THE FOLLOWING STATUS:

___ Full Time Regular Duty: No Restrictions
___ Full Time Modified Duty: With Restrictions
___ Part Time Regular Duty: No Restrictions for ___ Hours per Day
___ Part Time Modified Duty: With Restrictions for ___ Hours per Day

• JOB OFFER ACCEPTED ON: _____ (Please forward copy to OWCP)
• WORK RESTRICTIONS HAVE CHANGED. SEE MEDICAL DATED _____

NOTES: _____

EMPLOYER INFORMATION

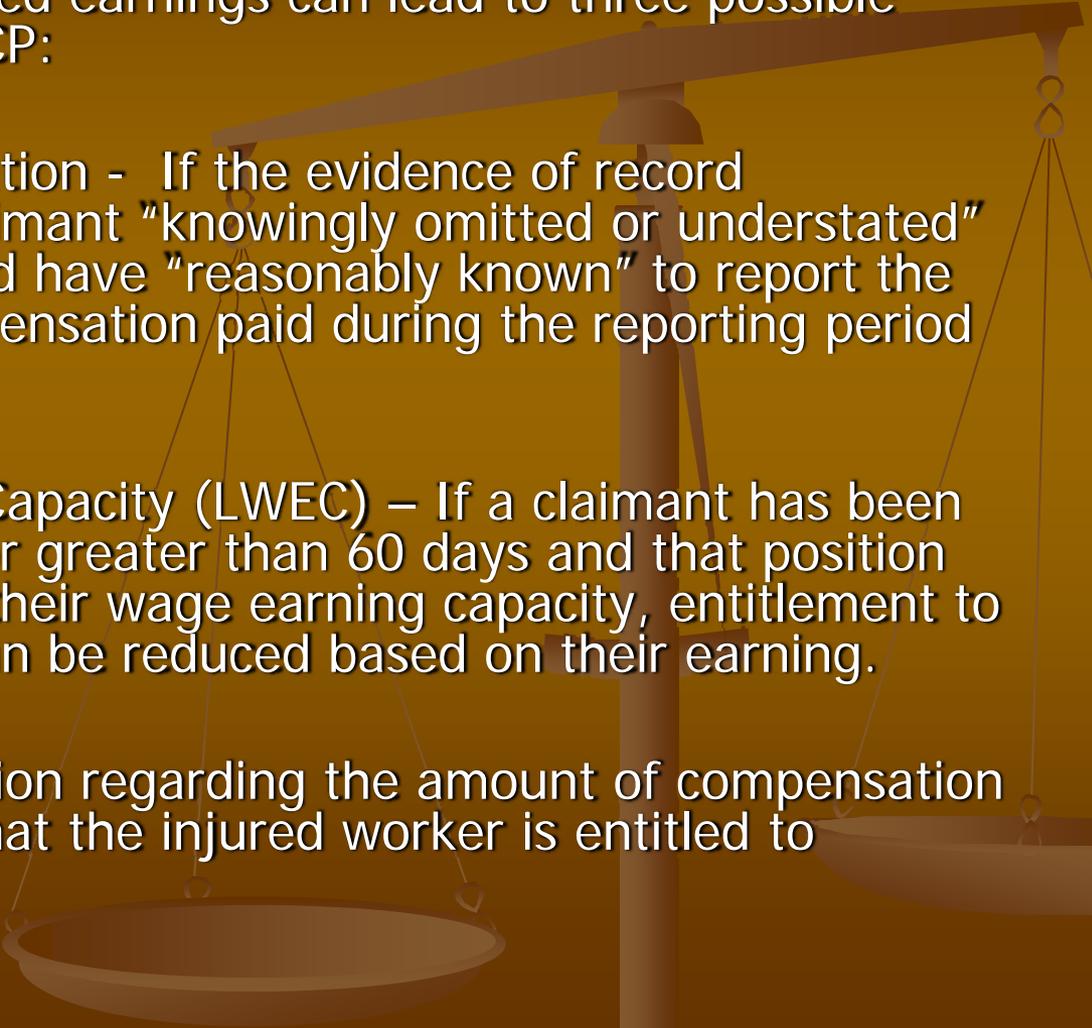
AGENCY _____
INJURY COMPENSATION SPECIALIST/DATE _____ PHONE _____



