

ORDER

**DEPARTMENT OF TRANSPORTATION
FEDERAL AVIATION ADMINISTRATION**

EA 3800.3A

EASTERN REGION
JAMAICA, N. Y., 11430

3/13/81

SUBJ: 1974 AMENDMENTS TO FECA RELATIVE TO TRAUMATIC JOB-RELATED INJURIES

1. **PURPOSE.** This order informs all supervisors of the 1974 amendments to the Federal Employees' Compensation Act (FECA) so that they will be able to handle traumatic job-related cases properly. It also updates important guidelines and procedures to assist in preparing and processing such claims.

2. **DISTRIBUTION.** This order is distributed to all supervisors in the Regional Office and in all field offices and facilities.

3. **CANCELLATION.** Order EA 3800.3 is canceled.

4. **BACKGROUND.** Substantial changes were made to the Federal Employees' Compensation Act (FECA) by the 1974 Amendments approved on September 7, 1974. A major provision of the new amendments provides that, when a Federal employee sustains a traumatic job-related injury and files a claim under the FECA, the employing agency is required to continue the employee's pay for the period of disability, not to exceed 45 days, if the employee requests such continuation of pay (COP). The 45 days are interpreted as calendar days and, if the employee has stopped work due to the disabling effects of the injury, the period starts at the beginning of the first full day or shift after the disability begins. This continuance of pay provision under Section 11 of the FECA became effective on November 6, 1974.

5. **DEFINITION.** A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable as to the time and place of occurrence and member or function of the body affected, and be caused by a specific event or incident or series of events or incidents within a single day or work shift. Occupational diseases and illness are NOT traumatic injuries by this definition, and are not covered under the new provisions.

6. **PROCEDURES.**

a. Upon receiving notice of injury, the first level supervisor shall:

(1) Promptly authorize medical care, if necessary, by issuing: Form CA-16, Request for Examination and/or Treatment, to a U. S. Medical Officer, or hospital, or any duly qualified physician or hospital of the employee's choice; Form CA-17, Duty Status Report, revised July 1979 (see Appendix 1); and a new OWCP Form CA-1333, "Federal Employees' Compensation Program Medical Provider's Claim Form," (see Appendix 2). The CA-17 informs the facility as to the employee's physical limitations, prognosis and date of expected return. All non-hospital providers are now required to submit bills on Form CA-1333 (or the American Medical Association Health Insurance Claim Form), or bills will be returned unpaid by OWCP to the sender. Employees should also furnish their medical providers with a CA-1333 on each visit. (Use of this form is optional for hospital billings.)

Distribution: REA-5; ZEA-120; FAF-7; AEA-60 (5 copies)
AEA-14 (10 copies)

Initiated By: AEA-14

(2) Provide the employee with Form CA-1 for reporting the injury and, upon receipt of the completed forms, return to the employee the Receipt of Notice of Injury.

(3) Make certain that the employee understands, as stated in Item 16, Form CA-1, that employee may elect continuation of regular pay or use annual or sick leave, if the injury is disabling. However, employee should also realize that, if his/her claim is denied, the continuation of regular pay shall be changed to sick or annual leave or leave without pay, or be considered an overpayment within the meaning of 5 USC 5584.

(4) Advise employee whether or not his/her claim is being controverted (see Item 3 and Item 6 of the Instructions, and Paragraph 6c below).

(5) Include, as an enclosure to Form CA-1, whether:

(a) There has been any change in the work environment which could have contributed to the injury or illness;

(b) There has been a pattern of sick leave usage;

(c) Any pattern of work performance or other factors exist which reflect a deterioration of the individual's ability to perform his/her duties; and

(d) Any information known to supervisor regarding the possibility of the reported injury or illness being a result of a pre-existing condition.

