INCIDENT PROCESSING OF INJURIES OR ILLNESSES FOR US FOREST SERVICE (USFS) EMPLOYEES ONLY

The instructions below are to be utilized on wildland fires and other emergency incidents. This document addresses all work related injuries and illnesses while on an incident assignment. CA-16, CA-1 and CA-2 forms and other related documents are attached.

1. Provide Medical Treatment

1.1. First priority is to get emergency medical care, if necessary. Emergency rooms are the best choice as they are required to provide treatment even without advance guarantee of payment.

1.2. Complete appropriate paperwork immediately following emergency care.

1.3. If the injury requires continuing medical care and the injured employee is unable to work, return the injured employee to their home unit as soon as possible. Do not keep them in camp

2. Form CA-16 Authorization for Examination and/or Treatment Process (Attachment 1)

2.1. Only Albuquerque Service Center – Human Resources Management (ASC-HRM) Workers' Compensation (WC) personnel, Compensation Claims Unit Leader (COMP), Compensation for Injury Specialist (INJR), or Finance Section Chief (FSC) assigned to the incident are authorized to issue Form CA-16 for FS regular and AD employees.

2.2. In accordance with 20 CFR §10.300(b), a supervisor and/or personnel representing the agency may provide verbal authorization for examination and/or treatment in the absence of the above referenced incident personnel if outside ASC-HRM regular business hours, Monday – Friday, 0700 – 1700, Mountain Time (MT). Contact ASC-HRM WC within 48 hours after medical treatment or on the next business day for issuance of the CA-16 by ASC-HRM WC.

2.3. Use the "Decision Tree" (Attachment 2) for guidance on the appropriate issuance of the CA-16.

2.4. **NEVER** issue Form CA-16 for Occupational Diseases, report these claims on a CA-2.

2.5. **NEVER** use Form CA-16 or Agency Provided Medical Care (APMC) to pay for **non-work** related medical care at the incident. This is the employee's responsibility and they must arrange payment with the medical provider. Contact ASC-HRM WC if in doubt about work-relatedness.

2.6. The Department of Labor (DOL) does not allow the issuance of a CA-16 if more than 7 calendar days have passed since the date of injury. Advise employees that they are entitled to file a claim, but the medical treatment cannot be authorized by the Agency.

2.7. Block 12 is the address of the DOL District Office servicing the state or geographical location of the employee's duty station. Refer to the Interagency Incident Business Management Handbook (IIBMH) Chapter 10, Section 15.

2.8. Block 13 contains the address for ASC-HRM WC (use for all USFS regular and AD employees):

USDA Forest Service, ASC-HRM
Workers' Compensation (MS 326)
4000 Masthead St. NE
Albuquerque, NM 87109

2.9. If an employee is filing a Workers' Compensation claim and requires a prescription but cannot pay for it while on the incident, it can be purchased with a purchase card and a commissary deduction will be made on the OF-288, Fire Time Report. The employee uses the receipt from the purchaser to claim reimbursement from the DOL. This should only be used if there are no pharmacies that accept the DOL fee schedule.

2.10. COMP, INJR or FSC should provide "Information for Medical Providers" (Attachment 4) to any treating medical providers for information regarding their participation in Federal Workers' Compensation programs.

2.11. Call ASC-HRM WC for guidance @ 877-372-7248, select option [2] for HRM, then follow the prompts for Forest Service employees.

2.12. Personnel on an incident without a COMP, INJR or FSC assigned must contact ASC-HRM WC for medical treatment authorization.

- Call the ASC-HRM Contact Center @ 877-372-7248, select option [2] for HRM, then follow the prompts for Forest Service employees, during regular business hours Monday – Friday 0700-1700 Mountain Time (MT) or the next business day following a weekend, or holiday.

- State you have an injured worker and are requesting authorization for medical treatment.

2.13. The following fillable forms may serve as immediate documentation pending completion in eSafety:

- 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

2.14. The following links are available for guidance in using eSafety:

- http://fsweb.asc.fs.fed.us/HRM/owcp/documents/eSafety_Tips-n-Tricks.pdf
- http://fsweb.asc.fs.fed.us/HRM/owcp/documents/eSafety_HowTo_Access.pdf
- http://fsweb.asc.fs.fed.us/HRM/owcp/WorkersComp_index.php

3. Catastrophic or Serious Injury.

3.1. A catastrophic injury is one that has the potential to cause loss of life or limb, involves multiple broken bones, serious burns, or involves multiple victims of one incident, such as a vehicle accident. Injuries that are considered catastrophic due to the enormous impact they have on the lives of the individuals who experience them, include but are not limited to the following: brain injury, spinal cord injury, accidental amputation, severe burns, multiple fractures, or other, neurological disorders. A catastrophic injury or illness very often causes severe disruption to the central nervous system, such as spinal cord injuries or severe burn injuries, which in turn affects many other systems of the body.

