HBK EL-505, Injury Compensation, December 1995 Forms

OWCP Form CA-16 Instructions

Authorization for Examination and/or Treatment

Summary

Purpose

Authorization for an employee to obtain medical care or treatment from a doctor or medical facility of his or her choice following an injury or illness.

Timeliness

Following a traumatic injury which does not require emergency care, the form must be issued within four hours after the injury or after request for medical care by the injured employee.

The form may be issued for an occupational illness or disease; however, it cannot be issued without the permission of the OWCP district office — a claims examiner or higher level OWCP person.

When a traumatic injury requires emergency care, and a CA-16 cannot be provided at the time of the care, it will be issued to the source of emergency care within 48 hours.

When to Prepare

Prepare this form at the following time:

- a. Following a traumatic injury which requires medical care.
- b. At the discretion of the control office, it may be issued following a recurrence if it is either within six months after the injury, within six months after the last medical care, or within six months after the return to work from the first period of disability (this is a very rare situation).

When Not to Prepare

- a. Following the submission of an occupational claim (CA-2) *unless authorized* by the OWCP district office.
- b. Following a heart attack, the employee or representative may file a CA-2 if they believe that the heart attack arose out of and in the course of their job.
- c. Following a recurrence if it is more than six months after the injury or after the return to work from the *first* period of disability.
- d. Should not be used to authorize a change of physicians after the initial choice has been made.
- e. An employee may not execute a CA-16 in his or her own behalf.

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f. When an injured employee is seen or treated by either a postal medical officer or contract doctor for a first aid case not reportable to OWCP district office

Who Prepares

- a. Authorized control office personnel.
- Trained and authorized control point personnel. Medical or Health unit medical personnel (if applicable) and authorized control points. Authorizing office must be supervisory level.

General Procedures

The authorized official will complete the CA-16 in triplicate. The original and one copy will be sent with the employee to the treating physician along with a pre-addressed envelope.

The physician will complete part B of the form and should be requested to either give the copy to the employee for immediate return to the control office/point, or mail it to the control office in the envelope provided.

Filing and Distribution

Filing and distribution procedures as follows:

- a. Send the original to the OWCP district office.
- b. Copy to claimant's Injury Compensation file.

Instructions

Part A – Authorization will be completed by the issuing, authorized official.

After an appointment has been made, enter the name and address of the
physician or hospital selected by the employee. If issued for emergency care,
indicate "emergency care," and enter the name and address of the source of
such care.

Note: If issued for a recurrence, the source of medical care should be the same as the previous authorization.

- Claimant's complete name; last name, first name, and middle name (Enter "NMN" if no middle name).
- 3. Date of injury per Items 10 and 21 on the CA-1; or, Item 29, on the CA-2.
- 4. Enter the employee's craft or title and either FTRS, PTRS, Casual, Transitional Employee, EAS, PCES, or other.
- 5. Provide a description of the injury or part of the body affected. Be specific, this information may assist the doctor.

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Note: It is permissible to add a stamped or typed statement such as *Limited* duty may be available, in accordance with the attached job or function description.

- 6. a. Check box 6.B.1. if there is *no doubt* as to the validity of the injury.
 - b. Check box 6.B.2. if there IS ANY DOUBT concerning the relationship of the injury to the employee's work, or any doubt that an injury occurred.
 - c. If the form is issued for an occupational claim, check 6.B.2.
- Complete if the form is issued for an occupational illness or disease. Insert name and title of approving OWCP official, a claims examiner, or higher level OWCP person.
- 8. Authorized official's signature.
- 9. Self-explanatory.
- 10. Commercial telephone number.
- 11. Date of issue.
- 12. Complete, but request return of the copy to the ICCO.
- 13. Complete with mailing address of the ICCO.

