2004 OPM Federal Workforce Conference

OWCP
Claims
Processing

Linda DeCarlo
Branch of Technical Assistance

FECA Overview

- Federal Employees' Compensation Act passed in 1916.
- Provides compensation to civilian employees of the US for disability due to personal injury or disease sustained in the performance of duty.
- Provides benefits to dependents if a work-related injury or disease causes death.

FECA Overview

- Funded through agency charge-backs.
- Remedial in nature.
- Non-adversarial – an attorney is not required.
- Sole remedy – a federal employee or surviving dependent is not entitled to sue the US or recover damages for injury or death under any other law.

FECA Overview

- Administered by the Department of Labor, Office of Workers' Compensation Programs, Division of Federal Employees' Compensation.
- National Office Organization.
- OWCP adjudicates the claim.
- 12 District offices.

FECA Overview

- Individual cases are protected under the Privacy Act – only the employee, his/her representative and agency personnel may routinely have access to information concerning the compensation claim.
- HIPAA does not apply to OWCP or employing agencies as it relates to information concerning the compensation claim.
- No one may require an employee or other claimant to waive his/her right to claim benefits.

Traumatic Injury

- Wound or other condition of the body caused by external force, including stress or strain.

- Caused by a specific event or series of events or incidents within a single work day or work shift.

CA-1

- Must be submitted to employing agency within 30 days of date of injury to be eligible for COP – however can be submitted up to three years after the injury.
- Must be transmitted to OWCP within 10 work days from the date the agency received it.

DO NOT HOLD!

CA-1 – Agency Responsibilities

- Review for completeness.
- Authorize medical care.
  - Form CA-16
- Advise employee of the right to elect COP.
- Advise employee of his/her responsibility to submit medical evidence.

CA-1

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

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 ☐ Male ☐ Female | 5. Home telephone | 6. Grade as of date of injury Level Step

7. Employee's home mailing address (Include city, state, and ZIP code)

8. Dependents
☐ Wife, Husband
☐ Children under 18 years
☐ 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 ☐ a.m. ☐ 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

CA-1

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 ☐ CSRS ☐ FERS ☐ Other, (identify)

20. Regular work hours From: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

21. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

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? ☐ Yes ☐ No (If "No," explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☐ No

30. Was injury caused by third party? ☐ Yes ☐ 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? ☐ Yes ☐ No

35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? ☐ Yes ☐ 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

Occupational Disease

- Condition attributable to exposure to work factors over a period longer than one work day or shift.
- COP is not provided.
- CA-16 is not issued.

CA-2

- Must be submitted to employing agency within 3 years of the date when the employee becomes aware, or reasonably should have been aware, of a possible relationship between the medical condition and the employment, or the date of last exposure.
- Must be transmitted to OWCP within 10 work days from the date the agency received it.

DO NOT HOLD!

CA-2

- Checklist
  - 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

CA-2

Notice of Occupational Disease and Claim for Compensation

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 ( )
6. Grade as of date of last exposure Level Step
7. Employee's home mailing address (Include city, state, and ZIP code)
6. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ 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 MO. Day Yr.
13. Explain the relationship to your employment, and why you came to this realization
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 lo 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.

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

Form CA-2
Rev. Jan. 1997

CA-2

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 From: : ☐ a.m. ☐ p.m. To: : ☐ a.m. ☐ p.m.

22. Regular work schedule ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

24. First dat medical care received Day Yr.

25. Do medical reports show employee is disabled for work? ☐ Yes ☐ No

26. Date employee first reported condition to supervisor Mo. Day Yr.

27. Date and hour employee stopped work Mo. Day Yr. Time: ☐ a.m. ☐ p.m.

28. Date and hour employee's pay stopped Mo. Day Yr. Time ☐ a.m. ☐ 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 Mo. Day Yr. Time : ☐ a.m. ☐ 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? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

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

Form CA-2
Rev. Jan. 1997

Recurrence

- A spontaneous return of symptoms or increase of disability due to a previous injury or occupational disease without intervening cause, or a return or increase of disability due to a consequential injury.
- A recurrence of a medical condition is defined as a documented need for further medical treatment for the accepted condition or injury when there is no accompanying work stoppage.
- Wage loss resulting from the withdraw of light duty accommodation.
- No event other than the previous injury accounts for the disability.

CA-2a

- No medical treatment is authorized at OWCP expense until the claim is adjudicated.
- If employee was entitled to COP and 45 calendar days of COP have not been exhausted, he/she may elect to use remaining days, as long as 45 days have not elapsed since the first return to work.
- Employee may use sick or annual leave pending adjudication of claim.

CA-2a

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: 05-31-05

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 ☐ Male ☐ Female
6. Home telephone
7. Home mailing address (include city, state, and ZIP code)
8. Dependents
   - ☐ Wife, Husband
   - ☐ Children under 18 years
   - ☐ 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)
    - ☐ Medical Treatment Only
    - ☐ 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.) ☐ Yes ☐ 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

CA-2a

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: ☐ a.m. ☐ p.m. To: ☐ a.m. ☐ p.m.

