



Worker's Compensation

Module 16



Agenda

- Overview of FECA
- Initial Response
- Continuation of Pay
- Supervisor Responsibilities
- OWCP Forms / Medical Documentation
- Leave Codes
- Group Activity



Overview of FECA

- Provides compensation benefits to civilian employees of the U.S. federal government for disability due to traumatic injury or disease or illness in performance of duties
- Provides payment of benefits to dependents for work-related death of an employee as a result of traumatic injury or occupational disease/illness



Overview of FECA

- Persons must have been a Technician employee at time of injury
- Notice of injury/disease must be filed within statutory time (3 yrs from date of incident or exposure or date awareness of work relationship)
- Must be able to identify the factors which caused the injury/disability



Overview of FECA

- Must have been in performance of official duties at time of incident
- Must prove federal employment cause – based on medical evidence from a physician who performed examination or provided treatment



FECA Does Not Cover.....

- State employees
- Military Status personnel
- Injuries incurred during drill



Initial Response

For a “Traumatic” On-The-Job Injury

- Seek Medical Treatment for the injured technician if necessary! *For emergencies, please accompany the technician to the emergency room and ensure that they receive immediate care!*

The following forms **MUST** be completed during the initial hospital/doctor’s visit and forwarded to the ICPA as soon as possible:

- CA-16 (Authorization for Examination and/or Treatment) within the first 48 hours after the injury.
- CA-20 (Attending Physician’s Report) if after the first 48 hours of injury
- CA-17 (Duty Status Report)

MOST FORMS ARE AVAILABLE TO PRINT AT:

<http://www.dol.gov/esa/owcp/dfec/regs/compliance/forms.htm>

* THE CA-16 IS A CONTROLLED FORM AND CAN ONLY BE OBTAINED BY THE ICPA.

- Report the Injury to the designated Safety Official .
- Complete a CA-1, Notice of Traumatic Injury, through EDI following the instructions in this guide. This step should be completed on the day of the injury or the following day, if at all possible.
- All completed forms must be received at the Human Resources Office no later than **TEN DAYS** from the date of injury. This includes a signed copy of the CA-1, CA-16, CA-17, and any other medical documentation from the physician if applicable.
- Call the Injury Compensation Program Administrator (ICPA) on the front cover if you have any questions about filing the claim.



CA-1

Filing a claim for a *Traumatic* Injury



- ✓ Wound or other condition of the body caused by external force, including stress or strain.
- ✓ Identifiable by time and place of occurrence and member of the body affected.
- ✓ Caused by a specific incident within a single day or work shift.

DIUCS/EDI:

https://cacdiucs3.cpms.osd.mil/forms/frmservlet?config=SAFER_ALONE_PRO

- This application requires Java and may take a minute to load.
- Once loaded click “OK” to agree with the disclaimer.
- Enter the employee’s **SSN** and **Birth date**
- For **Traumatic Injury** Claims (occurred during one work shift/ specific location/ time) fill out a **CA-1**.
- Note: White fields are required information to be filled out, yellow fields are optional, and grey fields are for HRO use.

Supervisor Entry

Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN) 123-45-6789

Date of Birth (MM/DD/YYYY) 05-26-1980

Claim Form Type

CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Exit

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Step 1 (Employee Data): The electronic form will open. All of the white fields will need to be completed with the correct information. Yellow fields are optional but should be completed if the information is known.

The screenshot shows the 'Emp. Data' tab of the EDI_CA1 form. The fields are as follows:

- 1. Name of employees: Last Name: SHERWIN, First Name: BEVERLY, Middle Name: C, Suffix: (not entered)
- 2. Social Security Number: [Redacted]
- 3. Date of birth: 05-26-1980
- 4. Sex: Male (unchecked), Female (checked)
- 5. Home Phone: [Empty]
- 6. Grade as of date of injury: Level: GS09, Step: 01
- 7. Employee's home mailing address: Street Address, City, State, ZIP Code
- 8. Dependents: Wife, Husband; Children under 18 years; Other
- Claim information: EDI claim number, Status, Trading partner ID: FECAEDI, Status time

Employee's
Information Item
#'s 1-8

Step 2 (Injury): Be very specific! Block 10 is a default; please be sure to change it to the correct date and time of injury. Complete blocks 13 and 14.