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OWCP Form CA-16

Authorization for Examination And/Or Treatment

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs



The following request for information is authorized by law (5 USC 8101 expenses may not be paid or may be subject to suspension under this filed as requested. Information collected will be handled and stored in Act, the Privacy Act of 1974 and OMB Cir. No. A-108.	OMB No.: 1215-0103 Expires: 10-31-94				
PART A - AU	THORIZATION				
1. Name and Address of the Medical Facility or Physician Authorized to Provide the Medical Service:					
2. Employee's Name (last, first, middle)	3. Date of injury (mo. day, yr.)	4. Occupation			
5. Description of Injury or Disease:					
6. You are authorized to provide medical care for the employee for a p condition stated in item A, and to the condition indicated either 1 or A. Your signature in item 35 of Part B certifies your agreement that established by OWCP and that payment by OWCP will be accept. B. 1. Furnish office and/or hospital treatment as medically near must have prior OWCP approval. 2. There is doubt whether the employee's condition is otherwise related to the employment. You are authorized studies, and promptly advise the undersigned whether circumstances of the employment. Pending further advict the condition may be to the injury or to the employment. 7. If a Disease or Illness is Involved, OWCP Approval for Issuing	2, in item B. all fees for services shall not exceed oted as payment in full for said service cessary for the effects of this injury. A caused by an injury sustained in the dot o examine the employee using index you believe the condition is due to be you may provide necessary conservations.	the maximo es. Any surgery ne performa dicated non to the alleg rvative trea	um allowable fee y other than emergency ance of duty, or is esurgical diagnostic ed injury or to any		
Authorization was Obtained from: (Type Name and Title of OWCP Official)	Name and Title of Authorizing Official: (Type or print clearly)				
10. Local Employing Agency Telephone Number:	11. Date (mo., day, year)				
12. Send one copy of your report: (Fill in remainder of address)	13. Name and Address of Employee	e's Place o	f Employment:		
U.S. DEPARTMENT OF LABOR Employment Standards Administration Office of Workers' Compensation Programs	Department of Agency				
	Bureau or Office Local Address (including ZIP Co	ode)			

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

Form CA-16 Rev. Oct. 1988

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PART B - AT "NDING PHYSICIAN'S REPORT					
14. Employee's Name (last, first, middle)					
15. What History of Injury or Disease Did Employee Give You?					
16. Is there any History or Evidence of Concurrent or Pre-existing Injury, D	16a. IDC-9 Code				
(If yes, please describe)					
Yes No 17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.) 18. What is Your Diagnosis?			18a. IDC-9 Code		
19. Do You Believe the Condition Found was Caused or Aggravated by th there is doubt)	e Employment A	ctivity Described? (Pl	ease explain your answer if		
Yes INO 20. Did Injury Require Hospitalization? Yes No		21. Is Additional Hos	spitalization Required?		
If yes, date of admission (mo., day, year)					
Date of discharge (mo., day, year)			No y Performed (mo., day, year)		
22. Surgery (If any, describe type)		23. Date Surgery Fer	ioimed (inc., day, year)		
		25. What Permanent Anticipate?	6. What Permanent Effects, If Any, Do You Anticipate?		
		28. Date of Dischard (mo., day, year)			
29. Period of Disability (mo., day, year) (If termination date unknown, so	30. Is Employe	e Able to Resume			
indicate) Total Disability: From To		Light Work Date:			
Partial Disability: From To	☐ Regu	Regular Work Date:			
31. If Employee is Able to Resume Work, Has He/She been Advised?	If Employee is Able to Resume Work, Has He/She been Advised? Yes No if Yes, Furnish Date Advised				
32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.					
33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.					
34. Do You Specialize? Yes No (If yes, state specialty)					
35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is	36. Address (N	lo., Street, City, State,	Zip Code)		
knowlingly made may subject me to felony criminal prosecution.	37. Tax Identifi	cation Number	38. Date of Report		
MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim From" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.					
For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 *U.S. Government Printing Offic* ? 391 — 312-377/51259					

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OWCP Form CA-16 (continued)

INSTRUCTIONS FOR AUTHORIZING OFFICIAL FOR COMPLETION OF PART A

SELECTION OF PHYSICIAN

A Federal employee injured by accident while in the performance of duty has the initial right to select a physician of his/her choice to provide necessary treatment. The supervisor shall immediately authorize examination and appropriate medical care by use of Form CA-16 issued to either a United States medical officer/hospital or any duly qualified physician/ hospital of the employee's choice.

If the employee elects to be treated by a private physician, a copy of the American Medical Association standards billing form (AMA OP 407/408/409; OWCP-1500a) should be supplied together with Form CA-16.