(6) Forward the original and two copies of Form CA-1 FULLY COMPLETED together with ALL other pertinent information and documents (including revised Form CA-17; medical reports, if available; etc.) to the Employment Branch, AEA-14, within five (5) working days following the receipt of the form from the employee—through the appropriate supervisory channels, and appropriate Operations Branch (AEA-460, AEA-540) or other divisional branches in the Regional Office, and together with the appropriate DOT accident and injury forms, as described in Par. 3b-EA1, Order 3900.24A EA SUP 3,7/1/80. Make certain to follow the Instructions on Form CA-1. INCOMPLETE FORMS MAY DELAY PROCESSING OF CLAIMS.

b. The Employment Branch will advise the Civil Aviation Security Division, AEA-700, of any claim which would not appear to be substantiated by the submitted documentation. The case will be reviewed by investigation personnel to determine whether their assistance is warranted.

c. When there is a time loss for which a traumatic injury claim is submitted, the supervisor, on the basis of the information submitted by the employee, or upon investigation, shall do one of the following:

(1) When, in the supervisor's judgment, the employee has suffered a traumatic injury, continue pay without charge to leave while the employee is off work (up to 45 calendar days), check the "No" box in Item 42 on Form CA-1.

(2) When the supervisor has a serious doubt as to the authenticity of the claim of traumatic injury, or otherwise questions its validity, for factual and/or medical reasons, he/she should controvert the claim in Item 42. However, the employee's pay will be continued without charge to leave while the employee is off work (up to 45 calendar days), only if the employee requests COP by marking Item 16b of the Form CA-1. Check the "Yes" box in Item 42 and GIVE FULL AND DETAILED INFORMATION for that item in support of controversion. OWCP's rule of thumb for Item 42 is simple but explicit: if the reason for controversion can fit the space provided on the form, the supervisor has not furnished sufficient explanation.

NOTE: All claims are adjudicated by OWCP. If OWCP determines that the employee is not entitled to continuation of pay during his/her absence from work, such pay will be terminated and the employee will be given the opportunity to charge the period of absence to sick or annual leave or leave without pay, or be considered an overpayment within the meaning of 5 USC 5584.

(3) Controvert (dispute or deny validity) and place employee on leave or leave without pay if the case meets one of the conditions given in Item 6 of Instructions on reverse side of Form CA-1. Check "Yes" in Item 42 and GIVE FULL AND DETAILED INFORMATION in that item in support of the controversion. (This controversion is a separate type from c (2) above where COP is allowed.)

d. The agency will keep the employee in a pay status for any fraction of a day or shift on which the disability begins with no charge to the 45-day period. The supervisor will be responsible for keeping a record of the number of calendar days the injured employee is kept in continuation of pay status (45 calendar day limit). Days off and portions of a day are counted as full days toward the 45-day period.

e. T & A Report.

(1) When pay is continued in connection with traumatic injury claims. Enter "17" and appropriate Start/Stop time for corresponding calendar day(s) in "Time Not Worked" code section of FAA Form 2730-68 (6-78), Time and Attendance Report; and enter date and time of the traumatic injury in the Remarks section in the bottom right space of the form.

(2) When pay is not continued in connection with traumatic injury claims. Make appropriate entries on T & A Report according to leave used. DO NOT place "17" in "Time Not Worked" code section or "Traumatic Injury" statement in Remarks section.

f. During the continuation of pay, the employee must report to his/her attending physician on a regular basis until released for work. The employee must request the physician to furnish an interim progress report (i.e., every week or as determined by the supervisor) on Form CA-17, Duty Status Report, revised July 1979. The CA-17 should go to the supervisor. A copy of the CA-17 should be sent by the supervisor to AEA-14. When the employee is continued in a pay status without charge to leave, the pay will continue until:

(1) The supervisor receives medical information that the disability has been terminated, or

(2) OWCP advises pay should be terminated, or

(3) The expiration of 45 calendar days following work stoppage.

g. General.

(1) Supervisors themselves must explain and complete each applicable item of a form fully in their own version, and MUST NOT rely on others to complete the item in their stead. Particularly where controversion has been checked "Yes" in Item 42, supervisors must furnish a detailed factual description of the circumstances to minimize the possibility of the claim being returned by OWCP for additional information. (In headset tone generating claims, include the following information: identification of specific ear involved; analysis of tape as to frequency/duration/pitch/relative decibel level/sound of alleged noise, results of FAA/Telco test of suspect headset, specifications of headset equipment involved, etc. In "anxiety state" claims, include separation distance of aircraft, role of claimant in the incident, etc.) See Appendix 3 for follow-up information which OWCP will request of claimants who have not provided sufficient information in their CA-1 forms in connection with headset/hearing claims or "anxiety state" claims.

(2) Even if no time is lost, the supervisor should complete the Form CA-1 fully in the regular manner for possible future reference.