3.2. When serious injuries occur, the COMP, INJR or FSC will call the ASC-HRM WC immediately, Monday-Friday during regular business hours, 0700-1700 MT, or the next business day, if outside of business hours, to discuss the next action to be taken. This allows the transition from the incident team to the ASC-HRM to flow smoothly.

4. First Aid Treatment

4.1. FS Form 6100-16, Agency Provided Medical Care (APMC) Authorization and Medical Report, is used for first aid treatment only. First aid **does not** include medical treatment for cuts requiring stitches, X-rays, MRIs, burn treatment, or treatment involving lost time or follow up treatment.

4.2. Employees should be advised of the difference between APMC and OWCP and given the choice to file a Workers' Compensation claim and have treatment authorized utilizing the CA-16, if appropriate (see Attachment 2) or to use APMC.

4.3. For more guidance regarding work-related injuries, incident personnel may call the ASC-HRM Contact Center @ 877-372-7248, select option [2] for HRM, then follow the prompts for Forest Service Employees, during regular business hours, Monday-Friday 0700-1700 MT, or the next business day following a weekend or holiday.

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

5.1. A traumatic injury is defined as an injury or exposure caused by an external force that occurs on, or can be attributed to **one work shift**.

5.2. The CA-1 will be completed in **eSafety** by the injured employee, or someone acting on the employee's behalf if the employee is not able to do so. The following information is in reference to a completed CA-1 in eSafety. The CA-1 will be generated by entering all required fields in eSafety. Page 1 of the CA-1 is to be filled out completely by the injured employee including signature in block 15. If the injured employee is unable to sign, the supervisor or someone acting on their behalf may complete and sign for the injured employee.

- A hand written copy may serve as immediate documentation of the injury while the details are clear, but it is **mandatory** that all CA-1 forms be generated from **eSafety** and are processed by ASC-HRM WC. The completed **eSafety** generated CA-1 (along with the CA-16, if issued) must be printed, signed and faxed to ASC-HRM WC at 866-339-8583 **within 48 hours** of the date the employee reported the injury. The original CA-1 is to be retained by the employee. ***Please note that failure to appropriately complete and forward these forms to ASC-HRM WC may result in treatment delays and/or treatment expenses being billed to the employee.***

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

5.3. If the CA-1 cannot be completed in **eSafety** at the incident, a hard-copy will be prepared at the incident and faxed to the home unit. It is imperative that these CA-1's be entered into **eSafety** at the home unit and faxed to ASC-HRM WC as explained in 5.9

5.4. Blocks 1-8 will reflect the injured employee's personal information. The following information is in reference to a completed CA-1 in eSafety. The CA-1 will be generated by entering all required information in eSafety.

- Note: Block #7 shall be the employee's **home** mailing address; those currently living in barracks should use the address their correspondence goes to in the off season.

5.5. Claims submitted for FS AD Casual Hires must be complete in **eSafety** using the link below for non-authenticated users and shall include all requested information prior to faxing to ASC-HRM WC:

- **Click Here for Non Authenticated Users**

- AD's complete Social Security Number (SSN).
- OF-288, Fire Time Report, and one of the following documents Single Resource Casual Hire Form, Resource Order or crew Manifest (if on a crew). This is needed in order to verify the AD was hired by the Forest Service and to facilitate the expeditious processing of the claim.
- Hiring unit supervisor, full legal name and phone number.

5.6. Supervisor completes page 2 of the CA-1 blocks 17 – 39.

Note: *The supervisor should indicate a phone number where they can be reached immediately in the event more information is needed.*

5.7. Block #17 shall reflect the ASC-HRM WC address:

USDA Forest Service, ASC-HRM
Workers' Compensation (MS 326)
4000 Masthead St., NE
Albuquerque, NM 87109

5.8. Block #18 is the injured employee's **duty station** physical address.

5.9. Fax the completed CA-1 (along with the CA-16, if available) to ASC-HRM WC **within 48 hours** of the employee reporting the injury. The employee should retain the original for their records.

