File Number:

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
P O BOX 8300 DISTRICT 2 NYC
LONDON, KY 40742-8300
(646) 264-3000

November 1, 2006

Date of Injury:
Employee:

RECEIVED NOV 0 6 2006

DECISION VACATING PRIOR DECISION

Dear

This is a decision concerning your request for reconsideration of the decision that denied your claim. As explained in the Decision of the Hearing Representative, your claim was denied because the medical evidence of record failed to explain how your diagnoses were related to what occurred at work on , when bundles of Reader's Digest magazine fell, striking you on your right arm in the elbow area.

In a letter dated which was received by the Office of Workers' Compensation Programs (OWCP) on , your representative, Paul H. Felser, requested a reconsideration of the denial. The letter referred to an "enclosed report" that confirms that you "suffered a work-related incident on or about ." but the only other correspondence received on is a disability certificate dated from M. D., a disability certificate which makes no reference to any occurrence on .

Further review of your claim disclosed an undated narrative report, received on rom Dr. This report was not of record when the prior decisions were issued in your claim, and therefore constitutes new evidence. In the report Dr. states:

> On , while [ ] was sweeping a bundles of catalogs came through the shoot [chute] striking down on her right arm. She then went to North Med with instructions to see me. She came to see me with swelling, pain and decreased range of motion the right elbow. I evaluated her on for her right elbow related to her worked related injury.

It is now clear that soon after the claimed injury you were seen by a physician who found you to have swelling and pain and decreased range of motion of the right elbow related to what happened at work on In the report Dr. diagnosed elbow sprain/strain "following the specific incident of injury on

Medical evidence has been received that explains that you suffered a right elbow sprain as a result of the incident at work on and for this reason the prior decision must be **vacated** and the claim must be **approved**.

Your claim that you sustained an employment injury on has been accepted for the condition **right elbow sprain**. The ICD-9 code, which is necessary for medical billing purposes, for this condition is: **841.8**.

US POSTAL SERVICE
ALBANY PERFORMANCE CLUSTER
INJURY COMPENSATION OFFICE
30 OLD KARNER ROAD
ALBANY, NY 12288

FELSER LAW FIRM, P.C.
P O BOX 10267
SAVANNAH, GA 31401

File Number

You are entitled to receive continuation of pay (COP) for your work absence from through Your employer reported that you returned to work on

At this time OWCP has not approved as work related any of the other conditions diagnosed by Dr. He does not explain how the left lateral epicondylitis diagnosed is related to the incident to your right arm. If you wish to expand the acceptance of this claim to include the condition left lateral epicondylitis as a result of the accepted right elbow sprain, you must submit medical evidence in which the physician explains whether, and in what way, the left lateral epicondylitis is related to the right elbow sprain.

Dr. diagnosed bilateral epicondylitis related to the repetitive nature of your employment but he does not explain how the condition is related to what occurred at work on If you wish to claim that you suffer from bilateral epicondylitis related to specific requirements of your employment you may do so by filing form CA-2, Notice of Occupational Disease and Claim for Compensation. If you file such a claim, you must describe the specific activities that you perform at work on a daily basis to which you attribute the condition.

On review of the record it is further noted that form CA-2a, Notice of Recurrence, was filed by you on You claimed that as of you lost time from work intermittently because of the effects of your work injury. Each claim filed under the Federal Employees' Compensation Act must be supported by medical evidence in which the physician states the history obtained, findings, diagnosis, and explains whether and how the diagnosed condition and disability are work related. In his report of Dr. stated that the follow-up visit was for bilateral elbow and shoulder pain but he does not address how these conditions relate to the incident at work. If you wish to pursue the recurrence claim you may do so by submitting medical evidence in which the physician explains whether, and in what way, the condition as of was related to what happened at work on

Enclosed is a notice entitled "Now That Your Claim Has Been Accepted . . ." which provides information about payment of bills, claims for compensation, and other matters pertinent to your claim. If you have any questions about your claim, you may contact this office at the above address.