(3) An Information Sheet, "Headset Communication Sound," has been prepared for controverted claims involving headset tone generating incidents; and an Information Sheet, " 'Anxiety State' Claims," has been developed for controverted claims pertaining to "near mid-air collision", "systems error" and the like. A copy of the applicable Information Sheet must be attached to each original CA-1 by the supervisor.

(4) Supervisors should review each Form CA-16 and Form CA-17 closely to familiarize themselves with the medical condition of the employee and to determine and take whatever follow-up action may be necessary.

(5) All CA forms and all correspondence relating to such claims to/from OWCP district offices should be channeled through AEA-14 in all instances, and not sent directly to OWCP, with the exception of medical provider's billings, and medical reports (see Paragraph 9d below).

(6) To minimize complaints by employees and their medical providers of delays in payment by OWCP for services rendered, CA-1333 must be used for all non-hospital billings and is optional for hospital billings. (The AMA claim form may be submitted for non-hospital billings in lieu of CA-1333.)

(7) In Item 23 of the CA-1, the reporting office is the field facility or organization where the claimant's supervisor is located and which is the claimant's regularly assigned duty station. Include zip code.

7. CLAIM FOR COMPENSATION.

a. If medical evidence shows that the disability is expected to continue beyond 45 days and compensation is desired after that period, a Form CA-7, Claim for Compensation on Account of Traumatic Injury, must be completed by the employee and supervisor and submitted to AEA-14 a reasonable period before, but not later than 3 working days after, the termination of the 45th day. The employee must also arrange for the physician to prepare (1) a medical report on Form CA-20, Attending Physician's Report, or (2) a narrative report. The physician should submit the CA-20 or narrative report directly to OWCP or may release it to the employee for submission along with CA-7 to AEA-14 to OWCP. FAA is responsible for pay continuation (in the approved cases) up to 45 days. After the 45-day period, compensation payments are taken over by OWCP on a claim for compensation initiated by an employee on a Form CA-7.

b. There is a three-day waiting period before compensation begins with OWCP after the 45-day period with FAA, unless the injury continues for 14 days or more beyond the 45 days. In that case, when the disability lasts for 59 days (i.e. 45 + 14) there is no three-day waiting period. Compensation is paid for all 14 days following the 45 days.

c. When the employee returns to work, the supervisor must mark the T & A Report to show the date the employee returned to work, and immediately send an original and two copies of Form CA-3, Report of Termination of Disability and/or Payment, to AEA-14. If the employee returns to work prior to submission of the CA-1, Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation, and the date of his return to duty is noted in Item 33 on the CA-1, the CA-3, Report of Termination of Disability and/or Payment, is not required. Should the employee suffer recurring disability because of the injury, the supervisor should complete Form CA-2a, Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation, and send to AEA-14 in duplicate. If the recurrence takes place within six months after the employee returns to duty, the FAA shall continue to pay without charge to leave for the balance of any unused portion of the 45 days of pay continuation.

8. LEAVE WITHOUT PAY. A completed SF-52 must be submitted to AEA-14 when LWOP for 80 hours or more is granted.

9. FORMS

a. Following is a list of the CA forms used in submitting claims for traumatic injury and the identifying stock numbers:

<u>Form Number</u>	<u>Title</u>
CA-1 (Rev. 9-78) NSN 0052-00-811-6003	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

CA-7 & CA-20 (Rev. 2-75) NSN 0052-00-857-9000	Claim for Compensation on Account of Traumatic Injury
CA-17 (Rev. 7-79) NSN 0052-00-847-4001	Duty Status Report

b. The following additional CA forms are also used in connection with job-related injuries (traumatic and non-traumatic):

<u>Form Number</u>	<u>Title</u>
CA-2 (Rev. 5-75) NSN 0052-00-858-4000	Federal Employee's Notice of Occupational Disease and Claim for Compensation
CA-2a (Rev. 7-76) NSN 0052-00-812-2002	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
CA-3 (Rev. 12-74) NSN 0052-00-400-2001	Report of Termination of Disability and/or Payment
CA-4 & CA-20 (Rev. 8-76) 0052-00-812-3001	Claim for Compensation on Account of Injury or Occupational Disease
CA-16 (Rev. 12-74) NSN 0052-00-812-4002	Request for Examination and/or Treatment
CA-1333 (12-79) NSN 0052-00-876-6000	Federal Employees' Compensation Program Medical Provider's Claim Form

