

NAF WORKERS' COMPENSATION EMPLOYER CHECKLIST
WHAT TO DO WHEN YOUR EMPLOYEE IS INJURED AT WORK

EMPLOYEE NAME: _____ DATE OF INJURY: _____

FOR ALL EMPLOYEE INJURIES/INCIDENTS:

___ LS-202: Always complete when an employee notifies you of an injury, including when no medical attention is sought by the employee. Forward to NAF Human Resources Office immediately after completion. This form should be received no later than 10 days from the date the employer is aware of the injury. Failure to send this form to the Department of Labor within 10 days can subject your installation to an \$11,000 penalty.

___ FREQUENTLY ASKED QUESTIONS BROCHURE: Give this informational brochure to the injured employee.

EMPLOYEE INJURIES REQUIRING MEDICAL ATTENTION:

___ LS-1: Complete and give this form to the employee authorizing initial medical treatment. ONLY give to the employee if you have received the medical provider information from the employee.

___ LS-204: If you have not received medical provider information from the employee (i.e., they are not sure which doctor they are going to go to), provide this form to the employee to have their physician complete.

___ Medical Release Form: Employees who seek medical care must complete this form authorizing CCSi to obtain the medical documentation to adjudicate the claim. No payments will be made without medical documentation to substantiate time loss from work and/or medical treatment.

___ Choice of Doctor Statement: Employees that seek medical care after the initial medical examination (usually an emergency visit) must complete this form. It will notify CCSi who they choose as their treating physician. They are only allowed one choice of treating physician.

___ MTF information: Provide these memorandums to the employee in the event they are treating with an MTF. They may present these to the MTF to avoid being charged by the MTF for treatment of their workers' compensation injury.

___ myMatrixx Flyer: Give to employees for immediate access to prescription benefits with no out-of-pocket expense.

EMPLOYEE INJURIES WITH LOST TIME:

___ Light Duty Advisory: Indicate whether or not Light Duty is available and forward to CPAC/NAF HRO.

___ Leave Option Form: Employees accruing leave must sign and submit. LWOP is mandatory until this form is signed by an employee and submitted to CCSI.

___ LS-210: (1) Complete this form every pay period the employee remains off work; and (2) upon return to work. All lost time is reported to CCSI with LS-210. NOTE: The date of injury is Administrative Leave.

___ Follow Up with Employee: The supervisor is responsible for communicating with the employee regarding their work status. Supervisors will require the employee to provide medical documentation of work restrictions (total or light duty status) to cover all periods of absence.

___ Extra information: CCSI and Department of Labor contact lists

**Employer's First Report of Injury
or Occupational Illness**
(See instructions on reverse)

U.S. Department of Labor

Office of Workers' Compensation Programs



OMB No. 1240-0003

1. OWCP No.		2. Carrier's No. 3 DIGIT SNN HERE		3. Date and Time of Accident (mm/dd/yyyy) (hh:mm am/pm)	
4. Name of injured/deceased employee (Type or print - first, M.I., last) First Name M.I. Last Name Telephone				5. Employee's address (No., street, city, state, ZIP, country) Street: City: St: Zip: Ctry:	
6. Injury is reported under the following Act (Mark one) A Longshore and Harbor Workers' Compensation Act B <input checked="" type="checkbox"/> Nonappropriated Fund Instrumentalities Act C Outer Continental Shelf Lands Act D Defense Base Act 1. Contracting Agency 2. Contract Number		7. Indicate where injury occurred (Longshore Act only) (Mark one) A <input type="checkbox"/> Aboard vessel or over navigable waters B <input type="checkbox"/> Pier/Wharf C <input type="checkbox"/> Dry dock D <input type="checkbox"/> Marine terminal E <input type="checkbox"/> Building way F <input type="checkbox"/> Marine railway G <input type="checkbox"/> Other adjoining area		8. Sex <input type="checkbox"/> M <input type="checkbox"/> F	9. Date of birth (mm/dd/yyyy)
14. Did employee stop work immediately? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. Date & hour emp returned to work (mm/dd/yyyy) (hh:mm am/pm)		10. Social security no. (Required by law) REQUIRED	
17. Did injury/death occur on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No		18. Dept. in which employee normally works(ed)		11. Did injury cause death? <input type="checkbox"/> No <input type="checkbox"/> Yes - If yes, skip to 16	
20. Date and hour pay stopped (mm/dd/yyyy) (hh:mm am/pm)		21. Which days usually worked per week? (Mark (X) days) S M T W T F S <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		12. Did injury cause loss of time beyond day or shift of accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Wages or earnings (include overtime, allowances, etc.) a. Hourly b. Daily c. Weekly d. Yearly		24. Exact place where accident occurred (See instructions on reverse). This item should specify area if accident was in maritime employment and occurred in area adjoining navigable waters.		13. Date and hour employee first lost time because of injury Date (mm/dd/yyyy) Time (hh:mm am/pm)	
26. Describe in full how the accident occurred (Relate the events which resulted in the injury or occupational disease. Tell what the injured was doing at the time of the accident. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident.) Employee states...		19. Occupation		16. Was employee doing usual work when injured/killed? (if no, explain in item 26) <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Nature of Injury (Name part of body affected - fractured left leg, bruised right thumb, etc.) If there was amputation of a member of the body, describe.		22. Date employer or foreman first knew of accident. (mm/dd/yyyy) (hh:mm am/pm)		25. How was knowledge of accident or occupational illness gained?	
28a. Has medical attention been authorized? <input type="checkbox"/> Yes <input type="checkbox"/> No		28b. LS-1 issued? Yes <input type="checkbox"/> No <input type="checkbox"/>		29. Enter date of authorization.	
30. Was first treating physician chosen by employee? <input type="checkbox"/> Yes <input type="checkbox"/> No		31. Has insurance carrier been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No			
▶ Name of:			Address - Enter number, street, city, state, zip code		
32. Physician					
33. Hospital					
34. Insurance Carrier ACIF c/o CCSI		PO BOX 541328 DALLAS, TX 75354			
35. Employer					
36. Employer's Business		37. Signature of person authorized to sign for employer		Phone number	
38. Official title and phone number of person signing this report		Name of person signing this report		39. Date of this report (mm/dd/yyyy)	