The screenshot shows the 'Injury' tab of the EDI_CA1 form. The fields are as follows:

- 9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): [Yellow field]
- 10. Date & time injury occurred: MM-DD-YYYY HH:MM [AM|PM]: 06-24-2009 12:00 AM
- 11. Date of this notice: MM-DD-YYYY: 06-24-2009
- 12. Employee's Occupation Description: HUMAN RESOURCES SPECIALIST
- 13. Cause of injury (Describe what happened and why): Be very SPECIFIC... What happened, where, equipment involved, etc.
- 14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg): Be very SPECIFIC... What part(s) and side(s) of the body were affected.
- a. Occupation code: 0201
- Cause of injury code: [Empty]
- b. OSHA Type: [Empty]
- c. OSHA Source: [Empty]
- Nature of Injury: [Empty]
- Anatomical location code: Part of Body, Side of Body

Click Tab

Change Default
Date and Time

Step 3 (Employee Signature): If employee needs to be off of work due to their injury, please chose “a” for continuation of pay (COP). If continuation of pay is used, the employee will need to provide medical documentation within 10 days of their injury or COP could be controverted.

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 intoxication, or by my willful misconduct, intent to injure myself or another person, nor by 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 as such.

b. Sick and/or Annual Leave

c. Unknown

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.

Step 4 (Witness): If a witness was present, please have them complete all of the information on this page.

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

The witness should give a **very detailed** description of the incident and should include all details that they feel may help with the claim. Please exclude opinions or diagnoses.

Name of Witness: Last Name First Name Middle Name

Signature of witness: _____ Date signed:

Street Address:

City:

State: ZIP Code:

Step 5 (Sup Rpt 1): Please fill out all fields. If the employee stopped work and will be using COP, fill out block 24.

The screenshot shows the 'Sup Rpt 1' tab in the EDI_CA1 software. The form is divided into several sections:

- 17. Agency name and address of reporting office:** Includes fields for Agency name, Street Address, City, State, and ZIP Code.
- 18. Employee's duty station:** Includes fields for Street Address, City, State, and ZIP Code.
- 19. Employee's retirement coverage:** Includes radio buttons for CSRS, FERS, and OTHER (identify).
- 20. Regular work hours:** Includes fields for From and To times in HH:MM [AM/PM] format.
- 21. Regular work schedule:** Includes checkboxes for Sun., Mon., Tues., Wed., Thurs., Fri., and Sat.
- 22. Date of injury:** MM-DD-YYYY format, with the value 06-24-2009 entered.
- 23. Date notice received:** MM-DD-YYYY format, with the value 06-24-2009 entered.
- 24. Date & time employee stopped work:** MM-DD-YYYY HH:MM [AM/PM] format.

A callout box labeled 'Click Tab' points to the 'Sup Rpt 1' tab in the software interface.

Step 6 (Sup Rpt 2): This page is optional but input the information if known. If the employee was injured during an authorized physical fitness program, block 28 should be "Yes" to let the Department of Labor know that they were in the performance of duty. No explanation is needed. Since military membership is a condition of employment, dual status technicians are entitled to OWCP benefits during authorized PT time. *(See Appendix for PT Policy Letter)

The screenshot shows the 'Sup Rpt 2' tab in the EDI_CA1 software. The form contains the following sections:

- 25. Date pay stopped:** MM-DD-YYYY format.
- 26. Date 45 day period began:** MM-DD-YYYY format.
- 27. Date & time employee returned to work:** MM-DD-YYYY HH:MM [AM/PM] format.
- 28. Was employee injured in performance of duty?** Includes radio buttons for Yes and No (If "No", explain).
- 29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?** Includes radio buttons for Yes (If "Yes", explain) and No.