A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee.

Generally, 25 miles from the place of injury, employing agency, or the employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered.

PERIOD OF AUTHORIZATION

Form CA-16 is valid for up to sixty days from date of issuance, and may be terminated earlier upon written notice from OWCP to the provider. It should not be used to authorize a change of physicians after the initial choice is exercised by the employee.

FEDERAL MEDICAL FACILITIES

 U.S. medical facilities include Public Health Service, Military, or VA hospitals. Federal health service facilities (health units) established under 5 USC 7901 are not U.S. medicalfacilities as used herein (see 20 CFR 10.400).

DEFINITION OF INJURY

• The term "injury" includes damage to or destruction of medical braces, artificial limbs and other prosthetic devices. Eyeglasses and hearing aids are included only if the damages were incidental to a personal injury which required medical services. Treatment for illness or disease should not be authorized unless approval is first obtained from OWCP.

DEFINITION OF PHYSICIAN

The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners within the scope of their practice as defined by State law. The reimbursable services of chiropractors under the FECA are limited by statute to physical examination, related laboratory tests and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

FORM COMPLETION

Part A shall be compelted in full by the authorizing official. The authorization is not valid unless the name and address of the physician or hospital is entered in Item 1 and the signature of the authorizing official appears in Item B. Check B1 or B2 or Item 6, whichever is appropriate. In case of illness or disease, only Box B2 may be checked.

Show the address of the proper OWCP Office in Item 12. Send original and one copy of Form CA-16 to the medical officer or physician. If issued for illness or disease, a copy must also be sent to OWCP.

ADDITIONAL INFORMATION

See 20 CFR and/or Chapter 810, Federal Personnel Manual (FPM).

Information for Physician - See Reverse Side

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OWCP Form CA-16 (continued)

INFORMATION FOR PHYSICIAN

YOUR AUTHORIZATION

Please read Part A of Form CA-16. You are authoreized to examine and provide treatment for the injury or disease described in Item 5, for a period of not more than 60 days from the date of issuance, subject to the conditions in Item 6. A physician who is debarred from the FECA program as provided at 20 CFR 10.450-457 may not be authorized to examine or treat an injured Federal employee. Authorization may be terminated earlier upon written notice from OWCP. For extension of the authorization to treat beyond the 60 day period, apply to the office shown in Part A, Item 12.

USE OF CONSULTANTS AND HOSPITALS

 You may utilize consultants, laboratories and local hospitals, if needed. Authorize semi-private accomodations unless a private room is medically necessary.
 Ancillary treatment may be provided to a hospitalized employee as necessary.

REPORTS

After examination, complete items 14 through 38, of Part B, and send your report, together with any additional narrative or explanatory material, to the address listed in Part A, item 12. If the employee sustained a traumatic injury and is disabled for work, reports on Form CA 17, "Duty Status Report" may be required by the employing agency during the first 45 days of disability. If disability continues beyond 45 days, monthly reports should be submitted. Reports from all consultants are also required. Delay in submitting medical reports may delay payment of benefits.

RELEASE OF RECORDS

 Injury reports are the official records of OWCP. They shall not be released to anyone nor may any other use be made of them without the approval of OWCP.

BILLING FOR SERVICES

OWCP requires that charges be itemized using the AMA standard "Health Insurance Claim Form" (AMA OP 407/408/409; OWCP-1500, or HCFA-1500). Each procedure must be identified, in Column 24 C of the form, by the applicable Current Procedural Terminology (4th edition) Code CPT 4). A copy of the form may be supplied by the employee at the time treatment is sought.

 Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, and X-rays to diagnose a subluxation of the spine; and treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by X-ray.

TAX IDENTIFICATION NUMBER

The provider's Tax Identification Number (TIN) is an important identifier in the OWCP system. To speed processing and to reduce inaccuracy of payment, the provider's TIN (Employer Identification Number or SSN) should be shown on all reports and billings submitted to OWCP. If possible, providers should decide on a single TIN - either corporate or personal - which is used consistently on OWCP claims.

ADDITIONAL INFORMATION

O Contact the OWCP shown in Item 12 of Part A.

Please Remove These Instructions Before Submitting Your Report.