This pamphlet attempts to answer the questions most frequently asked by our NAF employees when an on the job injury occurs.

NAF employees who are disabled as a result of an injury arising out of and in the course of his or her employment are entitled to benefits under the Longshore and Harbor Workers' Compensation Act. This is a Federal Law that is regulated by the Department of Labor.

Should you have additional questions that are not addressed in this pamphlet, please contact your Civilian Personnel Advisory Center/NAF Human Resources office.



**U. S. ARMY
NONAPPROPRIATED FUND
WORKERS' COMPENSATION
PROGRAM**

Army Central Insurance Fund
2455 Reynolds Road, Bldg. 2266, 2nd Floor
Ft Sam Houston, TX 78234-7588

- Q To whom do I report an on the job injury?
- A You should report any on the job injury to your supervisor. He/She will complete the proper paperwork and forward your claim to your Civilian Personnel Advisory Center (CPAC)/NAF Human Resources Office (HRO). The CPAC/NAF HRO will forward the claim to the claims service contractor and the Department of Labor.
- Q Who is our claims service contractor?
- A Workers' Compensation claims for our NAF personnel are adjudicated by CCSI. They are located in Dallas, TX.
- Q What benefits am I entitled to under workers' compensation?
- A If you are disabled from work for more than three days due to a compensable on the job injury, compensation will be paid at a rate of 66 2/3% of your average weekly wage. You are also entitled to authorized medical care.
- Q May I go to any doctor I choose?
- A You have the right to choose your treating physician one time. Your supervisor will provide you with a Form LS-1 authorizing your choice of physician for medical treatment. Any change in physicians must then be authorized by the claims service contractor. If you choose to see a chiropractor, be aware that under the Longshore and Harbor Workers' Compensation Act, chiropractors may only provide treatment consisting of manual manipulation of the spine to correct subluxation shown by x-ray, and they may not provide treatment for any other body part except the spine.
- Q How long will benefits be paid?
- A Benefits will be paid as long as you are disabled from work. Medical documentation must be supplied to the claims service contractor to substantiate any lost time from work.
- Q Does my regular pay stop once I have filed a workers' compensation claim?
- A You have two options in regards to receiving benefits for lost time.
- Option I** – If you have sick or annual leave accrued, you may elect to take it in lieu of waiting for your compensation check from the claims service contractor. Upon receipt of the compensation check you would then turn it in to the CPAC/NAF HRO and the payroll office will credit back the amount of leave it buys. You may not elect this option and also keep the compensation check.
- Option II** – You may elect to receive the compensation check directly from the claims service contractor and then you will be carried in an LWOP status until you return to work.
- You will be required to sign a **Benefit Option Form stating your intent**. If you elect LWOP, you will need to discuss with your CPAC/NAF HRO how this will affect your benefit premiums that are normally withheld from your paycheck.
- Q What happens if the doctor releases me to light duty?
- A You need to notify your employer and the claims service contractor that the doctor has released you to light duty status. If light duty is available, you will be required to start back to work.
- Q When will I start receiving benefits?
- A The first three days of lost time is considered the waiting period under the law. Benefits will be paid after three days of lost time and are payable on the 14th day after the employer has been notified of an on the job injury. If you miss more than 14 days, you will be paid for the waiting period.
- Q Will I have to pay for the visits to the doctor or hospital?
- A No. You should have all bills for authorized medical treatment sent to the claims service contractor.
- Q Will I be compensated if I am permanently disabled as a result of my injury?
- A If in the opinion of your treating physician you are permanently disabled as a result of the accident, you may be entitled to further benefits under the law. These benefits will be explained to you in the event this occurs.
- Q Am I covered as I travel to and from work under the law?
- A Generally speaking workers' compensation coverage does not cover you as you travel to and from work. You are required to be within the course and scope of your employment in order to have coverage.
- Q Who is watching out for my interests in connection with my workers' compensation claim?
- A The Department of Labor monitors all lost time claims. They have 11 district offices within the United States for this purpose.
- Q If I fail to notify my employer of an on the job injury do I lose my right to benefits?
- A The statute of limitation for filing a workers' compensation claim is thirty days from the date of injury. It is to your benefit to notify your employer immediately of any work related injury.

Request for Examination and/or Treatment

**U.S. Department of Labor
Office of Workers' Compensation Programs**



Part A - Authorization

OMB No. 1240-0029

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the employee's choice (See item below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course of employment.