A callout box labeled 'Click Tab' points to the 'Sup Rpt 2' tab in the software interface.

Step 7 (Sup Rpt 3): A “Third Party” refers to someone or something caused the injury at no fault to the employee (i.e. Gets hit by a car, falls from a defective ladder, etc.) If injury was caused by a third party, choose “Yes” in block 30 and fill out blocks 31, 32, and 33.

Click Tab

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 **Sup Rpt 3** Sup Rpt 4 Safety Data Sup Signature

30. Was injury caused by third party?
 Yes
 No

31. Name and address of third party (include city, state, and ZIP code)
 3rd party name: _____
 name continued: _____
 Street Address: _____
 City: _____
 State: _____ ZIP Code: _____

32. Name and address of physician first providing medical care (Include city, state, and ZIP code)
 Last Name _____ First Name _____ Middle Name _____ Title _____
 Street Address: _____
 City: _____
 State: _____ ZIP Code: _____

33. First date medical care received
 MM-DD-YYYY

33a. Provided by Agency medical facility?
 Yes No

34. Do medical records show employee is disabled for work?
 Yes No Unknown

Step 8 (Sup Rpt 4): Fill out blocks 35. If necessary expand on the details.

Click Tab

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 **Sup Rpt 4** Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?
 Yes No (If "No", explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.
 Yes (If "Yes", explain) No

37. Pay rate when employee stopped work
 Amount: _____ Per: **<not entered>**

Step 9 (Safety Data): This page will populate the OSHA 301 form that is sent to the safety officer. Please check all that apply to the specific injury.

Click Tab

EDI_CA1
Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | **Safety Data** | Sup Signature

Work Environment Exceptions

- Employee was member of general public rather than an employee at the time of injury.
- Injury resulted from non-work related event or exposure occurring outside of the work environment.
- Injury resulted from voluntary participation in a wellness program or in a medical, fitness, or recreational activity.
- Injury resulted from employee eating, drinking, or preparing food or drink for personal consumption.
- Injury resulted from personal grooming, self medication, or was intentionally self-inflicted.
- Injury resulted from a motor vehicle accident occurring on company premises while commuting to or from work.
- Injury is the common cold or flu.

Privacy Case Status: A Not A Privacy Case

General Recording Criteria

- Employee is deceased as a result of the incident.
- Employee suffered days away from work as a result of the incident.
- Employee's work activity was restricted as a result of the incident.
- Employee was treated in an emergency room as a result of the incident.
- Employee was hospitalized overnight as an in-patient.
- Employee lost consciousness as a result of the incident.
- Employee was transferred to another job as a result of the incident.

Preliminary OSHA Recordability

29 CFR 1904:

OSHA 300 Log Coding:

As Of: 06-24-2009 08:38:07 AM

Injury Classification: A Injury

Step 10 (Sup Signature): Fill out all of this page. You will need to include your email address. Click on the appropriate category in block 39. When complete, scroll down to the bottom of the page.

Click Tab

EDI_CA1
Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | **Sup Signature**

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:

Was an on-site investigation conducted?
 Yes No

What was the root cause of this injury?

Name of Supervisor: Last Name First Name Middle Name

Signature of supervisor: **Date signed:**
Supervisor's Title Supervisor's Email Address: Supervisor's Office phone number

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 expenses incurred or expected: forward this form to OWCP
- Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- First Aid Injury

Scroll down

Step 11 (View Claim): Once you have scrolled to the bottom of the page; click on “View Claim”. This will bring up a .PDF of the CA-1. Print the claim and obtain signatures from the employee, witnesses (if applicable), and the supervisor. *Fax a copy of the signed CA-1 along with all medical documentation to HRO at 614-336-7052.*

The screenshot shows a web form for supervisor signature. At the top right, there is a date field labeled "Date signed:" with the value "06-24-2009" and a placeholder "MM-DD-YYYY". Below this are fields for "Supervisor's Title", "Supervisor's Email Address:", and "Supervisor's Office phone number". The "Supervisor's Email Address:" field is highlighted in yellow and circled in black. A callout box points to this field with the text: "Enter the supervisor's email address. Hit 'TAB' to verify and reenter." Below the form are four buttons: "View Claim" (circled in black), "Submit Claim", "Cancel", and "Exit".