Unreported Earnings or Activities

Forfeiture and Fraud

Notification of Unreported Earnings



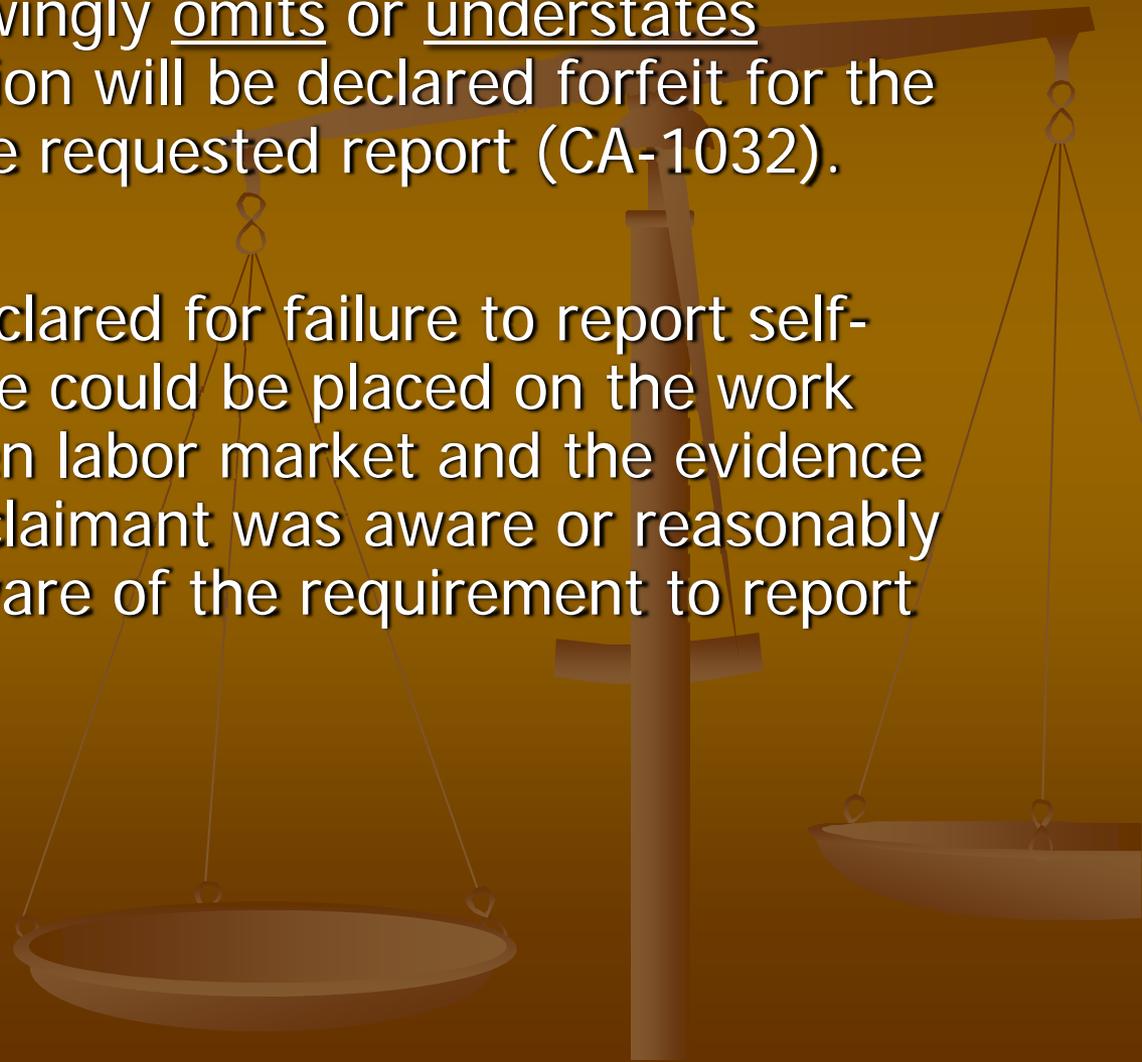
Notification of unreported earnings can lead to three possible decision issued by OWCP:

1. Forfeiture of Compensation - If the evidence of record establishes that the claimant "knowingly omitted or understated" earning and they should have "reasonably known" to report the earnings, then all compensation paid during the reporting period is forfeit
2. Loss of Wage Earning Capacity (LWEC) – If a claimant has been working in a position for greater than 60 days and that position reasonably represents their wage earning capacity, entitlement to future compensation can be reduced based on their earning.
3. Overpayment – A decision regarding the amount of compensation paid by OWCP above that the injured worker is entitled to receive.

The Road to Forfeiture

If the employee knowingly omits or understates earnings, compensation will be declared forfeit for the period covered by the requested report (CA-1032).

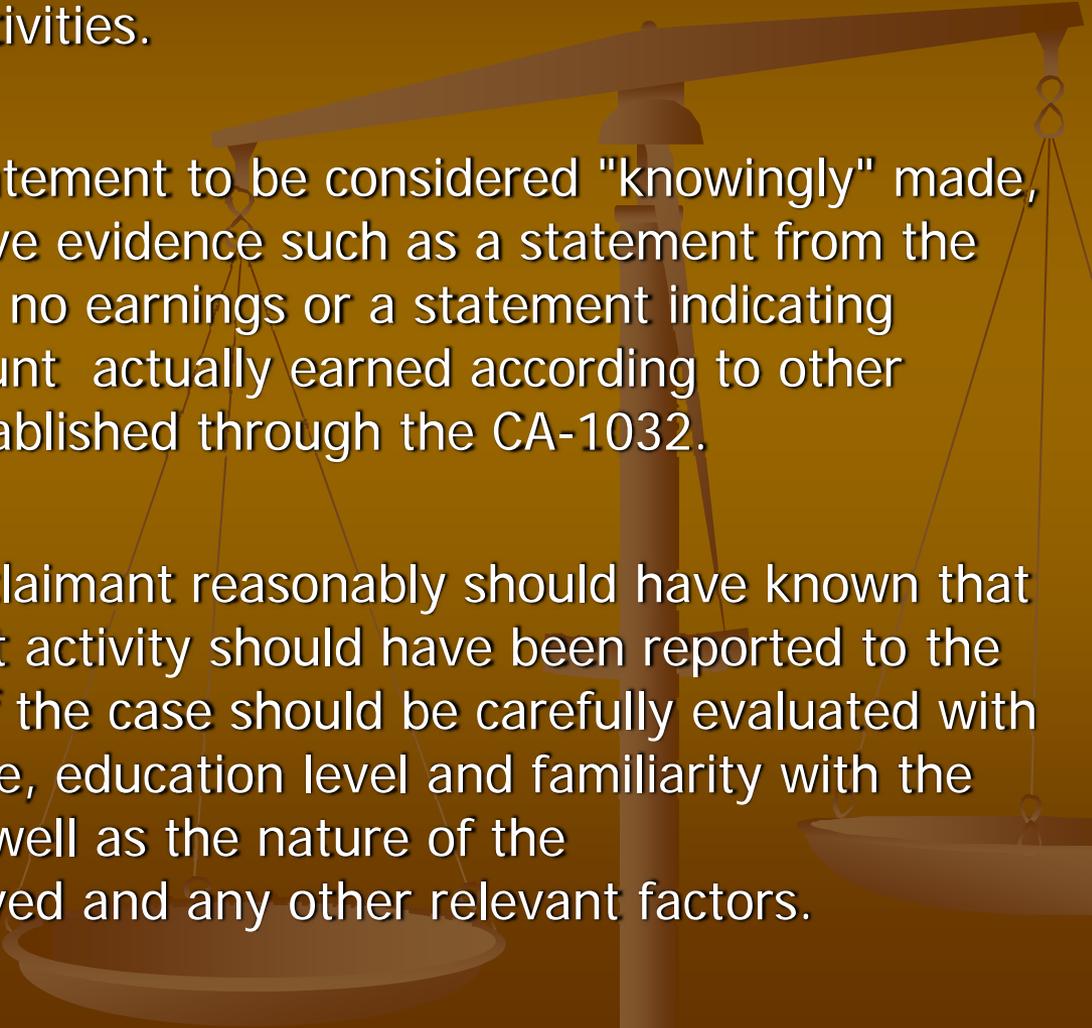
Forfeiture may be declared for failure to report self-employment if a value could be placed on the work performed in the open labor market and the evidence establishes that the claimant was aware or reasonably should have been aware of the requirement to report such employment.