Mark either box A or B in item 7. The original and at least two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the District Director and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:

- A Longshore and Harbor Workers' Compensation Act
- B Defense Base Act
- C Nonappropriated Fund Instrumentalities Act
- D Outer Continental Shelf Lands Act

2. Name and address of physician or medical facility authorized to provide medical service

* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diagnose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name: **FILL OUT COMPLETELY- DO NOT LEAVE BLANK. IF YOU DO NOT HAVE THIS**

line1: INFORMATION USE LS-204

city:

line2:

st:

3. Employee's Name

4. Date of Injury (mm/dd/yyyy)

5. Occupation

6. How accident or illness occurred

7. You are authorized to provide medical services to the employee as follows:

- A If you believe the condition is related to the injury, or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.
- B If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

You are requested to submit a written report of first treatment within 10 days to the District Director at the Office named in item 12 below (See back of this form for instructions as to medical report and the submission of your charges).

8. Signature and title of authorizing official (Sign all copies)

9. Name and address of employer

name:

line1:

line2:

city:

st:

10. Telephone (Area code and local number)

11. Date authorized (mm/dd/yyyy)

12. Send one copy of your report to:

U.S. Department of Labor
Office of Workers' Compensation Programs

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent

name:

line1:

line2:

city:

st:

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 65 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits (20CFR 702.419). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, N.W., Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Part B - Attending Physician's Report of Injury and Treatment

Instructions To Physician: This initial report should be completed and submitted within 10 days. Mail the original to the District Director (see Item 12 for address), and a copy to the company listed in Item 13. Subsequent reports should be made regularly on form LS-204 and/or in narrative form while the employee is in your care. Please read item 7 on the front of this form. Your Social Security Number is voluntary and is used for identification purposes only.

14. What history of injury or disease did employee give you?

15. Is there any history or evidence of pre-existing injury, disease, or physical impairment?

No Yes - Please describe

16. What are your findings (include results of x-rays, laboratory tests, etc.)?

17. What is your diagnosis?

18. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain your answer if there is doubt.)

Yes No

19a. Did injury require hospitalization? No Yes - Complete b, c, d

b. Name of hospital

c. Date admitted (mm/dd/yyyy)

d. Date discharged

20. Is additional hospitalization required?

Yes No

21. Surgery (If any, describe type)

22. Date surgery performed (mm/dd/yyyy)

23. What type of treatment did you provide other than hospitalization or surgery?

24. What permanent effects of the injury, if any, do you anticipate?

25. Date of first examination (mm/dd/yyyy)

26. Date(s) of treatment (mm/dd/yyyy)

27. Date of discharge from treatment (mm/dd/yyyy)

28. Period of disability (if termination date unknown - so indicate)

Total disability: From To

Partial disability: From To

29. Date employee able to resume work

To light work

To regular work

30. If employee is able to resume work, has he/she been advised? No Yes - Furnish date advised (mm/dd/yyyy)

31. If employee is able to resume only light work, indicate physical limitations and the type of work which can reasonably be performed with these limitations.

32. Remarks and recommendation for future care, if indicated.

33. Do you specialize? No Yes - State specialty

34. Signature and typed name of physician

35. Address and phone number

36. Physician's Federal Tax ID number

37. Date of this report (mm/dd/yyyy)

38. Medical bill (Charges for your services may be presented in the space below or on your billhead stationery.)

Date or period of treatment	Services and supplies must be itemized	Qty. or No.	Unit price		Amount
			Cost	Per	
Total					

Attending Physician's Supplementary Report
 (Longshore and Harbor Workers' Compensation Act,
 As Extended)

U.S. Department of Labor
 Office of Workers' Compensation Programs
www.dol.gov/owcp/dlhwc/index.htm



INSTRUCTIONS: Use this form to make progress reports and to make a final report when the patient is discharged. Progress reports should be submitted about every thirty days, the original to the District Director (See Item 19. on page 2) and one copy to the insurance carrier or self-insured employer. Please answer all questions fully. If a question is not applicable, enter "NA". The exact point of amputation or other permanent partial impairment must be known to determine compensation the injured is entitled to receive. If preferred, physician may submit a narrative report covering all information requested on this form. Use "Remark" on page 2 of form if more space is needed for any answer.		OMB No. 1215-0160
		FOR OFFICE USE
		OWCP No.
		Carrier's No.
1. Type of Report (Mark X one) <input type="checkbox"/> Progress <input type="checkbox"/> Final	2. Date of Injury (mm/dd/yyyy)	
3. Name of Injured employee	4. Employee's home address	
5. Name of employer	6. Name of insurance carrier ACIF c/o CCSI	
7a. Have you filed a previous report giving history? <input type="checkbox"/> Yes- skip to Item 8 <input type="checkbox"/> No-Answer 7b and 7c		
7b. State how many injuries occurred and give source of information. (If claim is for occupational disease, include occupational history and date of onset of related symptoms)	7c. Was employee previously under the care of another physician for this injury? <input type="checkbox"/> No <input type="checkbox"/> Yes- Give Physician's name and address and reason for transfer	
8. Is there any history or evidence of pre-existing injury, disease or physical impairment?		
9a. Present condition (include diagnosis, subjective complaints, objective findings, and any changes of condition since last report.)	9b. If employee was hospitalized since last report, indicate and give name and address of hospital.	
10a. Describe treatment provided		
10b. Date of first treatment	10c. Date of most recent treatment	10d. Has treatment been terminated? <input type="checkbox"/> No <input type="checkbox"/> Yes- Indicate reason
10e. Are you continuing treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes	10f. If treatment is continuing, estimate probable duration	

This report is authorized by 33 U.S.C. 907(b). While you are not required to respond on this form, your cooperation is needed to insure that the injured's workers' compensation case is properly processed by the U.S. Department of Labor. This form is used to request medical information which will be used to determine an injured worker's entitlement to compensation and medical benefits.