5.10. Include the employee's name and SSN on the upper right hand corner of the second page and all supporting documentation in case the pages are separated.

5.11. The original CA-1 and page 4 of the CA-1, Receipt of Notice of Traumatic Injury is given to the injured employee.

6. Completing Form CA-2 Notice of Occupational Disease and Claim for Compensation

6.1. Occupational disease is a condition produced by the work environment over a period **longer than a single workday or shift**. It may result from systematic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment. ***Note: A CA-16 is never issued with a CA-2.***

6.2. The CA-2 will be completed in **eSafety** by the injured employee, or someone acting on the employee's behalf, if the employee is not able to do so**.** The following information is in reference to a completed CA2 in eSafety. The CA-2 will be generated by entering all required fields in eSafety.

6.3. If the CA-2 cannot be completed in **eSafety** at the incident, a hard-copy will be prepared at the incident and faxed to the home unit for completion in **eSafety.** The home unit will fax the completed CA-2 to ASC-HR WC with all supporting documentation for processing to DOL.

- CA-2 – Notice of Occupational Disease and Claim for Compensation

6.4. Blocks 1-8 will reflect the injured employee's personal employee information.

- Note: Block #7 shall be the employee's home mailing address; those currently living in barracks should use the address their correspondence goes to in the off season.

6.5. Claims submitted for Forest Service AD Casual Hires must be completed in **eSafety** using the link below for non-authenticated users and shall include all the requested information prior to faxing to ASC-HRM WC

- **CLICK HERE for Non-Authenticated User**

- AD's complete Social Security Number (SSN).
- OF-288, Fire Time Report, and one of the following documents Single Resource Casual Hire Form, Resource Order or crew Manifest (if on a crew). This is needed in order to verify the AD was hired by the Forest Service.
- Hiring unit supervisor name and number.

6.6. Supervisor completes page 2 of the CA-2 blocks 19 through 35. ***Note:*** *The supervisor should indicate a phone number where they can be reached immediately in the event more information is needed.*

6.7. Block #17 shall reflect the ASC-HRM WC address:

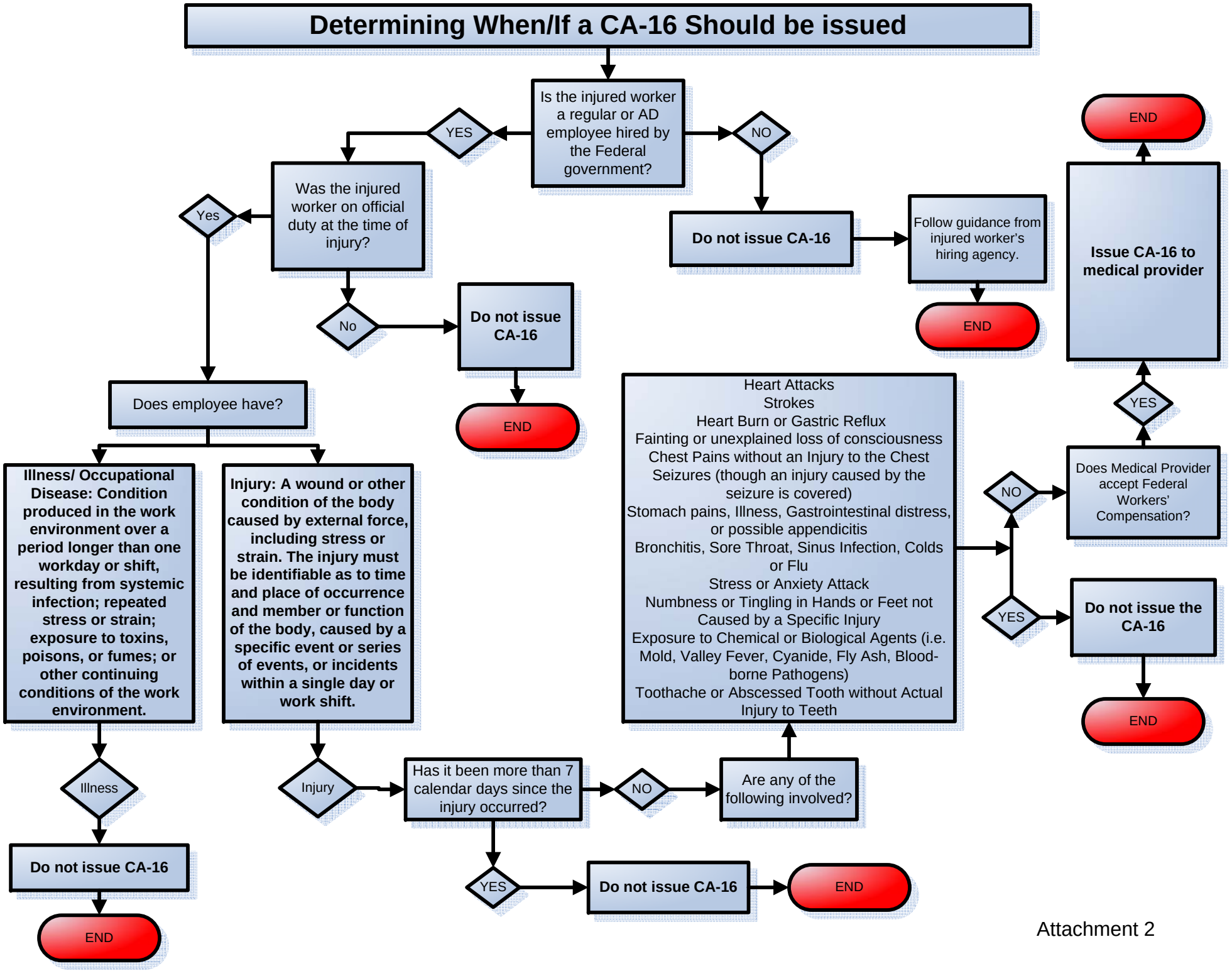
USDA Forest Service, ASC-HRM
Workers' Compensation (MS 326)
4000 Masthead St., NE
Albuquerque, NM 87109

