

**For:** State and County Offices and Kansas City Offices

**Office of Workers' Compensation Leave Buy Back (LBB) and Wage Loss Procedures**

**Approved by:** Deputy Administrator, Management



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**1 Overview**

**A**

**Background**

Surveys of employees who have applied for benefits under OWCP's indicated that the LBB process was cumbersome and time consuming. Subsequently, new LBB procedures have been developed.

**B**

**Purpose**

This notice:

- advises State and County Offices of changes in OWCP's LBB and wage loss procedures
- provides instructions for completing and processing applicable forms.

**C**

**Labor Relations Obligations**

Where exclusive representation exists, bargaining may be requested to the extent allowed by applicable statutes. Where contract language already addresses these policies and procedures for bargaining unit employees, contract language prevails.

Continued on the next page

<p><b>Disposal Date</b></p> <p>September 1, 2001</p>	<p><b>Distribution</b></p> <p>State and County Offices and Kansas City Offices; State Offices relay to County Office</p>
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## Notice PM-2233

### 1 Overview (Continued)

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#### D

##### Contact

Use the following table to determine the appropriate contact.

<b>IF located in...</b>	<b>THEN contact...</b>
an FSA State Office	Maria T. Ruiz, HRD, Performance Management, Benefits, and Awards Branch at 202-418-9034 or e-mail to Maria_Ruiz@wdc.fsa.usda.gov.
an FSA County Office	State Office.
KCAO, KCCO, KCFO, KC-ITSDO, KC-ITSTO, RMA-KC	Sue Collins or Mary Harvey, KCAO, Personnel Division at 816-926-6643.

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### 2 LBB Policies

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#### A

##### What is LBB

An employee who needs to be absent from work because of an on-the-job injury or illness beyond the allowable Continuation of Pay (COP) period must use annual leave, sick leave, or leave without pay (LWOP). LBB is the process of buying back periods of sick and/or annual leave used to cover an injury-related absence from work. LBB process should be initiated within 2 years from ending date of leave usage.

If an OWCP claim is approved, an employee using sick or annual leave may elect to receive compensation. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or 3/4 of base pay with 1 or more dependents. The Agency pays leave at 100 percent of salary.

For leave to be reinstated, the employee must refund to the Agency the difference between the leave paid by the Agency and the amount of compensation that would have been paid by OWCP.

When an employee elects to receive compensation through the Department of Labor (DOL) instead of using sick leave or annual leave, the employee's pay status must be changed to LWOP. An employee may elect to use leave and repay the Agency for the leave. If an employee is on LWOP, then nothing is repaid to the Agency.

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Continued on the next page

**2 LBB Policies (Continued)**

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**B**

**LBB and Taxes**

When an LBB payment is made during the same year that the leave is used, the employee's earnings are reduced by the amount repaid, and tax is not paid for the compensation received. When leave repurchase is not completed during the same year in which leave is used, the employee may not adjust the prior year's tax form. The employee may only claim the amount of leave paid as an employee expense, if the employee itemizes deductions. Address questions about LBB tax implications to IRS.

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**C**

**LBB and COP**

An employee may not repurchase leave used during a period when the employee was eligible for COP.

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**D**

**LBB and  
Disability Less  
Than 14  
Calendar Days**

When disability does not exceed 14 calendar days beyond the COP period, 3 calendar days of LWOP must be charged before compensation can be paid. If leave was used for this period, compensation cannot be paid for the 3 calendar days, but the employee will have to repay the amount paid during the 3 calendar days to be able to repurchase the leave.

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**E**

**When Disability  
Exceeds 14  
Calendar Days  
Beyond COP**

If disability exceeds 14 calendar days beyond the COP period, the 3 calendar days of LWOP are reinstated and counted towards the LBB period.