Sincerely,

Senior Claims Examiner

File Number:

NOW THAT YOUR CLAIM HAS BEEN ACCEPTED...

...you will need more information about payment of medical bills and compensation, and about your responsibilities in returning to work. You may also need to know about receiving benefits from more than one Federal agency, and about rehabilitation services. These services may include visits or telephone calls from nurses and counselors working for the Office of Workers' Compensation Programs (OWCP).

This fact sheet is designed to answer your basic questions about these subjects. It supplements the information found in Pamphlet CA-14, which was sent to you when you first filed your claim. You may obtain more detailed information from the OWCP district office handling your claim.

MEDICAL PAYMENTS

Your acceptance letter states the medical condition(s) which OWCP has accepted as work-related. Only treatment for those conditions should be billed to OWCP. Bills should be submitted as follows:

- ***Bills from 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). This form may be obtained from your agency if your medical provider does not have it. The provider must itemize codes to describe the services performed, and provide his or her tax identification number. The provider must sign the form (a signature stamp may also be used).

- ***Hospital Bills.*** These bills should be submitted on Form UB-92. They must be fully itemized, and the admission and discharge medical summaries should be sent with them.

- ***Pharmacy Bills.*** These bills should be submitted electronically by the pharmacy through clearinghouses, or on the Universal Claim Form. 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. Your physician's clinical notes or reports should show that the medicines prescribed were needed to treat your work-related injury.

- ***Chiropractors' Bills.*** We will pay for chiropractic treatment only if it involves manual manipulation of the spine to correct a spinal subluxation demonstrated by x-ray to be present, or if a medical doctor has prescribed physical therapy by a chiropractor. You are responsible for other charges.

- ***Reimbursement.*** If you have paid the charges, submit the bill as described above, and state that you are requesting reimbursement. Use Form CA-915, Claimant Medical Reimbursement Form, which may be obtained from your employer or from the district office.

Send a copy of your cancelled check or a receipt. Be sure to include your case file number on the upper right corner of the bill.

Reimbursement of pharmacy expenses should be requested on Form CA-915, which is used in addition to the Universal Claim Form. Please fasten small receipts to a full-size piece of paper with your name and case file number shown in the upper right corner.

Travel expenses should be claimed on Standard Form 1012, Travel Voucher.

- ***Fee Schedule.*** OWCP uses a schedule of maximum allowable medical changes for many procedures. You are not responsible for charges over the maximum allowed in the fee schedule.

- ***Time Limitations.*** Bills must be received in the district offices by the end of the calendar year after the date of service, or the date the claim was accepted, whichever is later. If you have many bills to submit, it is best to send them monthly rather than quarterly or yearly.

If a health benefits carrier has paid medical bills for your accepted condition, the carrier may submit complete, itemized billings to OWCP for consideration.

If OWCP previously returned any medical bills related to this injury because your case had not been accepted, they may be resubmitted to the district office for consideration of payment.

COMPENSATION PAYMENTS

If you lose, or expect to lose, pay because of your injury, you should:

- Obtain Form CA-7, Claim for Compensation, from your employing agency.

- Complete the front of the form (section 1-7). In Section 2, you may claim the period your doctor thinks that you will be disabled for work, or until your next medical appointment, up to 30 days of wage loss into the future.

- Give the form to your supervisor or compensation specialist for completion of the back of the form (Sections 8-15). To minimize any interruption of income, your employing agency should submit the completed Form CA-7 to the district office on the 40th day of continuation of pay (COP) and should include any medical evidence in its possession concerning the injury.

If you continue to lose pay because of work-related disability after the dates claimed on Form CA-7, you should:

- Obtain and complete another Form CA-7.

- Ask your physician to complete Form CA-20. Attending Physician's Report (attached to Form CA-7), unless medical evidence supporting disability for the period claimed has already been submitted.

- Give Forms CA-7 and CA-20 to your supervisor or compensation specialist for submission to OWCP, preferably about five days before the end of the period claimed on the Form CA-7.