THE OLD CA-1 and CA-2 FORMS SHOULD NO LONGER BE USED FOR REPORTING INJURIES AND OCCUPATIONAL DISEASE. THE CA-1 AND CA-2 FORMS LISTED ABOVE MUST BE USED.

c. All forms referred to in this notice are available through normal forms requisition channels from FAA Aeronautical Center, Oklahoma City, Oklahoma.

d. Medical provider's claims and medical reports may be sent to AEA-14 or directly to appropriate OWCP district offices, as follows:

- (1) U. S. Department of Labor
Office of Workers' Compensation Programs
1515 Broadway
New York, New York 10036

Servicing: New York and New Jersey

3/13/81

EA 3800.3A

- (2) U. S. Department of Labor
Office of Workers' Compensation Programs
Room 15100
3535 Market Street
Philadelphia, PA 19104

Servicing: Delaware, Pennsylvania and West Virginia

- (3) U. S. Department of Labor
Office of Workers' Compensation Programs
666 11th Street
Washington, D.C. 20211

Servicing: Maryland, Virginia and District of Columbia

for *J. Smith*
MURRAY E. SMITH
Director

1/13/81

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs

EA 3800.3A
Appendix 2
FEDERAL EMPLOYEES' COMPENSATION PROGRAM
MEDICAL PROVIDER'S CLAIM FORM

PATIENT INFORMATION

1. PATIENT NAME (First name, middle initial, last name)		2. PATIENT'S DATE OF BIRTH	
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
		6. FECA CASE NUMBER	
		7. NAME AND ADDRESS OF EMPLOYING AGENCY	
		10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)			
SIGNED		DATE	

PROVIDER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION		16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
17. DATE PATIENT ABLE TO RETURN TO WORK		18. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g., employing agency)				20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)				22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE (See instructions on reverse)					

24. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY)	D DX CODE	E		F
				CHARGES		

25. SIGNATURE OF PROVIDER (I certify that the statement on the reverse applies to this bill and is made a part hereof.)		27. TOTAL CHARGE		28. AMOUNT PAID		29. BALANCE DUE	
SIGNED		DATE		31. PROVIDER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.			
32. YOUR PATIENT'S ACCOUNT NO.		30. YOUR SOCIAL SECURITY NO.		33. YOUR EMPLOYER I.D. NO.			

*PLACE OF SERVICE CODES

1 - INPATIENT HOSPITAL	4 - PATIENT'S HOME	7 - NURSING HOME	0 - OTHER LOCATIONS
2 - OUTPATIENT HOSPITAL	5 - DAY CARE FACILITY (PSY)	8 - SKILLED NURSING FACILITY	A - INDEPENDENT LABORATORY
3 - DOCTOR'S OFFICE	6 - NIGHT CARE FACILITY (PSY)	9 - AMBULANCE	B - OTHER MEDICAL/SURGICAL FACILITY

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE

Patient Information:

- Item 1 — The name of the patient must be filled in here as indicated.
- Item 2 — Month, day and year of patient's birth.
- Item 4 — This should be filled in as completely and accurately as possible.
- Item 5 — The sex of patient must be indicated.
- Item 6 — Enter FECA Case No.
- Item 7 — The name and address of the employing agency should be included.
- Item 10 — The appropriate block should be checked.
- Item 12 — The patient's signature requests payment for the services rendered and certifies that the services were, in fact, rendered. This block must be signed or the claim cannot be processed.

Provider Information:

Since many different types of providers may use this form, it is unlikely that all the items will be completed by any single provider. For instance, item 22 would not be completed for emergency ambulance transportation.

- Item 14 — This item must contain the date of the first symptoms for an illness or the date of the accident for an injury.
- Item 15 — Month, day and year patient first consulted the provider for the condition for which the claim is being submitted.
- Item 16 — Provider should check the appropriate block.
- Item 17 & 18 — These items are for completion by the attending physician.
- Item 19 — This item must be completed on your initial claim for this patient.
- Item 20 — Complete if applicable (month, day, year).
- Item 21 — Complete if applicable.
- Item 22 — If the answer is yes, the amount of charges from the laboratory must be completed and the name and address of the laboratory must be entered in item 21.
- Item 23 — The diagnosis must always be included on a claim from a physician and, it should be included on all other claims if known.
- Item 24 — In column A enter the month, day and year for each service. "From" and "To" can be used for repetitive services such as hospital care charges or visits by a physician in a hospital.