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**3 LBB Procedures**

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**A**

**Required Forms**

Complete the following forms for LBB:

- CA-7
  - CA-7a
  - CA7b, Parts I through III
  - CA-20.
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Continued on the next page

**Notice PM-2233**

**3 LBB Procedures (Continued)**

**B**

**Processing LBB** Follow the instructions in this table to process LBB.

Step	Action
1	Administrative Officer (AO) provides employee with CA-7, CA-7a, and CA-20. If there is an existing CA-20 on file covering the same periods of disability that the employee wants to repurchase on CA-7 and CA-7a, then a copy of the existing CA-20 is sufficient. Otherwise, the employee is required to complete a new CA-20.
2	<p>Employee and supervisor shall complete CA-7 (Exhibit 1). The employee shall complete CA-7a (Exhibit 2) and return to AO to verify.</p> <p>AO shall:</p> <ul style="list-style-type: none"> <li>• review CA-7 and CA-7a for accuracy</li> <li>• verify number of hours claimed and dates of disability agree with medical documentation on file.</li> </ul> <p>CA-20, CA-7, CA-7a, payroll T&amp;A's, Work Schedule Log, leave slips, and physician's certificate of absenteeism dates must all agree. Employee and AO must also agree on leave repurchase amounts.</p>
3	<p>AO shall complete CA-7b, Part I. Use the formula at the bottom of the page to complete Section B.</p> <p>On CA-7b, Part II, insert the State Office address in "Employing Agency Address for Check" section. OWCP will send their check to this address, AO shall complete before transmitting to National Finance Center (NFC) for their estimate.</p> <p>Transmit completed CA-7a and CA-7b to NFC by FAX to Unit 2 at 504-255-4682.</p> <p>See Exhibit 3 for an example of CA-7b.</p> <p>CA-7b, Part II, lines H, I, and J, are completed by NFC. After NFC completes this part, CA-7b will be FAXed back to the agency (AO) within 5 workdays.</p> <p><b>Note:</b> To expedite the process, include the State Office FAX number on the transmission to NFC so that NFC can transmit the completed CA-7b back by FAX.</p>

Continued on the next page

3 LBB Procedures (Continued)

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**B**  
**Processing LBB**  
**Forms**  
**(Continued)**

Step	Action
4	After the estimate is received from NFC, send the package to the employee to complete Part III.
5	If the employee elects not to repurchase the leave, file all documents in the employee's Official Personnel Folder. Do not send any documents to DOL.
6	If the employee elects to repurchase the leave, prepare the package to be sent to DOL, OWCP.
7	<p>The completed package for DOL should include the following:</p> <ul style="list-style-type: none"> <li>• CA-7</li> <li>• CA-7a</li> <li>• CA7b</li> <li>• CA-20</li> <li>• a cover letter informing the claims examiner that the employee has decided to repurchase the leave.</li> </ul>
8	If medical evidence supports all hours claimed, then OWCP keys payment in full and issues approval of LBB letter (CA-1208). DOL will send the check to the Agency address on CA-7b, Part II.

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Continued on the next page

3 LBB Procedures (Continued)

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**B**  
**Processing LBB**  
**Forms**  
**(Continued)**

Step	Action
9	When the State Office receives the check from DOL, contact the employee and request the employee's portion of the payment. Both checks must be sent to NFC with AD-343.
10	<p>The final package sent to NFC must include the following:</p> <ul style="list-style-type: none"> <li>• completed AD-343</li> <li>• LBB approval letter from OWCP (CA-1028)</li> <li>• a copy of CA-7a</li> <li>• a copy of CA-7b</li> <li>• the employee's check</li> <li>• DOL's check.</li> </ul> <p>FEDEX the package to the following address:</p> <p>U.S. Department of Agriculture, Collection Section (ABCO)            13800 Old Gentilly Road            New Orleans, LA 70129            Attention: Ms. Darlene McGill            telephone: 504-255-4235.</p>
11	Once NFC approves LBB, they will send a "Restoration of Leave Buy Back" letter. State Office or AO shall follow the instructions in the letter.