6.8. Block #18 is the injured employee's **duty station** physical address.

6.9. Fax the CA-2 to ASC-HRM WC within 48 hours of the employee reporting the condition. The employee should retain the original for their records.

6.10. Include the employee's name and SSN on the upper right-hand corner of the second page, and all supporting documentation, in case the pages are separated.

6.11. The original CA-2 and page 3 of the CA-2, Receipt of Notice of Occupational Disease of Illness, are given to the injured employee.



Attachment 2

Attachment 3

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.

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

OMB No.: 1215-0103
Expires: 9-30-2011

PART A - AUTHORIZATION

1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:

Primary Care Medical Center
1000 South 12th St
Murray, KY 42071

2. Employee's Name (last, first, middle)	3. Date of Injury (mo. day, yr.)	4. Occupation
Bear, Smokey	**07/07/2009**	**Forestry tech**

5. Description of Injury or Disease:
Rolled right ankle

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. ☒ 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.

☐ 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) **XXXXXXX XXXXXXXXX** Comp/claims Specialst
10. Local Employing Agency Telephone Number: (XXX)XXX-XXXX	11. Date (mo., day, year) **07/07/2009**
12. Send one copy of your report: (Fill in remainder of address) **U.S. DEPARTMENT OF LABOR** **Office of Workers' Compensation Programs** **Dallas District Office** **525 South Griffin Street, Room 100** **Dallas, TX 75202** Please refer to the Interagency Incident Business Management Handbook Chapter 10, Section 15 for a complete list of DOL District Offices	13. Name and Address of Employee's Place of Employment: Department of Agency **US Forest Service** Bureau or Office **Albuquerque Service Center (ASC-HRM) Annex WC** Local Address (including ZIP Code) **3900 Masthead Street NE** **Albuquerque, NM 87109**

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

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (Last, first, middle)

Bear, Smokey

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)
☐ Yes ☐ No

16a. IDC-9 Code

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)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

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
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ 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? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all 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 any 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

38. National Provider System Number

39. Date of Report

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, D.C. 20402

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 memberships 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 (0 editor) 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 identifier 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.

U.S. GPO : 1999-454-845/92710

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are here by 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.

United States Department of Labor

Office of Workers' Compensation Programs

Division of Federal Employees' Compensation (DFEC)

Information for Medical Providers

A letter to Medical Providers

Must I enroll as a Provider?

To be paid for treating federal employees covered by the FECA, you must enroll. As of March 31, 2004, all bills submitted by unenrolled Providers will be returned along with instructions on how to enroll. Enrollment is free and is simply a registration process to ensure proper payments. It is not a PPO enrollment.

How do I enroll as a Provider?

