File Number:
Merit Review4-D-RECO

RECEIVED JUL 25 2016

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300
Phone: (904) 366-0100

July 21, 2016

Date of Injury:
Employee:

Dear Mr.

This concerns your compensation case and your request for reconsideration received on 05/03/2016.

We have evaluated the evidence submitted and have reviewed the merits of your case under 5 U.S.C. 8128. You have provided sufficient evidence to warrant modification of the decision dated 05/05/2015. Based on the information received, the decision is now vacated.

The reasons for this decision are outlined in the enclosed Notice of Decision.

Please see the enclosed acceptance letter for a discussion of your rights and responsibilities.

Sincerely,

Darryl Waters
Senior Claims Examiner

PAUL H FELSER
FELSER LAW FIRM
PO BOX 10267
SAVANNAH, GA 31412

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.

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NOTICE OF DECISION
Claimant Name:
Case Number:

ISSUE:

The issue for determination is whether the evidence presented is of sufficient probative value to vacate the decision dated 05/05/2015.

REQUIREMENTS FOR ENTITLEMENT:

In accordance with the regulations set forth in 20 CFR § 10.609, if an application for reconsideration is accompanied by new and relevant evidence or by an arguable case for error, OWCP will conduct a merit review of the case to determine whether the prior decision should be modified. If sufficient evidence exists to overturn the prior decision, it should be vacated.

BACKGROUND:

On you filed a claim for Occupational Disease indicating you sustained an injury or medical condition on as a result of your employment.

On you were asked to provide additional evidence in support of your claim. No evidence was received and your claim was denied because fact of injury was not established.

You disagreed with that decision and requested reconsideration and provided the following evidence:

- ROSHA 301 injuries and illnesses incident report from occupational health dated 11/01/2013
- Work Comp Status Report from Dr. dated
- Office visit summary report from Dr. dated
- Physical therapy notes with a date range from to
- Occupational health medical evaluation of work status dated and

- Medical recommendations from your physician dated
- Bill payment statement from dated and

On 05/05/2015 a formal decision was issued in your case finding that causal relationship was not established. The medical evidence or record did not provide an opinion from a physician explaining the cause and effect relationship between your employment and your medical condition.

You disagreed with the 05/05/2015 decision and requested reconsideration by letter/appeal request form received on 05/03/2016 from Paul Felser, Esq.

DISCUSSION OF EVIDENCE:

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The evidence reviewed in support of your reconsideration request includes a medical report dated from Dr.
In this medical report, Dr. provided the diagnosis for your medical condition which resulted from your employment as a sheet metal worker for more than 30 years. Dr. stated that your medical condition is a result of repetitive chronic mechanical stress involving your hands. Dr. noted specified each of your job duties which involved repetitive movements which continually aggravated your condition. He provided an opinion that he believed that your condition was not an aggravation of a pre-existing condition but rather a direct result of your employment. Dr. opined that your condition has rendered you totally disabled despite undergoing surgical intervention.

BASIS FOR DECISION:

The evidence is sufficient to vacate the decision dated 05/05/2015 because you have provided a medical report from a physician who has provide a rationalized medical opinion establishing that your medical condition was caused by your federal employment as a sheet metal worker.

CONCLUSION:

Therefore, the decision dated 05/05/2015 is vacated.

Your case is now approved for bilateral carpal tunnel syndrome and left trigger thumb.

Darryl Waters
Senior Claims Examiner

File Number:
CA-1008 OD-D-ACC

U.S. DEPARTMENT OF LABOR

OFFICE OF WORKERS' COMP PROGRAMS
PO BOX 8300 DISTRICT 6 JAC
LONDON, KY 40742-8300
Phone: (904) 366-0100

July 21, 2016

Date of Injury:
Employee:

Dear Mr. SAWYER:

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

Diagnosed condition(s)	ICD-10 code(s)
CARPAL TUNNEL SYNDROME, RIGHT UPPER LIMB	G5601
CARPAL TUNNEL SYNDROME, LEFT UPPER LIMB	G5602
TRIGGER THUMB, LEFT THUMB	M65312

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:
CA-1008 OD-D-ACC

Sincerely,

Darryl Waters
Senior Claims Examiner
Enclosure: NOW THAT YOUR CLAIM HAS BEEN ACCEPTED

PAUL H FELSER
FELSER LAW FIRM
PO BOX 10267
SAVANNAH, GA 31412

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.

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CA-1008 OD-D-ACC

NOW THAT YOUR CLAIM HAS BEEN ACCEPTED

CONTACT INFORMATION

General Information - Information can be obtained on the Department of Labor website at http://www.dol.gov under the Office of Workers' Compensation, Division of Federal Employees' Compensation. You may directly access the Division of Federal Employees' Compensation portion of the web site at http://www.dol.gov/owcp/dfec/index.htm.