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**Notice PM-2233**

**4 Wage Loss Procedures**

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**A**

**Required Forms**      Following are the forms needed to process wage loss:

- CA-7
  - CA-7b
  - CA-20.
- 

**B**

**Processing Forms for Wage Loss**      Follow the procedure in this table to process forms for wage loss.

Step	Action
1	AO provides employee with CA-7, CA-7a, and CA-20. If an existing CA-20 is on file and covers the same periods of disability that the employee is requesting as “Wage Loss” on CA-7 and CA-7a, then a copy of the existing CA-20 is sufficient. Otherwise, the employee is required to complete a new CA-20. The medical evidence on CA-20 must support the periods of wage loss claimed on CA-7 and CA-7a.
2	The employee shall complete, sign, and date CA-7a, then return to AO to verify.
3	AO shall: <ul style="list-style-type: none"><li>• review CA-7 and CA-7a for accuracy</li><li>• verify if hours claimed and dates agree with medical evidence on CA-20 and with payroll T&amp;A’s.</li></ul>
4	AO shall send the completed package, including all of the following, to DOL: <ul style="list-style-type: none"><li>• CA-7</li><li>• CA-7a</li><li>• CA-20</li><li>• cover letter from AO to OWCP requesting compensation for wage loss.</li></ul>
5	OWCP will return incomplete claims and claims with insufficient medical evidence to support all hours with disapproval letter, CA-1207.
6	If medical evidence supports all of the hours, OWCP keys payment in full and issues the approval letter for wage loss (CA-1208). DOL will send the check to the employee’s home address.

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Continued on the next page

CA-7, Claim for Compensation

Following is an example of a completed CA-7, page 1.

**LBB**

Claim for Compensation **U.S. Department of Labor**  
Employment Standards Administration  
Office of Workers' Compensation Programs

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**SECTION 1 EMPLOYEE PORTION**

a. Name of Employee Last: Doe, First: Jane, Middle: 0			OMB No.: 1215-0103 Expires: 10/31/99
b. Mailing Address (Including City, State, ZIP Code) 2400 Wolf St. Pennsylvania			c. OWCP File Number
E-Mail Address (Optional)		d. Date of Injury Month: 2, Day: 29, Year: 00	e. Social Security Number x x x x x x x x x x

**SECTION 2** Compensation is claimed for:

a. <input type="checkbox"/> Leave without pay	Inclusive Date Range		Intermittent?	Go to Section 3
	From	To		
b. <input checked="" type="checkbox"/> Leave buy back	4/20/00	4/28/00	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Go to Section 3, and Complete Form CA-7b
c. <input type="checkbox"/> Other wage loss; specify type, such as downgrade, loss of night differential, etc.	Type: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	Go to Section 3
d. <input type="checkbox"/> Schedule Award (Go to Section 4)		If intermittent, complete Form CA-7a, Time Analysis Sheet		

**SECTION 3** Have you worked outside your federal job during the period(s) claimed in Section 2? (Include salaried, self-employed, commissioned, volunteer, etc.)  Yes  No

Yes Name and Address of Business: \_\_\_\_\_  
N/A

No Name \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
Go to Section 4 Dates Worked: \_\_\_\_\_ Type of Work: \_\_\_\_\_

**SECTION 4** Is this the first CA-7 claim for compensation you have filed for this injury?

Yes Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"

No Has there been any change in your dependents, or has your direct deposit information changed, or has there been a claim filed with U.S. Civil Service Retirement, another federal retirement or disability law, or with the Department of Veterans Affairs since your last CA-7 claim?  
 Yes — Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)  No — Complete Section 7

**SECTION 5** List your dependents (including spouse):

Name	Social Security #	Date of Birth	Relationship	Living with you?	
				Yes	No
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>

a. Are you making support payments for a dependent shown above?  Yes  No If Yes, support payments are made to:

Name	Address	City	State	ZIP Code
_____	_____	_____	_____	_____

b. Were support payments ordered by a court?  Yes  No If Yes, attach copy of court order.

**SECTION 6** a. Was/Will there be a claim made against a 3rd party?  Yes  No

b. Have you ever applied for or received disability benefits from the Department of Veterans Affairs?