You can enroll online at https://owcp.dol.acs-inc.com. Click on "Provider" in the FECA section in the shaded section on the top left side of the screen. Then click on "Provider Enrollment" and follow the instructions.

Do you have instructions on how to enroll on-line as a Provider?

Yes. Our "Tools and Tips for Providers" page at http://www.dol.gov/owcp/dfec/regs/compliance/CBPtools.htm contains a link to these instructions. On this page we also have medical authorization and billing tips as well as instructions for using the ACS web portal to request medical authorization.

I have enrolled as a Provider. How do I register to use the web portal?

Go to the portal at http://owcp.dol.acs-inc.com. Click on "Provider" in the FECA section. Then click on "Web Registration" and follow the instructions. If you try this and have questions, need technical support or require additional assistance, call the Health Care Solutions Operations Center Helpdesk at 1-800-461-7485 or 1-850-558-1775.

Telephone inquiries regarding eligibility, medical authorizations, or bill payment status may be accessed 24 hours a day, 7 days a week available to Injured Workers, Employing Agencies, and Medical Providers via the Interactive Voice Response (IVR) system by calling 866-335-8319.

Do I have to enroll as a provider to use the web portal?

A provider may use the eligibility inquiry function without enrolling as a provider and registering to use the web portal. To use the on-line authorization, bill status, and payment status functions, a provider must enroll and must register to use the web portal. Both enrollment and web registration can be accomplished online at http://owcp.dol.acs-inc.com.

How do I find out if a prior authorization is required?

Whenever you treat an Injured Worker, check the ACS web portal (http://owcp.dol.acs-inc.com) or call the IVR at 866-335-8319 to see if the procedure requires authorization.

Level 1 procedures (for example, office visits, MRIs without contrast, and some other routine diagnostic tests) do not require authorization. If you need a hard copy confirmation of this, complete an online authorization request at http://owcp.dol.acs-inc.com and print the message displayed after the request is submitted.

Level 2, 3 and 4 procedures require authorization. These authorization requests can be made online at http://owcp.dol.acs-inc.com or via by faxing a completed authorization request and supporting documentation to 800-215-4901. The Medical Authorization forms are available online at http://owcp.dol.acs-inc.com. Click on "Forms and Links" and then choose FECA from the Program Specific Forms and Links box. Forms are available for Durable Medical Equipment, General Medical/Surgery, and Physical Therapy authorizations. These forms request the specific information needed to process each type of authorization request.

How do I make medical authorization requests?

You may request authorization online at http://owcp.dol.acs-inc.com. Or, you may fax the appropriate Medical Authorization form and supporting documentation to 800-215-4901. The Medical Authorization forms are available online at http://owcp.dol.acs-inc.com. Click on "Forms and Links" and then choose FECA from the Program Specific Forms and Links box. Forms are available for Durable Medical Equipment, General Medical/Surgery, and Physical Therapy authorizations.

Do you have any tips to help me with the authorization process?

Yes. Our "Tools and Tips for Providers" page at http://www.dol.gov/owcp/dfec/regs/compliance/CBPtools.htm has links to authorization and billing tips On this page we also have instructions for enrolling on-line and for using the ACS web portal to request medical authorization.

I have an Injured Worker who has a CA-16 but no claim number. How do I request an authorization?

CA-16s are issued by Employing Agencies to Injured Workers so they can seek immediate medical care. When there is a CA-16, NO authorization is needed for office visits and consultations, labs, hospital services (including inpatient), X-rays (including MRI and CT scan), physical therapy, and Emergency services (including surgery) related to the work injury. You must enroll as a Provider to be paid for services provided under a CA-16. The CA-16 DOES NOT cover non-emergency surgery, home exercise equipment, whirlpools, mattresses, spa/gym memberships, and work hardening programs. Authorization for these services can not be requested until a claim number has been established.

I'm a specialist to whom an Injured Worker has been referred for a consultation. Do I need an authorization?

An authorization is not required when an Injured Worker is referred by her/his treating physician to a specialist for a consultation. However, you must be enrolled as a Provider to be paid for the consultation visit.

I've tried to use the eligibility inquiry, but I get a message that the service requested isn't covered for the accepted conditions. What do I do?

Request authorization online at http://owcp.dol.acs-inc.com or fax the appropriate Medical Authorization form and supporting documentation to 800-215-4901. The Claims Examiner will determine if the claim can be expanded for a new condition based on information in file and information submitted with the request or if additional development is needed.

