

# Filing for a Traumatic Injury



# Traumatic Injury Defined

A traumatic injury (TI) 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 time and place of occurrence and member or function of the body affected. It must be caused by a specific event , incident, or series of events or incidents during a single day or work shift.
- Form CA-1 Notice of Traumatic Injury should be completed by the injured employee and the employing agency (EA) supervisor or injury compensation specialist.

# Form CA-1

- The front portion of the CA-1 should be completed by the injured employee unless incapacitated at which time the form may be completed by authorized EA official (Agency Reviewer (AR) in ECOMP).
- The injured employee must indicate a specific date of injury and date of notice on the CA-1.
- The CA-1 must be submitted to the EA within 30 days of the date of injury in order for the injured employee to be eligible for Continuation of Pay (COP). COP will be discussed in more detail further in the presentation.

# Form CA-1

- Not all CA-1 forms are submitted from the EA to OWCP; follow the filing instructions on the back of the form (i.e., cases with no lost time and no medical expense).
- If the form should be filed, it must be transmitted to OWCP within 10 work days from the date the EA received notice (not necessarily 10 days from the date that the form was actually signed).
- If the form should be filed, it must be transmitted to OWCP **even if the information provided by the claimant is incorrect**. You should provide a statement with the correct information when you transmit the form to OWCP.
- Do not delay the submission of the completed form because it was not accompanied by additional factual or medical evidence or the EA's incident investigation has not been completed.

# CA-1 - Agency Responsibilities


- Review the CA-1 for completeness.
- Verify that employee's home address is correct as noted in Block 7.
- The agency should promptly authorize medical care on Form CA-16 (Authorization for Examination and/or Treatment) and give the form to the claimant (or to someone acting on his or her behalf) to present to initial medical providers.
- Advise injured employee of his/her right to elect COP or to use annual or sick leave or LWOP if the injury is disabling.

# CA-1 - Agency Responsibilities

- The agency will notify the employee of the need to submit medical evidence of a disabling traumatic injury within 10 calendar days of the date disability begins, or pay may be terminated.
- Ensure that the OWCP Agency Code has been entered correctly in Block 17.
- Submit evidence refuting claim if the EA does not agree with the statements of the injured worker or witness (Block 35).
- The agency will inform the employee whether COP will be controverted and, if so, whether pay will be terminated, and the basis for such action.
- Ensure form has been dated and signed by EA representative.



# CA-1 Form Review

U.S. Department of Labor Office of Workers' Compensation Programs					
<b>Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation</b>					
<small>Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas. Witness: Complete bottom section 16. Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.</small>					
<b>Employee Data</b>					
1. Name of employee (Last, First, Middle)			1a. Email address		2. Social Security Number
3. Date of birth Mo. Day Yr.	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Home telephone	6. Grade as of date of injury Level Step		
7. Employee's home mailing address (include street address, city, state, and ZIP code) City State ZIP Code				8. Dependents <input type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 years <input type="checkbox"/> Other	
<b>Description of Injury</b>					
9. Place where injury occurred (e.g., 2nd floor, Main Post Office Bldg., 12th & Pine)					
10. Date injury occurred Mo. Day Yr.		Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	11. Date of this notice Mo. Day Yr.		12. Employee's occupation
13. Cause of injury (Describe what happened and why)					
14. Nature of injury (identify both the injury and the part of the body, e.g., fracture of left leg)				a. Occupation code	
				b. Type code	
				c. Source code	
				OWCP Use - NOI Code	
<b>Employee Signature</b>					
15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:  <input type="checkbox"/> a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.  <input type="checkbox"/> b. Sick and/or Annual Leave  I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Worker's Compensation Program (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.  Signature of employee or person acting on his/her behalf _____ Date _____  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 FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.  Have your supervisor complete this receipt attached to this form and return it to you for your records.					
<b>Witness Statement</b>					
16. Statement of witness (Describe what you saw, heard, or know about this injury)					
Name of witness		Signature of witness		Date signed	
Address		City		State	ZIP Code
If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP.					

