Authorization for Examination And/Or Treatment

U.S. Department of Labor
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.: 1240-0046
Expires: 10-31-2014

PART A - AUTHORIZATION

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

2. Employee's Identification (last, first, middle, SSN)	3. Date of Injury (mo. day, yr.)	4. Occupation

5. Description of Injury or Disease:

6. You are authorized to provide medical care for the employee for a period of up to sixty days from the date shown in item 3, subject to the condition stated in item A, and to the condition indicated in either 1 or 2, 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)
10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)
12. Send one copy of your report: (Fill in remainder of address) **U.S. DEPARTMENT OF LABOR** Office of Workers' Compensation Programs	13. Name and Address of Employee's Place of Employment: Department of Agency Bureau or Office Local Address (including ZIP Code)

Public Burden Statement

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

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

PART B - ATTENDING PHYSICIAN'S REPORT

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

15. What History or 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? If yes, date of admission (mo., day, year) Date of discharge (mo., day, year) ☐ Yes ☐ No

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 the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or 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 Identitication 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" (HCFA-1500, OWCP-1500, OWCP-04 or the UB-04). Physician services must be itemized by Current Procedural Terminology Code (CPT) using current CPT-4 coding schema; or, the UB-04 and the coding schemas acceptable on this form.

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

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

- A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical office or hospital or any duly qualified physician/ hospital of the employee's choice.
- If an employee elects to be treated by a private physician; a copy of the American Medical Association Standard Billing Form (AMA) OWCP-1500 should be supplied together with the submitted Form CA-16.
- If an employee, in an emergency situation has to be sent and/or admitted to an Acute Care Facility for emergency surgery or care, a copy of the OWCP Uniformed Billing Form (UB-04-1450), should be supplied together with the submitted Form CA-16.
- A physician who is excluded from the FECA program as provided at 20 CFR 10.815-826 may not be authorized to examine or treat an injured Federal employee.
- Generally, a roundtrip distance of up to 100 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

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

FEDERAL MEDICAL FACILITIES

- U. S. Medical Facilities include Army, Navy, Air Force or the VA. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medical facilities as used herein (see 20 CFR 10.300).

DEFINITION OF INJURY

- The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP. Simple exposure to a workplace hazard, such as an infectious agent, does not constitute a work place injury, entitling an employee to medical treatment under FECA.

DEFINITION OF PHYSICIAN

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

FORM COMPLETION

- Part A shall be completed in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate.
- Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

- See 20 CFR and/or Publication CA-810, Injury Compensation for Federal Employees
- If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from DFEC in the form of communication assistance, accommodation and modification to aid you in the FECA claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.

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Instructions for Authorized Physician/Medical Facility

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 injury, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.815-826 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A. Item 12.

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

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

USE OF CONSULTANTS AND HOSPITALS

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

REPORTS

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

RELEASE OF RECORDS

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

BILLING FOR SERVICES

- OWCP requires that when services are provided by a private physician, charges be itemized using the AMA standard Health Insurance Claim Form, HCFA-1500/OWCP-1500. The form should contain appropriate International Classification of Disease (ICD-9) coding schemas in Block-21, and related correctly to the Diagnosis Pointers referenced in Block 24E. The form should also identify services rendered using the Current Procedural Terminology (CPT-4), and HealthCare Common Procedure Codes (HCPC) schemas.

- OWCP requires that when services are performed in an emergency situation, and in an Acute Care Facility for emergency surgery or care, a copy of the OWCP Uniformed Billing Form (UB-04-1450), should be supplied together with the submitted Form CA-16. The form should contain the appropriate International Classification of Diseases (ICD-9) coding schemas in Blocks 66-70, and reference any surgical procedures performed in the facility in Blocks 74a-74e using the International Classification of Disease ICD-9 Surgical Procedure Codes. The UB-04 should be itemized in Block #42 in a summarization listing all ancillary services performed during the stay, and each service; (radiology, Labs, pharmacy, supplies etc;) should be referenced using Revenue Center Codes (RCC).

- 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/Facility Tax Identification Number (TIN) is an important identifier in the OWCP system. To ensure accurate processing and to reduce inaccuracy of payment, the provider billing on an OWCP-1500 billing form should reference the TIN (Employer Identification Number or SSN in Block #25, and indicate this identifier on all submitted reports and billings submitted consistently. The Tax Identification Number for Facilities billing on the UB-04 Billing form, should reference their Federal Tax Identification number in Block #5.

ADDITIONAL INFORMATION

- Contact the OWCP shown in Item 12 of Part A. Refer to Information for Medical Providers at http://www.dol.gov/owcp/dfec/

- If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from DFEC in the form of communication assistance, accommodation and modification to aid you in the completion of this form.

Please Remove These Instructions Before Submitting Your Report.

* U.S. GPO: i999-454-845/92710

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.