29. Regular work days ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ 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 ☐ a.m. ☐ 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 ☐ a.m. ☐ p.m.

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. ☐ Yes ☐ No

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? ☐ Yes ☐ No

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? ☐ Yes ☐ 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.

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.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)	42. Title	43. Work phone	44. Date (mo., day, year)

Conditions of Coverage

- Time
- Civilian Employee
- Fact of Injury
- Performance of Duty
- Causal Relationship

Conditions of Coverage
Time

- Employee has three years from:
  - Date of Injury
  - Date of First Awareness
  - Date of Last Exposure

Conditions of Coverage
Civilian Employee

- FECA covers all civilian employees except for non-appropriated fund employees.
- Temporary employees covered on the same basis as permanent employees.
- Contract employees, volunteers, and loaned employees are covered under some circumstances.

Conditions of Coverage
Fact of Injury

- Factual – Actual occurrence of an accident, incident, or exposure in time, place, and manner alleged.

- Medical – A medical condition diagnosed in connection with that accident, incident or exposure.

Conditions of Coverage Performance of Duty

- Injury occurred while performing assigned duties or engaging in an activity reasonably associated with the employment.
- Injury occurred on work premises.
  - Use of facilities for personal comfort.
  - Includes parking facilities owned by employer.
  - Coverage extended for a reasonable time before or after work hours.

Conditions of Coverage Performance of Duty

- Injury occurred off premises while engaging in work activities.
  - Employees are not covered en route between work and home unless the agency furnishes transportation, the employee is required to travel during a curfew or emergency or the employee is required to use their personal vehicle during the work day.

Conditions of Coverage Performance of Duty

- Other factors
  - Recreation
  - Horseplay
  - Assault
  - Harassment or Teasing
  - Idiopathic Falls
  - Emergencies
  - Union Representation

Conditions of Coverage Performance of Duty

- Recreation: an employee is considered in the performance of duty while engaged in formal recreation when either the employee is paid for participating or the recreational activity is required and prescribed as a part of the employee's training or assigned duties.

Conditions of Coverage Performance of Duty

- Horseplay: an employee is considered to be in the performance of duty if the horseplay was of a character that could reasonably be expected where workers are thrown into personal association for extended periods of time.

Conditions of Coverage
Performance of Duty

- Assault: an employee is considered to be in the performance of duty if the assault was accidental or arose out of an activity directly related to the work or work environment. An assault is not compensable if it arose out of a personal matter having no connection with the employment.

Conditions of Coverage Performance of Duty

- Harassment / Teasing: Employees who are harassed, teased or called derogatory names by coworkers are considered to be in the performance of duty provided that the reasons for the harassment or teasing are not imported into the employment from the employee's domestic or private life.

Conditions of Coverage
Performance of Duty

- Idiopathic Falls: Defined as one where a personal, non-occupational pathology causes an employee to collapse.

  Injuries that can be attributed to the intervention or contribution of some hazard or special condition of the employment, including normal furnishings of an office or other workplace are compensable.

Conditions of Coverage
Performance of Duty

- Emergencies: Coverage is extended to employees who momentarily step outside the sphere of their employment to assist in an emergency such as to extinguish a fire or help a person hit by a car.

Conditions of Coverage
Performance of Duty

- Union Representation: Employees performing representational functions, which entitle them to official time, are in the performance of duty.

  Activities relating to the internal business of the union organization, such as soliciting new members or collecting dues are not included.

Conditions of Coverage Performance of Duty

- Emotional Reaction: an employee who suffers from a medical condition resulting from factors of employment that result in an emotional reaction can be considered to be in the performance of duty.
  - Personnel actions such as the regular administrative functions of an agency (leave usage, disciplinary actions, etc.), performance ratings, performance assessments and informal discussions of performance, standing alone, are not sufficient to provide coverage under the FECA. For a personnel action to be compensable, the employee must establish an error or abuse of administrative authority by the agency. Without this showing, the emotional reaction is considered to be self-generated.

Conditions of Coverage
Statutory Exclusions

- Willful Misconduct – deliberate and intentional disobedience of rules / orders. Not carelessness.
- Drug or Alcohol intoxication – proximately caused the injury.
- Intent to injure self or others – intent must be established.

Conditions of Coverage
Causal Relationship

- Link between work-related exposure/injury and any medical condition found.
- Based entirely on medical evidence provided by physicians who have examined and treated the employee.
- Opinions of employee, supervisor, or witnesses not considered – nor is general medical information contained in published articles.

Conditions of Coverage
Causal Relationship

- Direct Causation – injury or factors of employment result in condition claimed through natural and unbroken sequence.
- Aggravation – preexisting condition worsened, either temporarily or permanently, by a work-related injury.
- Acceleration – a work-related injury or disease may hasten the development of an underlying condition.
- Precipitation – a latent condition that would not have manifested itself on this occasion but for the employment.