I want to prescribe a particular medication for a patient. It's not covered for the conditions accepted on the claim. What do I do?

If you believe a medication is necessary for the treatment of the injured worker's accepted conditions please submit medical documentation for review by the claims examiner. As is the case with anything sent to OWCP, please be sure to include the injured worker's claim/case number on every page. Please mail all documentation to U.S. Department of Labor, DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300.

How do I know what the accepted conditions are for a claim?

This information is now available online at http://owcp.dol.acs-inc.com click on the "Eligibility and Accepted Conditions" link. For instructions on how to use this functionality, click here.

My patient thinks that other diagnoses need to be added as accepted conditions on a claim. What should I do?

If an injured worker believes that additional or different conditions warrant acceptance on her/his claim, s/he needs to submit to OWCP medical documentation supporting expansion of the claim for review by the claims examiner. As is the case with anything sent to OWCP, this medical documentation should include the injured worker's claim/case number on every page and should be mail to U.S. Department of Labor, DFEC Central Mailroom, P.O. Box 8300, London, KY 40742-8300.

How do I learn the status of a medical authorization request?

Injured Workers, Providers, and Employing Agencies can check on the status of medical authorizations at http://owcp.dol.acs-inc.com. Having this information on the web is beneficial since authorization information is available 24 hours/day, 7 days/week without calling for an authorization number or waiting for the receipt of an authorization letter in the mail. Claimant eligibility, bill status, and medical authorization inquiry functionality is also available 24 hours a day via our Interactive Voice Response (IVR) system. To access the IVR, call 866-335-8319. To speak with a Customer Service Representative regarding an authorization, you may call 844-493-1966 which will be a toll call. This number is available Monday to Friday, 8am to 8pm, EST.

How do I learn the status of a bill or claim for reimbursement?

Injured Workers, Providers, and Employing Agencies can check on the status of bills and reimbursements at http://owcp.dol.acs-inc.com. Claimant eligibility, bill status, and medical authorization inquiry functionality is also available 24 hours a day via our Interactive Voice Response (IVR) system. To access the IVR, please dial 866-335-8319. To speak with a Customer Service Representative regarding a bill or reimbursement, you may call 844-493-1966 which will be a toll call. This number is available Monday tp Friday, 8am to 8pm, EST.

Can I bill electronically?

Yes! Using Electronic Data Interchange (EDI) has many benefits including

- Faster payment of claims -clean bills are processed in an average
- of 14 days or less
- Increased efficiency - greatly reduces keying errors or data omissions
- Transmission of bills 24 hours/day, 7 days/week
- Reduced cost and time of preparing and mailing paper claims
- No lost bills
- Ability to send claims in the X12N HIPAA standard

Information about this option is available at http://www.acs-gcro.com/ or by calling the EDI Technical Support line at 800-987-6717.

I think I might need some help in using the web portal. Do you have some instructions or a user manual?

Yes. Go to http://owcp.dol.acs-inc.com and click on the Help link (it's on the right side, above the yellow box). This will open a User Guide.

If OWCP authorizes a medical service as related to the FECA claim but does not pay my submitted bill in full, can I seek additional payment from the injured worker for the difference between what was billed and what OWCP paid?

No, you may **not** seek additional payment. If an authorized service has been rendered for the injured worker's accepted work-related condition, he or she is not responsible for charges over the maximum allowed in the OWCP fee schedule or other tests for reasonableness. 20 C.F.R. §10.801 (d) provides that by submitting a bill and/or accepting payment, the provider signifies that the service for which reimbursement is sought was performed as described and was necessary. In addition, the provider thereby agrees to comply with all regulations concerning the rendering of treatment and/or the process for seeking reimbursement for medical services, including the limitation imposed on the amount to be paid for such services. Therefore, if your bill is reduced by OWCP in accordance with its fee schedule, you may **not** charge the injured worker for the remainder of the bill. See also 20 CFR §10.813 and §10.815 (h).

What is the Fee Schedule and how do I get a copy?

The Federal Fee Schedule is applied to medical bills and to some durable medical equipment bills. Access the Federal Fee Schedule free of charge at http://www.dol.gov/owcp/dfec/regs/compliance/fee.htm.

Where do I send mail?

Send all mail and bills for Federal workers' compensation cases to:

U.S. Department of Labor
DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

Please be sure to include the claim number on every page you send.

What are the benefits of centralizing medical authorizations and billing?