Can you do a forfeiture based on a CA-7, rather than a CA-1032?

- If the CA-7 is prior to the current June 2005 version, ECAB will likely reverse the forfeiture decision. The Board is holding that prior versions of the CA-7 did not specifically inquire regarding the claimant's "earnings" and thus the language is not specific enough "to reasonably put an injured employee on notice that he had to report all earnings, no matter the source, for the period of claimed compensation".

Evidence Required to Establish Forfeiture



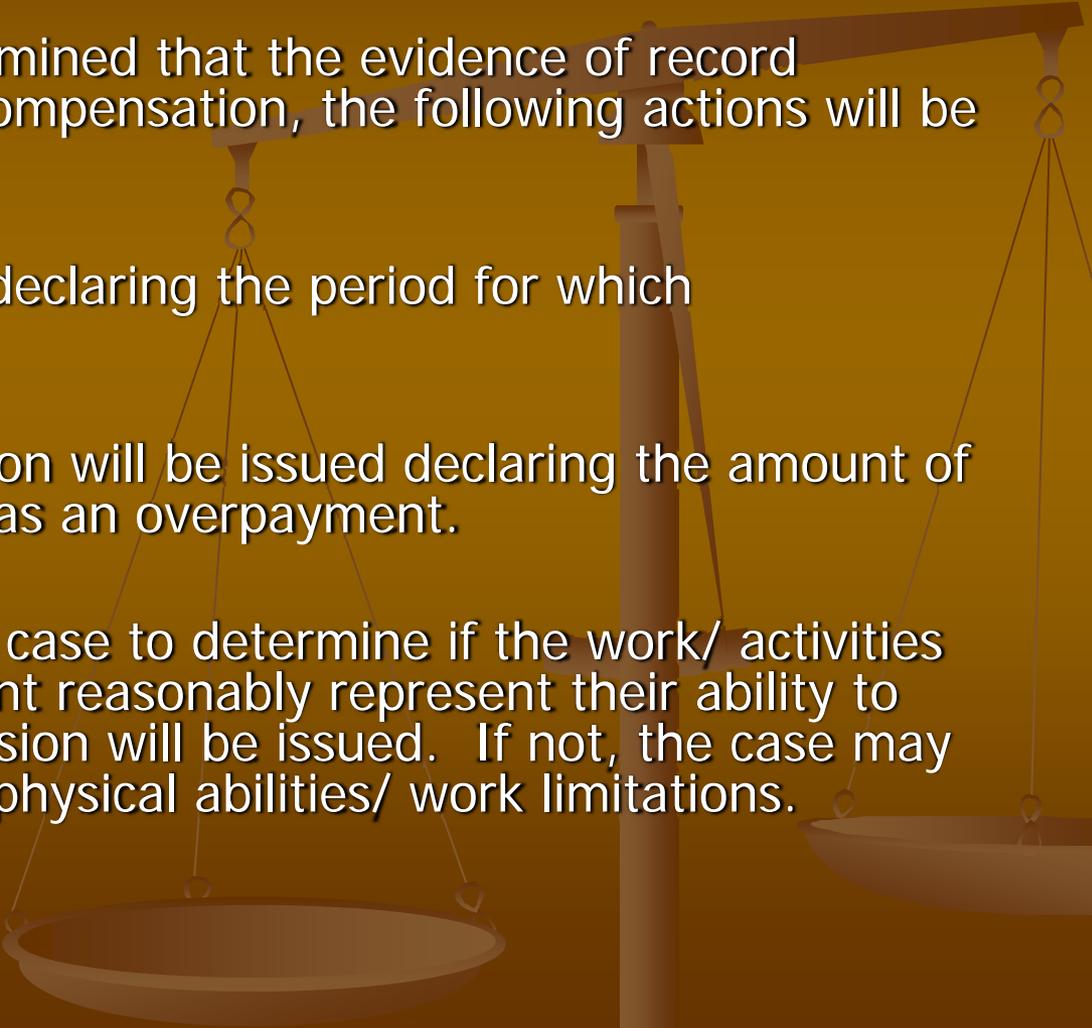
The evidence of record must establish that (1) the claimant "knowingly" made a false statement and (2) should have reasonably known to report earnings or employment activities.

