

Reviewing a CA-1 as a Supervisor

When an employee under your supervision has filed a FECA claim in ECOMP, you will receive an email message advising you that the form requires your review. The email message will contain: the ECOMP control number (ECN); form type; status; status changed date; employing organization; employee's initials; date of event and date filed. Click on the link within the message to access the form.

First, the employee's name and organization will be displayed, along with the date of the event and the date the claim was initiated. You must confirm that you have the authority to complete the supervisor portion of this employee's claim. To proceed with review of the claim, click "Yes, I will review this form."

If you believe that you do not have the authority to review the employee's claim, or that it was sent to you in error, click "No, I cannot review this form." You must also select a reason for refusing to review the claim. The employee and AR will be advised by email that you have declined to review the form and the reason you provided.

When you agree to review the form, your IP address will be recorded for security purposes, as noted. Click "I Agree" to proceed.

Next, a summary of information pertaining to the employee's claim will be displayed. Click "Continue" to proceed.

Information entered by the employee in each field of the CA-1 form will now be displayed. You may use the "Go to Field" button to view information entered in each field of the employee portion of the form, but it may not be edited. Click "Continue" to proceed.

Next, enter your name, title and office telephone number, as well as the name and address of the reporting office. You can also enter the OSHA site code, if known, but this field is optional. Click "Continue" to proceed.

Next, select the employee's occupation code, injury type code and injury source code from the drop down lists and select the employee's retirement coverage. If the employee has a set work schedule, answer "yes" to this question and enter the regular work hours and work schedule. If the employee does not work a set schedule, respond "no" to this question. The date of injury and date notice received are pre-populated from the employee's submission of the claim. The remaining fields are optional, but should be completed if this information is

available: date stopped work; date pay stopped; date 45 day period began; and date returned to work. Click "Continue" to proceed.

Next, indicate whether the employee was injured in performance of duty. If not, an explanation must be provided. Also indicate whether the injury was caused by the employee's willful misconduct, intoxication or intent to injure self or other. If so, an explanation must be provided. Additionally, indicate whether the injury was caused by a third party. If so, the name must be provided. The third party's address should also be provided if known, however this field is optional. The anatomical location of injury, nature of injury, cause of injury and extent of injury should be selected from the drop down lists. Completion of these fields by the supervisor is optional. If you do not complete them the codes will be selected by the Agency Reviewer (AR) during final review of the form. Click "Continue" to proceed.

Next, if available, the name and address of the physician first providing medical care, as well as the first date medical care was received, should be entered, however these fields are optional. You must indicate whether medical reports show the employee is disabled from work, and whether your knowledge of the facts of the reported injury agrees with the statements of the employee and/or witnesses. If not, an explanation must be provided. If you controvert the employee's entitlement to Continuation of Pay (COP), the reason must be stated. Please refer to the help text for a list of valid controversion reasons. If COP is not controverted, this section should be left blank. You should also enter the pay rate as of the date the employee stopped work, if applicable, however this field is optional. If you wish to note any exceptions to the information furnished on the CA-1 form by you or the employee, enter an explanation in the space provided. Click "Continue" to proceed.

Next, you may upload any attachments which you wish to submit with the claim. If additional space is needed to explain responses to any of the previous fields completed in the supervisor portion of the form, you may indicate "see attached" in that field and upload an explanatory statement in this step. Click "Continue" to proceed.

Finally, a summary of information entered in the supervisor portion of the CA-1 form is displayed. If any required information has not been entered, there will be a notice at the top of the screen and the field will be indicated in red. You will need to go back and complete all required fields before you can continue. If any information needs to be edited you may use the "Go to Field" button to return to the field and make changes. When all information has been confirmed, click "Continue" to proceed.

You must then indicate whether the form is ready for forwarding to the AR for final review. If you feel the claim is not ready for forwarding and requires resubmission, click "Request Resubmission" and select the reason from the drop

down list. The employee and AR will be notified by email that you have requested resubmission and the reason you provided.

If the claim is ready to be forwarded, click “Sign and Forward Form” You should also indicate whether the claim is related to any of the events listed in the drop down list. You must agree with the displayed acknowledgement statement to proceed.

Confirmation that the claim has been forwarded will then be displayed. You may view or save a PDF copy of the CA-1 by clicking the “View” or “Get PDF” buttons. Note that certain personally identifiable information will be masked in the PDF for the protection of the employee.

If the injured employee requires medical treatment for the injury, you may obtain Form CA-16, Authorization for Examination and/or Treatment, by clicking the button “Issue CA-16.” A copy of the form will be generated in PDF format, which may be printed and completed to authorize the employee to be treated for the claimed injury.

Please note that the completed CA-16 must be submitted to OWCP by mail or fax, and may not be uploaded in ECOMP.

When finished, click “Done” to exit.

Once the claim has been received by the AR, he or she will review the information entered for the claim by the employee and by you, the supervisor. The AR will be able to edit information in the supervisor portion of the form if necessary and upload additional attachments to the claim, and will determine if the claim needs to be submitted to OWCP for creation of a case.

Once final review of the CA-1 has been completed, the AR will print the form for your signature, as well as that of the employee. The CA-1 form with original signatures will be maintained by the employing agency.