In column B enter the appropriate place of service code shown at the bottom of the form. If the place of service is other than the patient's home or your facility, it should be so indicated in item 21.

In column C fully describe the service that was rendered. Hospital charges other than room charges must be itemized though date of service need not be given. It is not mandatory that a procedure code be entered but, it is preferred that the appropriate California Relative Value (CRV) Code be entered. When using the CRV Code, please indicate the year of the edition you used.

In column D it is not mandatory to enter a diagnosis code but it is preferred that the International Classification of Disease, Adapted (ICDA) Code be entered.

In column E the charge for each service described in column C should be entered.

Column F can be used for any additional remarks. If this claim, or any portion of this claim, has been previously submitted, it should be so indicated in this column.

Item 25 — The provider, or a representative, must personally sign and date the claim form. The claim cannot be processed unless it is signed. By this signature, the provider certifies that the described services were, in fact rendered as described either personally by the provider or under direct personal supervision: that the foregoing information is true, accurate and complete; furthermore, the services were medically necessary because of the condition indicated in item 23.

Item 27 — This amount must equal the total of all amounts entered in item 24 column E.

Item 28 & 29 — These items relate to bills with a running balance. They should be completed if applicable and previously submitted items should be so indicated in item 24 column F.

Item 30 — The Social Security Number should be used by all providers that are in independent practice.

Item 31 — This item must be completed in detail. Don't forget the zip code.

Item 32 — The patient's account number, as recorded in the provider's accounting system, may be entered for additional patient identification.

Item 33 — The Employer I.D. Number should be completed when the services are provided by an entity that has been assigned an income tax identification number other than the social security number, i.e., physicians in a professional association, claims from an institution such as a hospital, etc. Either item 30 or 33 must be completed or the claim will not be processed.

Please double check the claim for accuracy and submit it to the appropriate Federal Employees' Compensation Office. One who misrepresents or falsifies information may upon conviction be subject to fine and imprisonment under applicable federal laws.

OWCP FOLLOW-UP INFORMATION TO BE REQUESTED OF CLAIMANTS (COMPOSITE)

This is in reference to your claim (to have suffered loss of hearing or related auditory disability due to exposure to a loud and/or high pitched tone while in the course of your employment) (to have suffered a nervous or anxiety condition due to a traumatic injury occurring on the job). Additional evidence will be required from you, your employing agency and your physician before your claim will be in posture for a decision.

1. You must submit a detailed statement as to the nature of the incident and your relationship to it. Describe your immediate reaction to the incident. If pertinent, include, to the best of your knowledge, a description of the loudness, frequency and duration of the tone in question. State whether you have been involved in similar incidents in the past or have suffered a similar injury or disability or illness in the past. Your statement must be submitted to your supervisor for comment prior to being forwarded to OWCP.

2. Your supervisor must provide comments on your statement as well as his or her own description of the incident and your relationship to it, and provide copies of any agency records or documents concerning the incident. Your supervisor should obtain statements from co-workers who were present at the time of the incident and/or have knowledge of it. (In the case of a hearing/tone claim, specify which ear was used for the headset. A copy of the specifications of the equipment should be submitted, to include information as to the maximum volume and pitch levels. If the equipment was checked for malfunction, a copy of the report of the investigation should be submitted. If a tape recording or other record of the sound to which the claimant was exposed was made, this should be reviewed and the report of the findings submitted.) (All technical terminology such as system error, standard separation, etc. should be defined.)

3. You must arrange to have your treating physician submit a detailed narrative medical report. To be of value, this report should contain the following:

- a) A detailed history of the incident to agree with the history being provided to OWCP.
- b) A diagnosis of the disabling condition.
- c) A history of any past treatment for a similar illness or disability.
- d) Medical findings, including the results of any tests, x-rays, copies of EKG's, etc.
- e) Period of total and/or partial disability due to the diagnosed condition.
- f) The physician's opinion, with medical reasons in support of the doctor's opinion, as to how the disability was proximately caused, aggravated, accelerated, or precipitated by the traumatic injury you have claimed.

If OWCP receives no further correspondence or evidence from you within 90 days from the date of this letter, OWCP will assume that you do not intend to pursue the claim and will issue a decision based on the evidence of record.