- 1 For an omission or understatement to be considered "knowingly" made, the file must contain positive evidence such as a statement from the claimant that he or she had no earnings or a statement indicating earnings less than the amount actually earned according to other sources. This is usually established through the CA-1032.
- 2 To determine whether the claimant reasonably should have known that the earnings or employment activity should have been reported to the Office, the circumstances of the case should be carefully evaluated with respect to the claimant's age, education level and familiarity with the reporting requirements, as well as the nature of the employment/earnings involved and any other relevant factors.

Determine the Period of the Forfeiture

- If Form CA-1032 issued and completed by the claimant, the entire period covered by the form or fifteen months from the date signed by the claimant, whichever is less, is forfeit.
- If no CA-1032, the period of forfeiture is limited to the period the claimant actually worked and did not report earnings. *See Jack Langley, 34 ECAB 1077.*

Administrative Actions



Once the office has determined that the evidence of record supports a forfeiture of compensation, the following actions will be taken:

1. A decision will be issued declaring the period for which compensation is forfeit.
2. A preliminary determination will be issued declaring the amount of the forfeit compensation as an overpayment.
3. The office will review the case to determine if the work/ activities performed by the claimant reasonably represent their ability to work. If so, a LWEC decision will be issued. If not, the case may be further developed for physical abilities/ work limitations.

An interesting case...

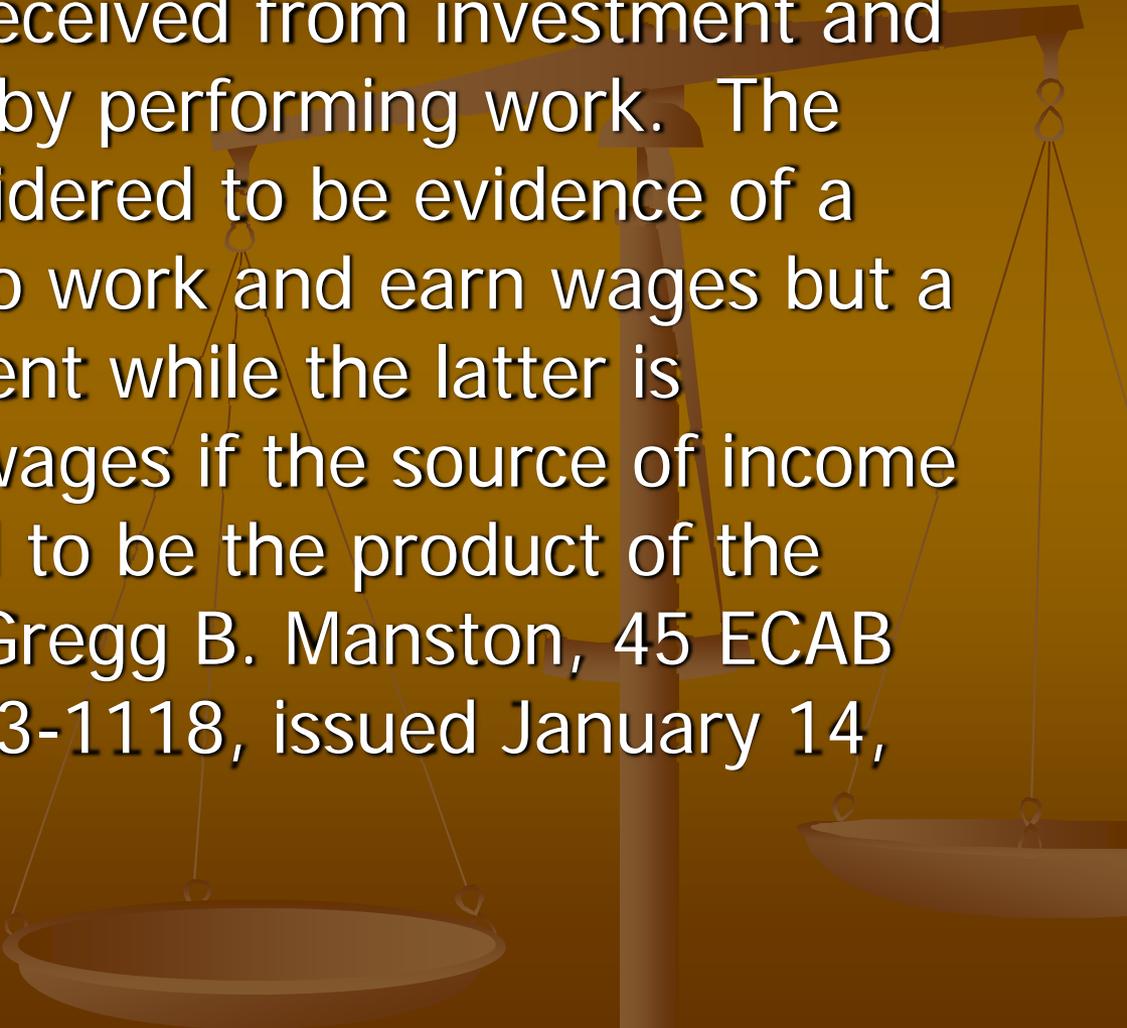
The claimant had worked using two different names and social security numbers. Medical evidence dated July 24, 1990 from her attending Board-certified psychiatrist indicated that the claimant suffered from a form of mental illness in which two personalities were present, each using a different name. The claimant was totally divorced from one personality when she was in the other, and could not remember anything about the other personality.

The Board found that the Office did not establish that the claimant knowingly omitted earnings for a portion of the period that was declared subject to forfeiture. During one of the reporting periods covered by the CA-1032 forms, the claimant was suffering from two personalities, and therefore, a finding that she had "knowingly" omitted earnings could not be made for that period of time. The Board did affirm that periods of time covered by CA-1032 forms signed prior to the July 24, 1990 medical report were subject to forfeiture, since the medical evidence did not specify when the two separate personalities began to manifest themselves.