11. Will the injury result in permanent restriction, total or partial loss of function or a part or member, or permanent disfigurement of the head, face, or neck, or some other part of the body which will handicap the employee in securing or maintaining employment?

No Yes-Describe

12. Is employee working? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. When do you estimate employee can a. Resume limited work of any kind? Date (mm/dd/yyyy)	b. Resume regular work? Date (mm/dd/yyyy)
--	---	--

14. If employee is unable to do his/her regular work, but can do limited work, specify work limitations due to this injury.

15. In your opinion, was the occurrence described above (or in the previous report which gave this information) the competent producing cause of the injury and disability?

Yes No

16. Is rehabilitation treatment or service or evaluation recommended? <input type="checkbox"/> Yes- Explain <input type="checkbox"/> No- Explain	17. If rehabilitation treatment or services or evaluation is recommended, has referral been made? <input type="checkbox"/> Yes- To whom? <input type="checkbox"/> No- Explain
---	--

18. Remarks	19. Send the original of your report to: Office of the District Director U.S. Department of Labor Office of Workers' Compensation Programs
-------------	--

20. Name of attending physician (Type or Print)	21. Signature of physician
---	----------------------------

22. Address	23. Telephone No. (Area Code)	24. Date of Report
-------------	-------------------------------	--------------------

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) section 901 of Title 33 to the US Code and 33 U.S.C. 907 (b) authorize collection of this information. The purpose of this information is to determine an injured worker's entitlement to compensation and medical benefits under the Longshore and Harbor Workers' Compensation Act (LHWCA). Completion of this form is not mandatory; however, failure to provide the information may result in the loss of compensation benefits. Additional disclosures of this information may be to: (1) the employer which employed the claimant at the time of injury, or to the insurance carrier or other entity which secured the employer's compensation liability. (2) physicians and other medical service providers for use in providing treatment or medical/vocational rehabilitation, making evaluations and for other purposes relating to the medical management of the claim. (3) the Department of Labor's Office of Administrative Law Judges (OALJ), or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matter arising in connection with the claim. (4) Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the LHWCA to determine whether benefits are being and have been paid properly, and where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by law. (5) Failure to disclose all requested information may delay the processing of the claim, the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. (33 U.S.C. 907 6). Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, to the U. S. Department of Labor, 200 Constitution Avenue, NW, Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND COMPLETED FORMS TO THIS OFFICE.

Choice of Doctor Statement

Date completed _____	Date of injury/illness _____
-------------------------	---------------------------------

Employee Name _____

I choose as my Physician:	
Doctor's name _____	
Address: _____	
City, ST ZIP _____	
Telephone # () _____	Fax # () _____
Specialty (if known) _____	

Signature of Associate/Claimant _____
Address _____
City/ST/Zip _____
Telephone Number _____

MTF TREATMENT INFORMATION FOR NAF WORKERS' COMPENSATION INJURIES

- Per attachment 1, initial treatment is not to be billed to the NAFI. Follow-up care may be billed to the NAFI at the interagency rate.
- Attachment 2 replaced attachment 1 on March 26, 2008.
- Per attachment 3, the Assistant Secretary of the Army (M&RA) designated NAF employees with on-the-job injuries as eligible for initial and follow-up care at MTFs without reimbursement and satisfies the contingency set forth in the second attachment by the Assistant Secretary of Defense and is retroactive to March 26, 2008.

[\[Categorical Listing\]](#) [\[Numerical Listing\]](#)



THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

MAR 5, 1997

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)

SUBJECT: Policy for Billing Occupational Health or Workers' Compensation Cases for Department of Defense Employees in Military Treatment Facilities

This memorandum clarifies our billing policy for occupational health or workers' compensation cases in military treatment facilities. Emergency medical care (including initial treatment after on-the-job injury or illness) provided Department of Defense (DoD) employees injured on the job, whether appropriated or nonappropriated fund, will not be billed. Nonemergent or follow-up occupational health or workers' compensation care for nonappropriated fund employees will be billed to the employer at the interagency rate.

I recognize that appropriated fund DoD employees are governed by the Federal Employees Compensation Act (FECA), nonappropriated fund employees are governed by the Longshore and Harbor Workers' Compensation Act, and that military treatment facilities are legally authorized to collect from nonappropriated fund instrumentalities for all occupational health or workers' compensation care. However, due to the potential impact of this action on service morale, welfare and recreation programs, I am establishing this policy to forego collections for emergency medical care. I am taking this action under the authority of 10 U.S.C. 1074 (c) to establish, by regulation, the limited entitlement to emergency medical care.

The point of contact is LCDR Pat Kelly at (703) 681-8910 or pkelly@ha.osd.mil.

A handwritten signature in black ink, appearing to read "Stephen C. Joseph".

Stephen C. Joseph, M.D., M.P.H.

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

HA POLICY 97-035

[\[Top\]](#)

Last update: 1/5/1999



THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

MAR 26 2008

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Policy for Billing for Care Furnished by Military Treatment Facilities to
Federal Employees for On-the-Job Injuries and for Occupational Health

This memorandum clarifies our billing policy for care furnished by military treatment facilities (MTFs) to Federal employees for on-the-job injuries and for occupational health. It replaces Health Affairs Policy 97-035, Policy for Billing Occupational Health or Workers' Compensation Cases for Department of Defense Employees in MTFs.