<input type="checkbox"/> Yes	Claim Number	Full Address of VA Office Where Claim Filed	Nature of Disability and Monthly Payment
<input type="checkbox"/> No	_____	_____	_____

c. Have you applied for or received payment under any Federal Retirement or Disability law?  Yes  No

<input type="checkbox"/> Yes	Claim Number	Date Annuity Began	Amount of Monthly Payment	Retirement System (CSRS, FERS, SSA, Other)
<input type="checkbox"/> No	_____	_____	_____	_____

**SECTION 7** I hereby make claim for compensation because of the injury sustained by me while in the performance of my duty for the United States. I certify that the information provided above is true and accurate to the best of my knowledge and belief.

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. In addition, a felony conviction will result in termination of all current and future FECA benefits.

Employee's Signature Jane O Doe Date (Mo., day, year) 8/17/00

CA-7

CA-7, Claim of Compensation (Continued)

Following is an example of a completed CA-7, page 2.

Employing Agency Portion																												
For first CA-7 claim sent, complete sections 8 through 15.																												
For subsequent claims, complete sections 12 through 15 only.																												
<b>SECTION 8</b> Show Pay Rate as of		Additional Pay Type	Additional Pay Type	Additional Pay Type																								
Date of Injury: <u>2 / 29 / 00</u>	Base Pay <u>\$ 29,439 per year</u>	Type <u>N/A</u>	Type <u>N/A</u>	Type <u>N/A</u>																								
Grade: <u>6</u>	Step: <u>5</u>	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____																								
Date Employee Stopped Work:		Type _____	Type _____	Type _____																								
Date: <u>3 / 03 / 00</u>	\$ <u>29,439</u> per year.	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____																								
Grade: <u>6</u>	Step: <u>5</u>																											
Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence (SUB), Quarters (QTR), etc. (List each separately)																												
<b>SECTION 9</b>																												
a. Does employee work a fixed 40-hour per week schedule? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																												
1. If Yes, circle scheduled days:                    S    M    T    W    TH    F    S																												
2. If No, show scheduled hours for the two week pay period in which work stopped. Circle the day that work stopped.																												
<b>FOR EXAMPLE ONLY</b>																												
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>S</th> <th>M</th> <th>T</th> <th>W</th> <th>TH</th> <th>F</th> <th>S</th> </tr> </thead> <tbody> <tr> <td>WEEK 1 From <u>5/14</u> to <u>5/20</u></td> <td></td> <td>8</td> <td>4</td> <td>6</td> <td style="text-align: center;">(6)</td> <td></td> <td></td> </tr> <tr> <td>WEEK 2 From <u>5/21</u> to <u>5/27</u></td> <td></td> <td>8</td> <td></td> <td>6</td> <td>6</td> <td></td> <td>4</td> </tr> </tbody> </table>						S	M	T	W	TH	F	S	WEEK 1 From <u>5/14</u> to <u>5/20</u>		8	4	6	(6)			WEEK 2 From <u>5/21</u> to <u>5/27</u>		8		6	6		4
	S	M	T	W	TH	F	S																					
WEEK 1 From <u>5/14</u> to <u>5/20</u>		8	4	6	(6)																							
WEEK 2 From <u>5/21</u> to <u>5/27</u>		8		6	6		4																					
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	S	M	T	W	TH	F	S																					
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WEEK 2 From <u>3/05</u> to <u>3/11</u>		9	9	9	9	cws																						
b. Did employee work in position for 11 months prior to injury? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																												
If No, would position have afforded employment for 11 months but for the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No																												
<b>SECTION 10</b> On date pay stopped, was employee enrolled in:																												
a. Health Benefits under the FEHBP? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Code <u>V N Z</u>																												
c. Optional Life Insurance? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Class _____ (D-Z only)																												
b. Basic Life Insurance? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes																												
d. A Retirement System? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Plan <u>FERS</u> (Specify CSRS, FERS, Other)																												
<b>SECTION 11</b> Continuation of Pay (COP) Received (Show inclusive dates):																												
From <u>3 / 03 / 00</u> To <u>4 / 16 / 00</u>																												
Intermittent? <input type="checkbox"/> Yes — Complete Time Analysis Sheet, Form CA-7a																												
<input checked="" type="checkbox"/> No																												
<b>SECTION 12</b> Show pay status and inclusive dates for period(s) claimed:																												
Sick Leave From <u>4 / 20 / 00</u> To <u>4 / 20 / 00</u>																												
Annual Leave From <u>4 / 20 / 00</u> To <u>4 / 28 / 00</u>																												
Leave without Pay From <u>/ /</u> To <u>/ /</u>																												
Work From <u>/ /</u> To <u>/ /</u>																												
Intermittent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If intermittent, complete Form CA-7a, Time Analysis Sheet.																												
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If leave buy back, also submit completed Form CA-7b.																												
<b>SECTION 13</b> Did employee return to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																												
If Yes, date <u>5 / 01 / 00</u>																												
If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?																												
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If No, explain: <u>Job essentially same however, put on temporary light duty.</u>																												
<b>SECTION 14</b> Remarks:																												
<b>SECTION 15</b> An employing agency official who knowingly certifies to any false statement, misrepresentation, or concealment of fact, with respect to 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 this form is true to the best of my knowledge, with any exceptions noted in Section 14, Remarks, above.																												
Signature _____ Title _____ Date <u>/ /</u>																												
(Agency Official)																												
Name of Agency _____																												
If OWCP needs specific pay information, the person who should be contacted is:																												
Name _____ Title _____																												
Telephone No. ( ) - - Fax No. ( ) - - E-Mail Address _____																												