Ruth Moreno Rios, Docket No. 94-1977, Issued July 14, 1997

Other ECAB cases.....

- The Office may not base application of the forfeiture provision strictly on conclusions drawn in an investigation, but rather the evidence of record must establish that the claimant had unreported earnings from employment which were knowingly not reported. Louis P. McKenna, Jr., 46 ECAB ____ (Docket No. 93-2436, issued December 8, 1994).

- 
- The Board has held that there is a distinction between income received from investment and earnings received by performing work. The former is not considered to be evidence of a claimant's ability to work and earn wages but a return on investment while the latter is considered to be wages if the source of income can be established to be the product of the claimant's work. Gregg B. Manston, 45 ECAB ____ (Docket No. 93-1118, issued January 14, 1994).

Office Decision Affirmed

- The Board found that appellant was subject to the forfeiture provisions of the Act because he failed to report earnings to the Office as required. The evidence revealed that appellant was self-employed in running a video arcade business and performed activities in the operation of the business which demonstrated that he was physically able to perform remunerative work and was no longer totally disabled. **Although appellant contended that the video arcade business did not produce a net profit, this reason has not been accepted by the Board as a reasonable justification for the failure to report employment or earnings to the Office as required.** William G. Austin, 39 ECAB ____ (1988).

Office Decision Affirmed

- Appellant, a former letter carrier, was found to have forfeited his right to compensation because he knowingly omitted or understated his earnings from the sale of illegal substances. The Office had informed appellant of his obligation to report his employment or earnings as periodically requested on Office form CA-1032. Appellant advised the Office he was not working or earning any outside income. An investigation of the inspector general, which included police surveillance reports, revealed that appellant had self-employment as a dealer of controlled substances. The Board noted that appellant's "earnings" came from illegal activities as opposed to earnings from private industry or self-employment in a legitimate business venture but that this fact would not protect a claimant who is in receipt of compensation benefits from the reporting requirements imposed by section 8106(b). **The receipt of money from illegal activities may be characterized by the Office as "income" or "earnings" to the claimant from self-employment.** Norman R. Moon, 42 ECAB ____ (Docket No. 91-0700, issued September 30, 1991).

Office Decision Affirmed

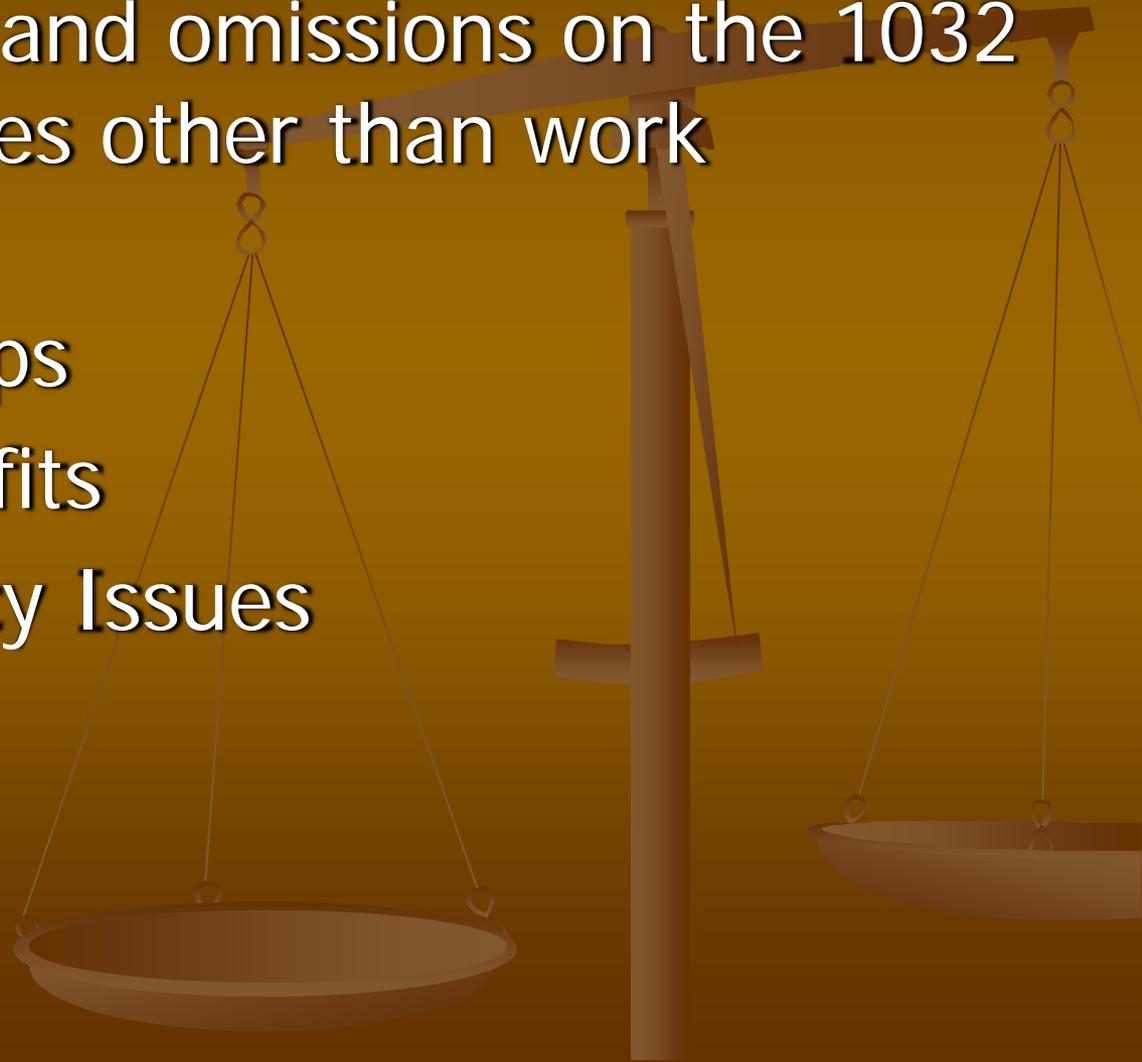
- Appellant knowingly failed to report self-employment and earnings as a youth minister at a church where he received free housing or living expenses in return for his work. Appellant stated that he was a volunteer and that he did not knowingly fail to report employment. **The broad, inclusive language of the forms showed that appellant knew that he was required to report his employment. A youth minister job description listed specific duties, noted the time required for duties, and stated that housing and utilities were provided as compensation. Appellant was not a volunteer nor were his work activities otherwise *de minimus*. As he "knowingly" omitted his earnings, the Office properly found that he forfeited compensation.** James M. Steck, 49 ECAB ____ (Docket No. 95-2406, issued October 22, 1997).