Claimant Query System (CQS) – You can view your case and compensation claim status, billing updates (including reimbursements), coverage limitations, and other information online at http://owcp.dol.acs-inc.com.

Medical Authorizations and Billing Inquiries – All medical providers should contact our medical authorization and bill processing contractor (ACS) for all authorizations and billing questions. Automated information is available 24 hours per day at 1-866-335-8319 or online at http://owcp.dol.acs-inc.com. The medical authorization fax line is 1-800-215-4901. If you, your doctor, or other medical providers require direct contact with a customer service representative, you may call 1-844-493-1966, Monday – Friday, 8am – 8pm EST.

Compensation Payments - Automated information regarding compensation payments is available 24 hours per day by phoning 1-866-OWCP IVR (1-866-692-7487).

Questions about your claim - If you have any questions regarding your FECA claim, you may contact the Office at the phone number and address listed on the front page of this letter. If you write to us, please put your case file number on each page.

Forms - Most of the billing and claim forms described below are available at: http://www.dol.gov/owcp/dfec/regs/compliance/forms.htm.

Change of Address - If your contact information changes (i.e. mailing address or telephone number), notify us promptly in writing over your signature. We cannot accept these changes over the telephone.

Submission of Information - You can submit requested information or other documentation pertaining to your FECA case to the address at the top of this letter, OR you can electronically upload documents into your case using the Employees' Compensation Operations and Management Portal (ECOMP). You can access ECOMP from any internet browser at: 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."

Attorneys and Authorized Representatives - You do not need the services of an attorney or representative to claim benefits under the FECA. However, you may obtain such services if you wish to do so, at your own expense. Before we can release information to, or discuss your case with, any representative, including a family member, we will need a statement signed by you, stating that you designated someone to represent you in your OWCP claim. The contact information for that party is also required.

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MEDICAL AUTHORIZATIONS AND EXPENSES

General Information - This acceptance letter (first page) describes the medical condition(s) OWCP accepts as work-related, and only treatment for those conditions should be billed to the Office. Your case file number must appear on all bills.

Authorizations – OWCP must approve in advance any surgery or procedure other than emergency surgery (that is, a procedure which must be performed right away to preserve life or the function of an organ or body part). You (or your medical provider) should contact OWCP for authorization at least 30 days before the intended date of the procedure. We will advise you of the information needed to determine whether OWCP can authorize the requested procedure.

Fee Schedule - You are not responsible for charges over the maximum allowed in the OWCP fee schedule. Our regulations provide 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. If a provider's bill is reduced by OWCP in accordance with its fee schedule, the provider is not allowed to charge you for the remainder of the bill. [20 C.F.R. §10.801 (d)]

Time Limitations - Bills and travel vouchers must be received within the calendar year following the year in which the medical service was rendered or the claim was accepted, whichever occurs later.

Providers – All medical providers must be enrolled with our Central Bill processing contractor (ACS) so that services can be authorized and medical bills can be processed. You may use the Provider Search function at http://owcp.dol.acs-inc.com to find medical providers who accept FECA cases. Note, however, that this tool only lists those physicians who opted to be included in the look-up, which means it may not capture every physician in a particular area who will accept FECA cases.

Physicians and Other Medical Providers (Except for Hospitals and Pharmacies) - Bills for your accepted condition must be submitted on the standard American Medical Association (AMA) billing form HCFA-1500, also known as OWCP-1500, to the address noted in the letterhead. Providers must itemize services for each date separately; use AMA (not state) CPT codes to describe the services performed; and provide their tax identification number (EIN) and ACS provider number. The provider must sign the form (a signature stamp may also be used).

Hospitals - These bills must be submitted on Form UB-04, also known as OWCP-04. These bills must be fully itemized, and the admission and discharge medical summaries should also be sent.

Pharmacies -These bills should be submitted electronically by your pharmacy via Point of Sale. If this is not available, bills must be submitted on the Universal Claim Form or equivalent. The pharmacy should include the following items: the case file number, the nine-digit tax ID number, the NDC number, the prescription number, the quantity of medication prescribed, the name of the prescribing physician, and the date of purchase. Pharmacies must complete the following fields: 403-D3 (Fill Number), 405-D5 (Days Supply), 408-D8 (Dispense as Written), 415-DF (Number of Refills Authorized) and 442-E7 (Quantity Dispensed). Your physician's clinical notes or reports should show that the medications prescribed were needed to treat your work-related injury. Pharmacies can obtain decisions on coverage of medications by calling 1-866-335-8319.