The new system is designed to allow our contractor, ACS, to approve services and payments based on established treatment guidelines and OWCP staff decisions regarding covered conditions. In turn, this allows OWCP staff to dedicate more time to entitlement issues and return to work efforts. We have made eligibility, medical authorization, and billing information accessible 24 hours a day/7 days a week to Injured Workers, Employing Agencies, and Providers via the Interactive Voice Response (IVR) system and the web. Providers can now request, and for routine services receive, authorization on-line which is easier for providers and speeds up the authorization process.

Why did you change to a toll number to talk with a Customer Service Representative?

We offer an automated toll-free Interactive Voice Response (IVR) system at 866-335-8319 which provides access to information regarding eligibility, authorization, and bill payment status. This information is also available online at http://owcp.dol.acs-inc.com. A great deal of information is available through the automated toll-free IVR and web based processes which are available 24/7. All of these allow for a greater savings to DFEC so that future enhancements can be implemented.

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 completes all yellow fields on this page except Block 13 a & b and witness statement (Block 16)**

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,

Employee Data

1. Name of employee (Last, First, Middle): Bear | Smokey |
2. Social Security Number: 555-55-5555
3. Date of birth (Mo. Day Yr.): 8/9/1964
4. Sex: X Male ☐ Female
5. Home telephone: 909-555-5555
6. Grade as of date of injury: Level 4 Step 1
7. Employee's home mailing address (Include city, state, and ZIP code): 1234 Conifer Lane; Priest River; NM; 87109
8. Dependents: X 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): Physical address where injury occurred
10. Date injury occurred (Mo. Day Yr.): 1/15/2015
Time: 0800 ☐ a.m. ☐ p.m.
11. Date of this notice (Mo. Day Yr.): 1/16/2015
12. Employee's occupation: Forestry Technician
13. Cause of injury (Describe what happened and why): While cutting line, I slipped on a piece of wood and feel to the ground, hitting a large rock with right knee. BE SPECIFIC ABOUT THE INJURY

a. Occupation code
b. Type code
c. Source code
OWCP Use - NOI Code

14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg): Bruised right knee, possible dislocated knee cap

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of th United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for wo

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

☐ b. Sick and/or Annual Leave

****Volunteers, ADs, and YCC are not eligible for COP nor do they earn annual or sick leave. Leave blank.**

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furni 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 Smokey Bear **Date** 1/16/2015

Any person who knowingly makes any false statement, misre ompensation as provided by the FECA or who knowingly accepts compens ative remedies as well as felony criminal prosecution and may, und nent or both.

Must have wet signature

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): I saw Smokey fall down and hit his right knee on a rock while he was cutting line and I went to help him up because he was in a lot of pain

Witness statement can be submitted on a separate document

Name of witness: Woodsy Owl
Signature of witness: Woodsy Owl
Date signed: 1/16/2015
Address: 1235 Conifer Lane
City: Priest River
State: NM
ZIP Code: 87109

**Supervisor completes all applicable yellow fields on this page

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

Supervisor's Report

17. Agency name and address of reporting office

US Forest Service, ASC-HRM

4000 Masthead NE (MS 326)

Albuquerque NM 87109

The reporting office for all FS is the ASC-HRM
Always use this address in this block

OWCP Agency Code

OSHA Site Code

18. Employee's duty station (Street address and ZIP code)

Cibola National Forest, 2113 Osuna Rd NE Albuquerque NM 87113

19. Employee's retirement coverage ☐ CSRS ☐ FERS ☐ Other, (identify)

Leave blank if unknown

20. Regular work hours From: 0700 ☒ a.m. ☐ p.m. To: 1530 ☐ a.m. ☒ p.m.

21. Regular work schedule **Check applicable days** ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

22. Date of Injury Mo. Day Yr. 1/10/2015

23. Date notice received Mo. Day Yr. 1/11/2015

24. Date stopped work Mo. Day Yr. 1/10/2015 Time: 1130 ☒ a.m. ☐ p.m.

25. Date pay stopped Mo. Day Yr. N/A

26. Date 45 day period began Mo. Day Yr. 1/11/2015

27. Date returned to work Mo. Day Yr. 1/11/2015 Time: 0700 ☒ a.m. ☐ p.m.

Block 24 - If no time lost, enter N/A
Block 25 – Enter date or leave blank if employee has not returned to work