If disability continues, submit additional Forms CA-7 (and CA-20 if needed) through your employer for each period claimed, unless OWCP informs you otherwise.

MISSING CHECKS

While OWCP authorizes compensation payments, the Treasury Department actually issues them. If you are missing a payment, wait 10 days and then request tracer action. You should make this request in writing and clearly identify the missing check. Be sure to sign the letter before sending it to this office. Allow about six weeks for response.

SCHEDULE AWARD

You may claim a schedule award for permanent impairment by filing Form CA-7 through your employing agency, once you have reached maximum medical improvement from your injury. Compensation for a

schedule award is based upon the permanent loss or loss of use of a member or function of the body due to the work-related injury.

RETURN TO WORK

When you return to work, or obtain new employment, notify this office right away. If you receive a compensation check which includes payment for a period you have worked, return it to us immediately to prevent an overpayment of compensation. By law, OWCP may terminate your continuation of pay or compensation if you refuse (without good cause) to accept work which is within your medical restrictions.

OTHER IMPORTANT INFORMATION

OWCP NURSE SERVICES. Depending on the kind of injury you have and how severe it is, OWCP may ask a registered nurse to contact you concerning your recovery and return to work. The nurse may contact you by telephone or pay you a personal visit. She or he will discuss your medical progress with you and address any problems you may be having in returning to work. If necessary, she or he will coordinate with other OWCP personnel, your physician and your employing agency. *OWCP may terminate your continuation of pay or compensation if you fail to cooperate with the nurse.*

VOCATIONAL REHABILITATION SERVICES. You are responsible for asking your doctor when you can return to work, and for advising your agency when your doctor says you can work in some capacity. If OWCP determines that you are indefinitely disabled for your usual job, and your agency has not provided light duty, you are eligible for vocational rehabilitation services. The goal of such services is reemployment with your employing agency, another Federal agency, or a private employer. *OWCP may reduce your benefits if you fail to cooperate with vocational rehabilitation and placement efforts.*

DUAL BENEFITS. Compensation for wage loss includes payments for temporary total disability and for loss of wage-earning capacity. You may not receive Federal retirement benefits and compensation for wage loss for the same periods of time. You may, however, receive a retirement annuity and compensation for a schedule award for the same period.

PENALTY. 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 Federal Employees' Compensation Act, or who knowingly accepts compensation to which he or she is not entitled, is subject to felony criminal prosecution and may, under appropriate U.S. criminal code provisions, be punished by a fine of not more than $10,000 or imprisonment for not more than five years, or both.

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U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation Programs (OWCP)

Effective 9/2/03, the Federal Employees' Compensation (FEC) division of OWCP consolidated its medical authorization and bill payment processes. To assist us in this change we need you to review your addresses and contact numbers to ensure your mail, billing, and medical authorization requests are directed to the appropriate location.

All mail and bills for Federal workers' compensation cases should be sent to:

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

Employers should continue to send the previously designated CA forms to the district office that has jurisdiction of the case.

With this change, you will be able to monitor the status of bill processing via a

WEBSITE

http://owcp.dol.acs-inc.com

If you need to speak with us about a bill payment or reimbursement matter, you should call our toll-free number:(866) 335-8319. Our local district office personnel should not be contacted for payment status on pending bills or reimbursement requests.

Phone medical authorization requests should be directed to our new toll-free phone number:

Phone Medical Authorizations - (866) 335-8319

Effective 9/2/03, you should not contact your local OWCP/FEC district office to request a medical authorization.

Urgent medical authorization requests can be faxed to our new FAX number:

FAX Medical Authorizations - (800) 215-4901

Local district office dedicated medical authorization fax numbers will not be operational effective 9/2/03.

If you are an injured worker and are currently receiving compensation payments via electronic deposit, any reimbursement requests will also be paid electronically.

These changes will allow us to serve you more efficiently. We thank you for you cooperation.