Policy (see attached matrix):

- Bill the non-appropriated fund (NAF) instrumentality at the interagency rate for the following services furnished to a NAF employee, unless the Secretary of the Military Department responsible for the MTF concerned has designated NAF employees as eligible for care without reimbursement:
 - Occupational health – initial or follow-up care
 - On-the-job injury (workers' compensation) – initial or follow-up care
- Do not bill the Department of Defense (DoD) when furnishing occupational health care (initial or follow-up) or care for an on-the-job injury (initial or follow-up) to appropriated fund DoD employees.
- Bill all other Federal Agencies (including Coast Guard, National Oceanic and Atmospheric Administration, and the Public Health Service) at the interagency rate for all workers' compensation care for an on-the-job injury and for occupational health care furnished to a Federal employee.
- Bill an employee for non-work-related care *unless* he is also a Uniformed Services beneficiary. Bill the Coast Guard, National Oceanic and Atmospheric Administration, or the Public Health Service for services furnished to these employees. Do *not* bill the employee if he is a Military Department Uniformed Services beneficiary; collect other health insurance information, and bill in accordance with 10 United States Code 1095.

HA POLICY: 08-002

Discussion:

The working definition of occupational health includes:

Preventive health care, health promotion, curative health care, first aid, rehabilitation and compensation, where appropriate, as well as strategies for prompt recovery and return to work.

TRICARE's Uniform Business Office Manual defines workers' compensation as:

Expenses incurred to cover injury or illness due to a work-related accident or cumulative trauma. Workers' compensation law varies from state to state.

Appropriated fund Federal employees are governed by the Federal Employees Compensation Act. See the attached matrix for billing policy.

Non-appropriated fund employees are governed by the Longshore and Harbor Workers' Compensation Act. MTFs are legally authorized to bill non-appropriated fund instrumentalities for all workers' compensation care.

My point of contact is Lieutenant Colonel Jeanne Yoder, at (703) 681-6757, or *Jeanne.Yoder@tma.osd.mil*.


S. Ward Casscells, MD

Attachments:

As stated

cc:

Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

Billing Policy Matrix

	Department of Defense (DoD) NAF Employee (Non-Uniformed Services Beneficiary)	DoD NAF Employee (Uniformed Services Beneficiary)	Appropriated Fund DoD Employee (Non-Uniformed Services Beneficiary)	Appropriated Fund DoD Employee (Uniformed Services Beneficiary)	Other Federal Agency* (Non-Uniformed Services Beneficiary)	Other Federal Agency (Uniformed Services Beneficiary)
Occupational (Occ.) Health (initial care)	Bill non-appropriated fund instrumentalities (NAFIs) at interagency rate (IAR)	Bill NAFI at IAR	No bill	No bill	Bill Agency at IAR	Bill Agency at IAR
Occ. Health (follow-up care)	Bill NAFI at IAR	Bill NAFI at IAR	No bill	No bill	Bill Agency at IAR	Bill Agency at IAR
Workers' Comp (initial care)	Bill NAFI at IAR	Bill NAFI at IAR	No bill	No bill	Bill Agency at IAR	Bill Agency at IAR
Workers' Comp (follow-up care)	Bill NAFI at IAR	Bill NAFI at IAR	No bill	No bill	Bill Agency at IAR	Bill Agency at IAR
Nonwork-related care	Bill employee	Do not bill employee (collect other health insurance (OHI) information and bill accordingly)	Bill employee	Do not bill employee (collect OHI information and bill accordingly)	Bill employee	Do not bill employee (collect OHI information and bill accordingly)

* Includes Coast Guard, National Oceanic and Atmospheric Administration, and Public Health Service

DOCUMENT MANAGEMENT DIVISION

REQUEST FOR OFFICIAL HEALTH AFFAIRS POLICY AND WEB POSTING

Subject: Policy for Billing for Care Furnished by MTFs to
Federal Employees for On-the-job Injuries and for
Occupational Health


Livelihood: 142856, 142859

Action Office/Action Officer: MC+FS/LtCol Jeanne Yoder

Phone: 681-6757

CHIEF OF STAFF DECISION:

Upon signature, assign a Health Affairs policy number and post on the MHS Web site.

Approved: 

Disapproved: _____



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS
111 ARMY PENTAGON
WASHINGTON DC 20310-0111

1 OCT 2008


SAMR

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Designation of Nonappropriated Fund (NAF) Employees as Eligible for Military Treatment Facility (MTF) Care

1. Assistant Secretary of Defense (ASD) memorandum dated 26 March 2008 (enclosed) authorizes the billing of Nonappropriated Fund Instrumentalities (NAFIs) at the interagency rate for occupational health (initial or follow-up care) and on-the-job injury (workers' compensation - initial or follow-up care) furnished to a NAF employee, unless the Secretary of the Military Department responsible for MTFs concerned designates NAF employees as eligible for care without reimbursement.
2. Currently, NAFIs are often billed for occupational health (initial or follow-up care) and on-the-job injury (workers' compensation - initial or follow-up care) provided to NAF employees at MTFs. The billings to NAFIs have a financial impact on Soldiers and Families and the Morale, Welfare, and Recreation program. Such expenses generally are passed on to Soldiers and Families in terms of higher fees or reduced services. Billings are not made for the same services provided to APF employees working with NAF employees in the same activities, thus creating a disparity between the two workforces.
3. Accordingly, on behalf of the Secretary of the Army, I hereby designate NAF employees, to include AAFES employees, as eligible for care by MTF without reimbursement by the responsible NAFI, for occupational health and on-the-job injury as described above, effective retroactive to the ASD memorandum date (26 March 2008).
4. Please contact Ms. Capella-Weinard, 703-601-4361, for more information.