28. Was employee injured in performance of duty? ☒ Yes ☐ No (If "No," explain)

If questionable, contact FS WC

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes,"

If yes, a statement may be submitted on a separate sheet of paper

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)

Third party does not include other FS employees or employees of another Government entity

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

Enter if known

33. First date medical care received Mo. Day Yr. 1/10/2015

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)

If questionable, contact FS WC

36. If the employing agency controverts continuation of pay, state the reason in detail.

If questionable, contact FS WC

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) Gifford Pinchot

Must have wet signature

Signature of supervisor Gifford Pinchot Date 1/11/2015

Supervisor's Title Supervisory Wildlife Biologist Office phone

Provide a number where you are reachable

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

One of the boxes here must be selected

Form CA-1
Rev. Apr. 1999

Notice of Occupational Disease and Claim for Compensation

Reset Print

U. S. Department of Labor
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): Bear Smokey
2. Social Security Number: 555-55-5555
3. Date of birth (Mo. Day Yr.): 8/19/1964
4. Sex: M
5. Home telephone: 909-555-5555
6. Grade as of date of last exposure: Level 4 Step 1
7. Employee's home mailing address (include street address, city, state, and ZIP code): 1234 Conifer Lane

Employee's home address

City: Idyllwild State: CA ZIP Code: 92549

8. Dependents
   - [X] Wife, Husband
   - [ ] Children under 18 years
   - [ ] Other

Claim Information

9. Employee's occupation: Forestry Technician

a. Occupation code:

10. Location where you worked when disease or illness occurred (include street address, city, state, and ZIP code): Priest Lake Ranger District – 32203 Highway 57

City: Priest River State: ID ZIP Code: 83856

11. Date you first became aware of disease or illness (Mo. Day Yr.): 1/15/2014

12. Date you first realized the disease or illness was caused or aggravated by your employment (Mo. Day Yr.): 10/15/2014

13. Explain the relationship to your employment, and why you came to this realization

Repeated long hours of computer work, right and left wrist hurting
Possible carpal tunnel syndrome

OWCP Use - NOI Code

b. Type code: c. Source code:

14. Nature of disease or illness: Possible carpal tunnel syndrome, both wrists

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 I 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 oth Act.

I hereby authorize any physician or hospital (or any o furnish any desired information to the U.S. Department of Labor, presentative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Must have wet signature

Signature of employee or person acting on his/her behalf *Smokey Bear* Date 10/16/2014

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.

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

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

Supervisor's Report

19. Agency name and address of reporting office
US Forest Service, ASC-HRM
4000 Masthead NE (MS 326)
City: Albuquerque
State: NM
ZIP Code: 87109

The reporting office for all FS is the ASC-HRM
Always use this address in this block

OWCP Agency Code: **Leave blank for FS WC**
OSHA Site Code: **Leave blank for FS WC**

20. Employee's duty station (include street address, city, state, and ZIP code)
32203 Highway 57
City: Priest River
State: ID
ZIP Code: 83856

21. Regular work hours From: 0700 a.m. p.m. To: 1530 a.m. p.m.

22. Regular work schedule **Check applicable boxes** ☐ Sun. ☐ Mon. ☐ Tues. ☐ Wed. ☐ Thurs. ☐ Fri. ☐ Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)
Complete blocks 23-25, if known
City
State
ZIP Code

24. First date medical care received Mo. 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. 10/15/2014

27. Date and hour employee stopped work Mo. Day Yr. 10/15/2014 Time 1430 a.m. p.m.

Leave blank if not applicable or enter N/A

28. Date and hour employee's pay stopped Mo. Day Yr. N/A Time a.m. p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness Mo. Day Yr. **Enter if known**

30. Date returned to work Mo. Day Yr. Time a.m. p.m. **Enter if known and applicable**

31. If employee has returned to work and work assignment has changed, describe new duties
Be as detailed as possible

32. Employee's Retirement Coverage ☐ CSRS ☐ FERS ☐ Other, (Specify)
Enter if known, otherwise, leave blank for FS WC

33. Was injury caused by third party? ☐ Yes ☐ No If "No," go to Item 34.

34. Name and address of third party (include street address, city, state, and ZIP code)
Third party does not include other FS employees or employees of another Government entity
City
State
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): Woodsy Owl

Must have wet signature

Signature of Supervisor: *Woodsy Owl*
Date: 10/15/2014
Supervisor's Title: Supervisory Wildlife Biologist
Office phone: **Provide a number where you are reachable**