Office Decision Reversed

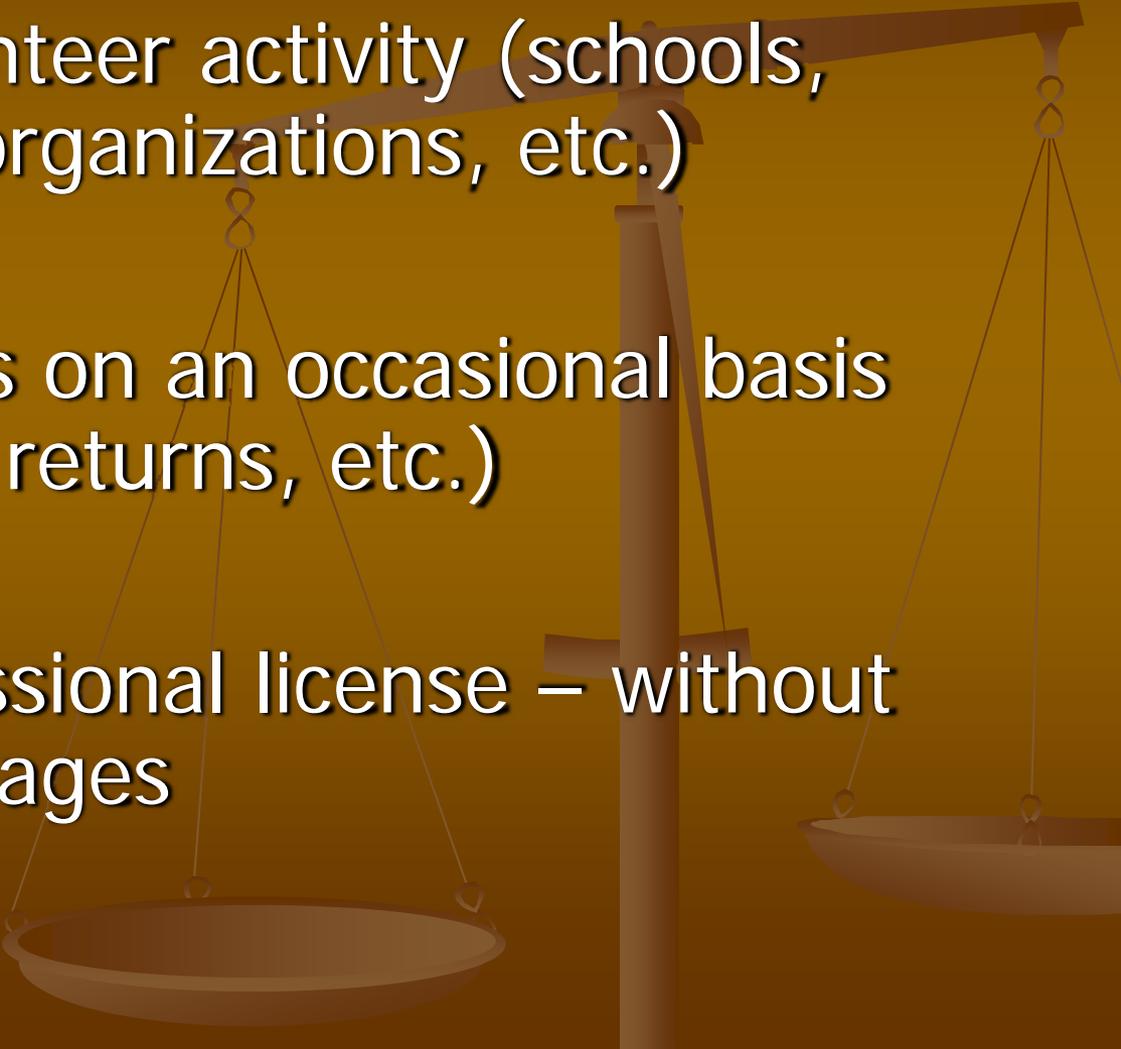
- Appellant, a food inspector, was found to have forfeited his right to compensation based on his failure to report earnings from two farms that he owned and leased. The Board found that the evidence did not establish that any income appellant received from owning a farm on which cattle were raised was the product of his work rather than representing the return on his capital. **The occasional activities that appellant engaged were not the type that would constitute a job that would generally be available in the open labor market.** The Board found that the present case was similar with Harlan H. Golden, 35 ECAB 1180 (1984), in which the injured employee shared in the profits of operating a farm with his sons. The Board reversed the Office's forfeiture and overpayment determinations. Jack Sipe, 43 ECAB ____ (1992) [Docket No. 91-1820, issued May 22].