Encl


RONALD L. JAMES 10/08
Assistant Secretary of the Army
(Manpower and Reserve Affairs)

DISTRIBUTION:

**ASSISTANT SECRETARY OF THE ARMY (FINANCIAL MANAGEMENT
AND COMPTROLLER)**

ADMINISTRATIVE ASSISTANT FOR SECRETARY OF THE ARMY

THE SURGEON GENERAL

DEPUTY CHIEF OF STAFF, G1 (CIVILIAN PERSONNEL POLICY)

ASSISTANT CHIEF OF STAFF FOR INSTALLATION

**MANAGEMENT/COMMANDER, INSTALLATION MANAGEMENT
COMMAND**

**COMMANDER, FAMILY AND MORALE, WELFARE AND RECREATION
COMMAND**



COMMANDER, ARMY AND AIR FORCE EXCHANGE SERVICE



Workers' Compensation Prescription Information

Employer:

Please fill out employee information below and provide employee with this document to take to any pharmacy with prescriptions.

	
Employee Name:	
Group#:	10602382
Member ID (SSN):	
Date of Injury:	
Processor:	myMatrixx
Bin#:	014211
Day supply is limited to 7 days for a new injury.	
myMatrixx Help Desk: (877) 804-4900	

Employer Signature:	Phone:	Date:
------------------------	--------	-------

Employee:

CCSI & US Army MWR has partnered with *myMatrixx* to make filling workers' compensation prescriptions easy.

This document serves as a temporary prescription card. A permanent prescription card specific to your injury will be forwarded directly to you within the next 3 to 5 business days.

Please take this letter and your prescription(s) to a pharmacy near you. myMatrixx has a network of over 60,000 pharmacies nationwide. If you need assistance locating a network pharmacy near you, please call myMatrixx toll free at (877) 804-4900.

IF YOU ARE DENIED MEDICATION(S) AT THE PHARMACY PLEASE CALL (877) 804-4900

Pharmacist: Please obtain above information from the injured employee if not already filled in by employer to process prescriptions for the workers' compensation injury only. Document only valid if signed and dated by employer above.

For questions or rejections please call (877) 804-4900. Please do not send patient home or have patient pay for medication(s) before calling myMatrixx for assistance.

NOTE: Certain medications are pre-approved for this patient; these medications will process without an authorization. All others will require prior approval.

FOR ALL REJECTIONS OR QUESTIONS CALL: (877) 804-4900

LIGHT DUTY ADVISORY

To: CONTRACT CLAIMS SERVICES, INC./ARMY

From: _____

Date: _____

Subject: Availability of Work

Our employee, _____, was injured on _____.

Mark one:

- 1) Light or modified duty IS AVAILABLE
- Light or modified duty IS NOT AVAILABLE

Mark one:

- 2) The duty will be provided in the employee's regular job position.
- The duty will be provided in an alternate job position.
- 3) Hourly rate of Pay _____ Hours per week _____

Printer Name/Position of Person Offering Job

Phone Number

Signature of Person Offering Job

Date Signed

FAX A COPY OF THIS FORM TO CCSI AT 1-800-616-1389

US ARMY NONAPPROPRIATED FUND

WORKERS' COMPENSATION CLAIM LEAVE OPTIONS

Workers' compensation benefits are provided to injured employees in accordance with Army Regulation 215-1, Chapter 19, Section XV.

Employees entitled to receive workers' compensation benefits for illness or injury may elect to accept one of the following leave options in accordance with the AR 215-3, Chapter 5. LWOP is mandatory until employee signs and submits this form.

OPTION I. Receive workers' compensation disability benefits from the claims administration service contractor supplemented with accrued sick and/or annual leave up to an amount not exceeding your basic salary. This is accomplished by the payment of full leave benefits to the employee, with partial reimbursement (about 2/3) of the leave used through the employee's assignment of all workers' compensation temporary disability benefits.

I ELECT TO RECEIVE FULL LEAVE BENEFITS AND HEREBY REQUEST THAT ALL WORKERS' COMPENSATION TEMPORARY DISABILITY BENEFITS BE MAILED TO ME AT:

NAF CIVILIAN PERSONNEL OFFICE ADDRESS

I UNDERSTAND THAT MY LEAVE BALANCE WILL BE CREDITED WITH THE APPROPRIATE NUMBER OF HOURS BASED ON THE AMOUNT OF MY WORKERS' COMPENSATION TEMPORARY DISABILITY BENEFITS CHECK. I WILL ENDORSE THE CHECKS RECEIVED FROM THE CLAIMS SERVICE CONTRACTOR.

EMPLOYEE'S SIGNATURE

DATE

OPTION II. Receive only workers' compensation temporary disability benefits from the claims service contractor.

I ELECT TO BE PLACED ON LEAVE WITHOUT PAY FOR THE ENTIRE PERIOD OF ABSENCE DUE TO INJURY.

