

File Number: 102139174
CA-1008 OD-D-ACC

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 10 CHI
LONDON, KY 40742-8300
Phone: (312) 789-2800

April 20, 2016

Date of Injury:
Employee:

Dear Ms. CLYMER:

This is to notify you that your claim for an occupational disease has been accepted for the following condition(s):

<u>Diagnosed condition(s)</u>	<u>ICD-10 code(s)</u>
UNSPECIFIED ROTATOR CUFF TEAR OR RUPTURE OF RIGHT SHOULDER, NOT SPECIFIED AS TRAUMATIC	M75101

Please advise all medical providers who are treating you for this injury of the accepted ICD-10 code(s). Accurate coding facilitates timely bill processing.

If the current accepted condition(s) need to be revised or additional complications related to the current accepted condition(s) need to be added, your physician should explain in writing, with medical rationale, the relationship between any additional condition and the work injury or the current accepted condition(s) noted above.

If you lose time from work due to your work related condition, you may claim compensation using Form CA-7.

If you have not been released to full duty, have your treating physician provide a medical report that includes appropriate work restrictions and a statement as to when you will be released back to full duty without restrictions.

Please refer to the attachment entitled "Now That Your Claim Has Been Accepted" for important information pertaining to how to contact us, medical authorizations, payment of bills, and returning to work.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

File Number:
OD FM-dev (Orthopaedic)-O-I

<https://www.ecomp.dol.gov/>

When you access the website, choose the "Upload Document" option. You will be asked to provide your case number, last name, date of birth and date of injury to upload a document. ECOMP will then provide you with a Tracking Number so that you can verify when OWCP has received your document. For more detailed information about this document submission feature, visit the ECOMP website and click "Help."

Sincerely,

James Golliday
Claims Examiner

TO THE EMPLOYING AGENCY:

If the employee was treated at an agency medical facility for this injury, the employing agency must provide the treatment notes directly to OWCP.

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Sincerely,

James Golliday
Claims Examiner

Enclosure: NOW THAT YOUR CLAIM HAS BEEN ACCEPTED

NOTICE TO EMPLOYING AGENCY:

If Form CA-7 claiming compensation for wage loss is filed, you are reminded that 20 C.F.R. §10.111(c) requires the submission of a CA-7 within 5 working days. Please fully complete any form submitted and provide contact information to avoid delay of payment.

Please submit an update regarding this employee's work status.