Cases that do NOT lead to Forfeiture:

- Mis-statements and omissions on the 1032 form about issues other than work activity:
 - Food Stamps
 - State Benefits
 - Dependency Issues



Cases that typically do NOT lead to Forfeiture:

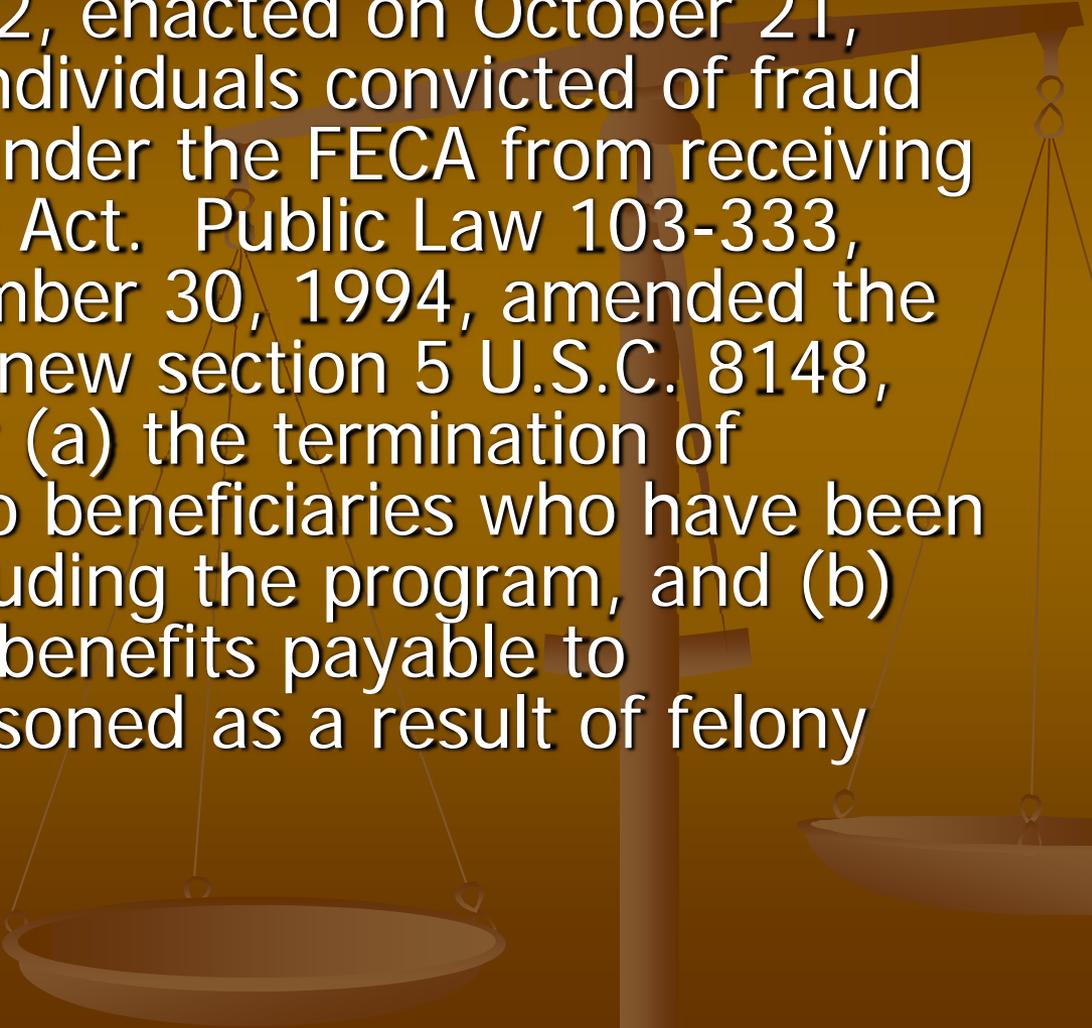
- Occasional volunteer activity (schools, hospitals, civic organizations, etc.)
 - Helping relatives on an occasional basis (completing tax returns, etc.)
 - Holding a professional license – without proof of work/wages
- 

FECA Fraud and Criminal Prosecution



Fraud Against the Act

Public Law 103-112, enacted on October 21, 1993, prohibited individuals convicted of fraud related to claims under the FECA from receiving benefits under the Act. Public Law 103-333, enacted on September 30, 1994, amended the FECA by adding a new section 5 U.S.C. 8148, which provides for (a) the termination of benefits payable to beneficiaries who have been convicted of defrauding the program, and (b) the suspension of benefits payable to beneficiaries imprisoned as a result of felony conviction.



§8148 Forfeiture of benefits by convicted felons

(b) (1) Notwithstanding any other provision of this chapter (except as provided under paragraph (3)), no benefits under this subchapter or subchapter III of this chapter shall be paid or provided to any individual during any period during which such individual is confined in a jail, prison, or other penal institution or correctional facility, pursuant to that individual's conviction of an offense that constituted a felony under applicable law.

(2) Such individual shall not be entitled to receive the benefits forfeited during the period of incarceration under paragraph (1), after such period of incarceration ends.

§8148 Continued

- (3) If an individual has one or more dependents as defined under section 8110(a), the Secretary of Labor may, during the period of incarceration, pay to such dependents a percentage of the benefits that would have been payable to such individual computed according to the percentages set forth in section 8133(a) (1) through (5).
- (c) Notwithstanding the provision of section 552a of this title, or any other provision of Federal or State law, any agency of the United States Government or of any State (or political subdivision thereof) shall make available to the Secretary of Labor, upon written request, the names and Social Security account numbers of individuals who are confined in a jail, prison, or other penal institution or correctional facility under the jurisdiction of such agency, pursuant to such individuals' conviction of an offense that constituted a felony under applicable law, which the Secretary of Labor may require to carry out the provisions of this section.