Enter the supervisor's email address. Hit "TAB" to verify and reenter.

PRINT!
Send a signed copy to the
ICPA.



Step 12 (Submit Claim): After you have printed a copy of the CA-1, Click “Submit Claim”. An electronic notice will be sent to the ICPA that a new claim has been filed. They will go into EDI/DIUCS and authenticate the claim. A claim number will be issued within 2 weeks of submission. It is very important that once issued, the claim number is given to all providers that have seen the employee for their injury to ensure prompt medical bill payment.

This screenshot is identical to the one in Step 11, but the "Submit Claim" button is circled in black. A callout box points to this button with the text: "Click 'Submit Claim' to send an electronic notice to the ICPA."

Click "Submit Claim" to send an electronic notice to the ICPA.



Continuation of Pay (COP)

- COP is the continuation of an employee's regular pay for a period not to exceed 45 calendar days.
- Time lost on the day or shift of the injury **does not count toward COP.**
- The employee's regular pay includes any night or shift differential and various kinds of premium pay (but not Sunday or overtime pay).
- To be eligible for COP the employee must:
 - File a Traumatic Injury Claim. Occupational Illness claims are not entitled to COP.
 - File the claim within **30 days** from the DOI.
 - Begin any lost time within 45 days from the DOI.



Continuation of Pay (COP)

- COP is a calendar day entitlement. The employee is entitled to 45 calendar days of COP. This includes holidays and RDOs.
- Time off covered under COP does not have to be continuous.
- Any portion of a day charged to COP will count as one day of the entitlement. Special timekeeping codes are used for COP.



Continuation of Pay (COP)

- Time off covered by COP will be supported by medical documentation.
- The employee initially has **10 calendar days** to provide medical documentation supporting time off work. COP will be charged for this period of time.
- If the employee does not provide the medical documentation within this time period, then COP can be stopped.
- Once the employee provides the medical documentation, COP will be given retroactively to the date it was first stopped.



Continuation of Pay (COP)

- ***COP can be used for....***



Surgery....



Recovery....



**Doctor's Visits/
Physical Therapy.....**



Supervisor's Responsibilities

- Provide a safe work environment
- Enforce safety regulations
- Ensure employees are aware of health and safety requirements
- Encourage reporting of incidents
- Must know what the employee's responsibilities are so you can relay information



Supervisor's Responsibilities

- File CA-1 online
- Ensure accurate, complete, prompt submission of claims (to OWCP within 14 days of incident)
- Investigate incidents; obtain statements; controvert questionable claims
- Coordinate return to work with employee
- Coordinate personnel actions with HRO



OWCP Forms / Medical Documentation

For Traumatic Injury Cases:

- CA 1----- Report of Injury (must be filed online)
- CA 16----- Authorization for Treatment (ONLY WITHIN FIRST 48HRS)
- CA 17 -----Duty Status Report
- CA 20----- Attending Physician's Report
- **SUPPORTING MEDICAL DOCUMENTATION**
- **Light Duty Memo**



Leave Codes

- **LU Type Hour Code** is used when the employee loses time on the date of injury
- **LT Type Hour Code** is used when the employee loses time after the date of injury
- **KA Type Hour Code** is used when the employee is in a Leave Without Pay (LWOP) status. The system will convert to this payroll code if employee is ineligible for COP and sick leave and annual leave balances have been exhausted.
- **KD Type Hour Code** is used when the employee is requesting compensation from OWCP and a CA-7 has been filed.



Group Exercise



Worker's Compensation

Website for Filing Claims:

https://cacdiucs3.cpms.osd.mil/forms/frmservlet?config=SAFER_ALONE_PRO

HRO webpage:

<http://hr.ong.ohio.gov/HR.aspx>





Worker's Compensation POC's

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