Form CA-1  
Revised October 2018

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# CA-1 Form Review

Official Supervisor's Report: Please complete information requested below:			
Supervisor's Report			
17. Agency name and address of reporting office (include street address, city, state, and ZIP code)			OWCP Agency Code
			OSHA Site Code
City		State	ZIP Code
18. Employee's duty station (include street address, city, state and ZIP code)		City	State ZIP Code
19. Employee's retirement coverage <input type="checkbox"/> CSRS <input type="checkbox"/> FERS <input type="checkbox"/> Other, (identify)			
20. Regular work hours		21. Regular work schedule	
From: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. To: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		<input type="checkbox"/> Sun. <input type="checkbox"/> Mon. <input type="checkbox"/> Tues. <input type="checkbox"/> Wed. <input type="checkbox"/> Thurs. <input type="checkbox"/> Fri. <input type="checkbox"/> Sat.	
22. Date of injury		24. Date stopped work	
Mo. Day Yr.		Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
25. Date pay stopped		27. Date returned to work	
Mo. Day Yr.		Mo. Day Yr. Time: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
23. Date notice received			
Mo. Day Yr.			
28. Was employee injured in performance of duty? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain)			
29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? <input type="checkbox"/> Yes (If "Yes," explain) <input type="checkbox"/> No			
30. Was injury caused by third party?		31. Name and address of third party (include street address, city, state, and ZIP code)	
<input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," go to item 32.)		City State ZIP Code	
32. Name and address of physician first providing medical care (include street address, city, state, ZIP code)			33. First date medical care received
City State ZIP Code			Mo. Day Yr.
34. Do medical reports show employee is disabled for work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Does your knowledge of the facts about this injury agree with statements of the employee and/or witnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," explain)			
36. If the employing agency controverts continuation of pay, state the reason in detail.			37. Pay rate when employee stopped work
			Per
Signature of Supervisor and Filing Instructions			
38. A supervisor who knowingly certifies to any false statement, misrepresentation concealment of fact, etc. in respect of this claim may also be subject to appropriate felony criminal prosecution.			
I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:			
Name of supervisor (Type or print)			
Signature of supervisor			Date
Supervisor's Title			Office phone
39. Filing instructions			
<input type="checkbox"/> No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)			
<input type="checkbox"/> No lost time, medical expense incurred or expected: forward this form to OWCP			
<input type="checkbox"/> Lost time covered by leave, LWOP, or COP: forward this form to OWCP			
<input type="checkbox"/> First Aid Injury			

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# Administrative Authorization of Limited Benefits

- Some traumatic injury claims are administratively handled to allow payment of up to \$1500 in medical expenses and payment of COP by the EA.
- Administrative Authorization of Limited Benefits cases are not reviewed or adjudicated by a claims examiner.



# Administrative Authorization of Limited Benefits

- Main Criteria:
  - Not controverted/challenged by the EA
  - Claim created within 6 months of injury
  - No claim for wage loss (beyond COP period)
  - Claim does not involve excluded source/nature of injury code (e.g. MVA, stress, third party, communicable disease)
  - No third party liability

# Administrative Authorization of Limited Benefits

- If later developments trigger reopening of the case, a claims examiner will need to review and adjudicate the claim .
- Triggers include:
  - Receipt of claim for wage loss (CA-7)
  - Receipt of surgery request
  - Receipt of medical bills over \$1500
- Reopened Administrative Authorization of Limited Benefits cases do not count against EA timeliness submission goals.



# Questions

1. A traumatic injury is caused by a specific event, incident, or series of events or incidents during:

- a) A single day or work shift
- b) Multiple work shifts

# Questions

2. When filing a Notice of Traumatic Injury, the injured employee and the employing agency should utilize Form CA-1.

- a) True
- b) False

# Questions

3. A CA-1 should be submitted to OWCP within 10 work days from the date the employing agency receives notice. The employing agency should not delay the submission of the completed form because it was not accompanied by additional factual or medical evidence.

- a) True
- b) False

# Questions

4. The agency plays an important role in helping injured employees file a Notice of Traumatic Injury claim. The agency responsibilities include:
- a) Verify that the employee's home address is correct as noted in Block 7.
  - b) Review the CA-1 for completeness.
  - c) Advise injured employees of their right to elect COP, use annual or sick leave, or LWOP if the injury is disabling.
  - d) Notify the employee of the need to submit medical evidence within 10 calendar days of the date disability began.
  - e) Ensure that the correct employing agency has been selected.
  - f) All of the above

# Questions

5. Administrative Authorization of Limited Benefits cases are not reviewed or adjudicated by a claims examiner. These cases are administratively handled to allow payment of up to \$1500 in medical expenses and payment of COP by the employing agency. Certain triggers may cause further development of these types of cases. All of the triggers below will open the case for further development by OWCP except:

- a) Receipt of surgery request
- b) Receipt of claim for wage loss (CA-7)
- c) Receipt of a copy of an injured employee's birth certificate
- d) Receipt of medical bills over \$1500



# Take Away Tips

- 1) A traumatic injury (TI) is defined as a wound or other condition of the body caused by external force, including stress or strain. It must be caused by a specific event, incident, or series of events or incidents during a single day or work shift.
- 2) Form CA-1 Notice of Traumatic Injury should be completed by the injured employee and the employing agency (EA) supervisor or injury compensation specialist.
- 3) The CA-1 must be submitted to the EA within 30 days of the date of injury in order for the injured employee to be eligible for Continuation of Pay (COP).

# Take Away Tips

- 4) The CA-1 must be transmitted to OWCP within 10 work days from the date the EA received notice.
- 5) The EA should review the CA-1 for completeness.
- 6) Some traumatic injury claims are administratively handled to allow payment of up to \$1500 in medical expenses and payment of COP by the EA. These are called administrative authorization of limited benefits cases and they are not reviewed or adjudicated by a claims examiner. These cases are typically not controverted and have no claim for wage loss.