18 U.S.C. 1920

"§1920. False statement or fraud to obtain Federal employee's compensation

"Whoever knowingly and willfully falsifies, conceals, or covers up a material fact, or makes a false, fictitious, or fraudulent statement or representation, or makes or uses a false statement or report knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the application for or receipt of compensation or other benefit or payment under subchapter I or III of chapter 81 of title 5, shall be guilty of perjury, and on conviction thereof shall be punished by a fine of not more than \$250,000, or by imprisonment for not more than 5 years, or both; but if the amount of the benefits falsely obtained does not exceed \$1,000, such person shall be punished by a fine of not more than \$100,000, or by imprisonment for not more than 1 year, or both".

(2) The table of sections for chapter 93 of title 18, United States Code, is amended by amending the item relating section 1920 to read as follows:

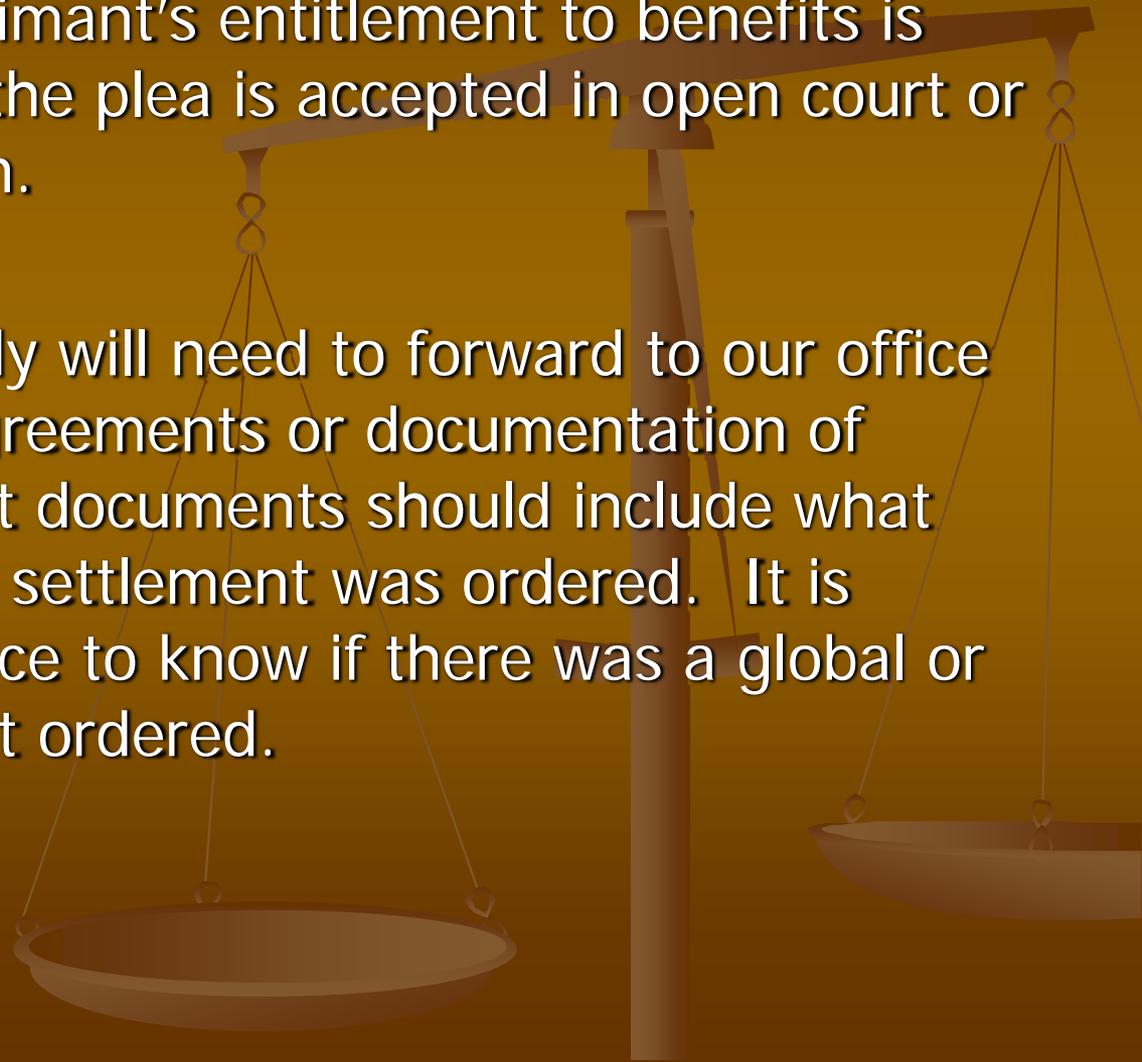
"1920. False statement or fraud to obtain Federal employee's compensation".

(c) EFFECTIVE DATE.-The amendments made by this section shall take effect on the date of the enactment of this Act. The amendments made by subsection (a) shall apply to claims filed before, on, or after the date of enactment of this Act, and shall apply only to individuals convicted after such date of enactment.

Fraud Conviction

Under §8148, the claimant's entitlement to benefits is terminated the date the plea is accepted in open court or the date of conviction.

The investigative body will need to forward to our office any accepted plea agreements or documentation of conviction. The court documents should include what form of restitution or settlement was ordered. It is important for our office to know if there was a global or non-global settlement ordered.



Pretrial Diversion

During pretrial diversion the case is put on hold for a period of 6 months to one year, and if the defendant abides by the terms of the pretrial diversion agreement, the case is dismissed and there is no conviction. In such a circumstance, there's no actual "conviction," and termination under 5 U.S.C. § 8148(a) is not appropriate.

