

RECEIVED SEP 23 2019

U.S. DEPARTMENT OF LABOR

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

September 20, 2019

Date of Injury
Employee:

Dear _____

This is to notify you that your claim for a traumatic injury on _____ has been accepted for the following condition(s):

<u>Diagnosed condition(s)</u>	<u>ICD-10 code(s)</u>
AGGRAVATION OF HERNIATED DISC WITH RADICULOPATHY AT L4-L5	M51.26
AGGRAVATION OF SPONDYLOLISTHESIS AT L4-L5	M43.16

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.

Dr. _____ also gave a diagnosis of postlaminectomy syndrome; however, he did not provide an opinion about whether or not the incident on _____ caused or aggravated the diagnosis. Please provide this information within 30 days otherwise a decision may be issued regarding the diagnosis based on the evidence in file.

If your injury results in lost time from work, you may be eligible to receive continuation of pay (COP) until you recover or return to light duty, up to a maximum of 45 calendar days. If wage loss continues after your entitlement to COP expires, you may claim compensation using Form CA-7.

The evidence in your case file at this time indicates that you may not have returned to work in a full-time capacity. OWCP is not a retirement program and our primary goals are your medical recovery and return to full-duty employment. We strive for an active team approach where OWCP, the employing agency, and the medical providers work collaboratively with you to facilitate medical recovery and sustainable return to work. Your case is currently being evaluated to determine what steps we can take to help you achieve these goals.

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.

File Number:
CA-1008 TI-D-ACC

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.

Sincerely,

Division of Federal Employees' Compensation

Enclosure: NOW THAT YOUR CLAIM HAS BEEN ACCEPTED

PAUL H FELSER
FELSER LAW FIRM, P.C.
7393 HODGSON MEMORIAL DRIVE
SUITE 102
SAVANNAH, GA 31406

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 send a copy of the position description (including physical requirements) for the job held on date of injury.

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

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodation(s) and/or modification(s), please contact OWCP.