EMPLOYEE'S SIGNATURE

DATE

Employer's Supplementary Report of
Accident or Occupational Illness

U.S. Department of Labor
Office of Workers' Compensation Programs



Notice: This Report must be filed promptly with the District Director in every case in which (1) Form LS-202 does not show date injured employee returned to work, and (2) each time injured employee has returned to work and later becomes disabled for work (33 U.S.C.930(b)). If the employee was disabled for work more than 3 days, compensation payments should be reported on Forms LS-206 and LS-208. Medical reports must be sent to the District Director promptly following first treatment and thereafter while treatment continues. Please type or print all information. (if additional space is needed, use back of form.) The information will be used to determine entitlement to benefits.

OMB No. 1240-0003

For Office Use

1. OWCP No.

2. Carrier's No.

3. Name of injured employee (First, middle initial, last)	4. Date of accident (Month, day, year)
---	--

5. Address of injured employee (Number and Street, City, State, ZIP code)	6. Name and address of your insurance carrier
---	---

7. Initial Period of Disability (Use Inclusive Dates for a and b)		
a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

8. If this report covers a period of disability after the date shown in item 7c. state each subsequent period of disability. Use inclusive dates for a. and b.		
a. From (Month, day, year)	b. Through (Month, day, year)	c. Date returned to work (Month, day, year)

9. Did employee receive medical attention? a. <input type="checkbox"/> Yes - Give dates, names and addresses of doctors and hospitals providing treatment.	b. <input type="checkbox"/> No - Explain
---	--

10. Was employee treated by his or her choice of physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Was form LS-1 given to employee when injury was reported to you? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	--

12. Name of employer (Firm Name)	13. Employer's address (Number and Street, City, State, ZIP code)
----------------------------------	---

14. Signature of person authorized to sign for employer	15. Name, official title and phone number of person signing	16. Date of report (month, day, year)
---	---	---------------------------------------

Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. (33 U.S.C.930(b)). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, 200 Constitution Avenue, NW, Room C-4315, Washington, D.C. 20210, and reference the OMB Control Number.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.

DEPARTMENT OF THE ARMY
NAF WORKERS' COMPENSATION PROGRAM

CLAIMS SERVICE CONTRACTOR

CONTRACT CLAIMS SERVICES INC. (CCSI)
P.O. BOX 541328
DALLAS, TX 75354-1328

TELEPHONE: 1-800-743-2231 (972) 554-1141

FAX: 1-800-616-1389 (972) 721-0442

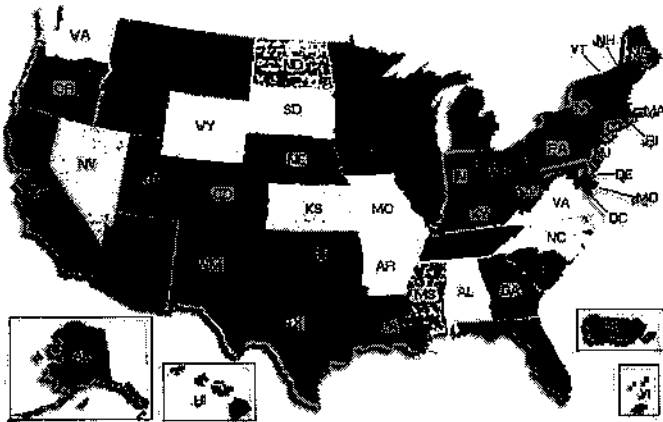
EXT

MANAGER:	DANA CHESNUT dana.chesnut@ccsholdings.com	2993
ASSISTANT MANAGER:	BOBBY MORGAN bobby.morgan@ccsholdings.com	2970
SUPERVISOR:	RENEE DAVIS renee.davis@ccsholdings.com	2996

Division of Longshore and Harbor Workers' Compensation (DLHWC)

District Office Locations

A list of the DLHWC District Office locations and a map that shows their geographical jurisdictions is shown below. Clicking on a map area will take you to the corresponding District Office information.



District Offices

Click on the appropriate District office below for jurisdiction and contact information (address, telephone number).

Boston	New York	Baltimore	Norfolk	Jacksonville	New Orleans
Houston	San Francisco	Honolulu	Seattle	Long Beach	District 40

Region I — Boston

(Jurisdiction - Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont. Defense Base Act jurisdiction - east of the 75th degree west longitude, Newfoundland, and Greenland.)

Address and Phone number	Director
Longshore District Office #1, Boston U.S. Department of Labor OWCP/DLHWC JFK Federal Building, Room E-250 Boston, MA 02203 Phone : (617) 624-6750 Fax : (617) 624-6603	District Director: David B. Groeneveld Regional Director: Robert Sullivan

Region II — New York

(Jurisdiction - New Jersey, New York, Puerto Rico, Virgin Islands. Defense Base Act jurisdiction - Mexico, Central and South America (including coastal islands); areas east of the continents of North and South America to the 60th degree east longitude, (including Iraq, Afghanistan and Iran) and any other areas or locations not covered under any other district office.) Click here for information on the New York Region.

Address and Phone number	Director
Longshore District Office #2, New York U.S. Department of Labor OWCP/DLHWC 201 Varick Street, Room 740 Post Office Box 249 New York, NY 10014-0249 Phone #: (646) 264-3010 Fax #: (646) 264-3002	District Director: Richard V. Roblotti Regional Director: Robert Sullivan

Region III — Philadelphia

Baltimore Longshore District Office (Jurisdiction - Delaware, District of Columbia, Maryland, Pennsylvania, West Virginia)

Address and Phone number	Director
Longshore District Office 4, Baltimore U.S. Department of Labor OWCP/DLHWC 31 Hopkins Place Room 410-B - Federal Building Baltimore, MD 21201 Phone: (410) 962-3677 Fax: (410) 962-2796	District Director: Theresa Magyar Regional Director: R. David Lotz

Norfolk Longshore District Office (Jurisdiction - Virginia)

Longshore District Office 5, Norfolk U.S. Department of Labor OWCP/DLHWC Federal Building, Room 212	District Director: Theresa Magyar
--	-----------------------------------

200 Granby Mall Norfolk, VA 23510 Phone: (757) 441-3071	Regional Director: R. David Lotz
---	----------------------------------

Region IV — Atlanta	
<i>(Jurisdiction - Alabama, Florida, Georgia, Kentucky, North Carolina, South Carolina, Tennessee). Click here for information on the Atlanta Region.</i>	
Address and Phone number	Director
<i>Longshore District Office 6, Jacksonville</i> U.S. Department of Labor OWCP/DLHWC Charles E. Bennett Federal Building 400 West Bay Street, Room 63A, Box 28 Jacksonville, FL 32202 Phone: (904) 357-4788 Fax: (904) 357-4787	District Director: Charles Lee Regional Director: Richard Brettell

Region VI — Dallas	
<i>Houston Longshore District Office (Jurisdiction - Texas, Oklahoma, New Mexico, Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio, Wisconsin, Missouri, Nebraska, Kansas, Defense Base Act jurisdiction - Canada, west of the 75th degree and east of the 110th degree west longitude.)</i>	
Address and Phone number	Director
<i>Longshore District Office 8, Houston</i> The Houston office has moved to a new location effective April 27, 2009. New contact information is shown below: U.S. Department of Labor OWCP/DLHWC Mickey Leland Federal Building 1919 Smith Street, Suite 870 Houston, TX 77002 Phone: (713) 209-3235 Fax: (713) 209-3257	District Director: Brad Soshea Regional Director: Rebecca Houser (Acting)
<i>New Orleans Longshore District Office (Jurisdiction - Louisiana, Arkansas, Mississippi)</i> <i>Longshore District Office 7, New Orleans</i> All US Postal Service mail should be sent to P.O. BOX 30728, New Orleans, LA 70190-0728. Delivery via Fed Ex or other commercial delivery service may be addressed to the office address below. U.S. Department of Labor OWCP/DLHWC 600 S. Maestri Place Suite 617 New Orleans, LA 70130 Phone: (504)589-2671 Fax: (504)589-3969	District Director: David A. Duhon Regional Director: Rebecca Houser (Acting)

Region IX — San Francisco	
<i>San Francisco Longshore District Office (Jurisdiction - California (north of the northern boundaries of the counties of San Luis, Obispo, Kern, and San Bernardino), Arizona, Nevada) Click here for information on the San Francisco Region.</i>	
Address and Phone number	Director
<i>Longshore District Office 13, San Francisco</i> U.S. Department of Labor OWCP/DLHWC 90 7th Street, Suite 15100 San Francisco, CA 94103-6716 Phone: (415) 625-7669 Fax: (415) 625-7470	District Director: R. Todd Bruininks Regional Director: Sharon Tyler
<i>Honolulu Longshore District Office (Jurisdiction - Hawaii, Defense Base Act cases jurisdiction - all areas west of the continents of North and South America (excluding coastal islands) to 60 degrees east longitude (excluding Iran, Iraq and Afghanistan).</i> <i>Longshore District Office 15, Honolulu</i> U.S. Department of Labor OWCP/DLHWC 300 Ala Moana Blvd., Room 5-135 Post Office Box 50209 Honolulu, HI 96850 Phone: (808) 541-1983	District Director: R. Todd Bruininks Regional Director: Sharon Tyler
<i>Long Beach Longshore District Office</i>	

(Jurisdiction - California (south of the northern boundaries of the counties of San Luis, Obispo, Kern, and San Bernardino))	
Longshore District Office 18, Long Beach U.S. Department of Labor OWCP/DLHWC 401 East Ocean Blvd., Suite 720 Long Beach, CA 90802 Phone: (562) 980-3577 Fax: (562) 980-3587	District Director: Marco Adame Regional Director: Sharon Tyler

Region X — Seattle	
(Jurisdiction - Alaska, Oregon, Washington, Colorado, Idaho, Montana, N.Dakota, S.Dakota, Utah, Wyoming, Defense Base Act jurisdiction - Canada, west of the 110th degree west longitude, and all areas in the Pacific Ocean north of the 45th degree north latitude.)	
Address and Phone number	Director
Longshore District Office 14, Seattle U.S. Department of Labor OWCP/DLHWC 1111 Third Avenue, Suite 620 Seattle, WA 98101-3212 Phone: (206) 398-8255 Fax: (206) 398-8211	District Director: R. Todd Bruininks Regional Director: Sharon Tyler

District 40 — Washington, DC	
(Jurisdiction - Washington DC, administrates DISTRICT OF COLUMBIA WORKMEN'S COMPENSATION ACT only)	
Address and Phone number	Director
Longshore District Office #40, Washington DC DC Department of Employment Services 64 New York Ave NE - 2nd Floor Washington DC 20002 Phone: (202) 671-1070 Fax: (202) 671-1929	District Director: Charles Green

 [Back to Top](#)