CA-7b, Leave Buy Back (LBB) Worksheet/Certification and Election

Following is an example of a completed CA-7b, page 1.

Leave Buy Back (LBB) Worksheet/ Certification and Election	U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs
<b>Employee Statement</b> — Please carefully read instructions on pages 3 and 4 before filling out this form.	
A. Name of Employee: (Last, First, Middle) Doe, Jane O.	B. OWCP File Number:
C. Social Security Number: xxx xx xxxx	
D. Period for Which Compensation is Claimed to Repurchase Leave From: <u>4</u> / <u>20</u> / <u>00</u> To: <u>4</u> / <u>28</u> / <u>00</u>	
<b>I. Agency Estimate of FECA Entitlement:</b>	
<b>A. Weekly Base Payrate (excluding overtime)</b>	
• Date of Injury <u>2</u> / <u>29</u> / <u>00</u> \$ <u>566.13</u>	
• Date Stopped Work <u>3</u> / <u>03</u> / <u>00</u> \$ <u>566.13</u>	
• Date of Recurrence      _____ / _____ / _____      \$ _____	
Enter the greatest amount and the effective date of that amount on line 1.	1. <u>566.13</u> <u>01</u> / <u>02</u> / <u>00</u> (effective date)
<b>B. Additions to Base Pay:</b> If employee works a regular schedule, state the amount earned weekly. If irregular schedule, state amount earned 1 year prior to date entered on line 1 + by 52.	
• Night Differential	2. <u>N/A</u>
• Sunday Premium	3. <u>N/A</u>
• Subsistence/Quarters	4. <u>N/A</u>
• Other (Specify)	5. <u>N/A</u>
<b>C. Total Weekly Payrate (Add lines 1 through 5)</b>	6. <u>566.13</u>
<b>D. Compensation Rate (Circle either 2/3 or 3/4)</b>	7. <u>2/3</u> <u>3/4</u>
<b>E. Total Hours Claimed on CA-7a</b>	8. <u>53</u>
<b>F. Total Hours Worked per Week</b>	9. <u>40</u>
<b>G. Formula (for FECA Entitlement)</b>	
$                     \$ \frac{566.13}{\text{(Weekly Payrate See Line 6)}} \times \frac{3/4}{\text{(Compensation Rate See Line 7)}} \times \frac{53}{\text{(Hours See Line 8)}} - \frac{40}{\text{(Hours Wkd/Wk See Line 9)}} = 10. \$ 562.59                 $	
Page 1	Form CA 7b June 1996

CA-7b, Leave Buy Back (LBB) Worksheet/Certification and Election (Continued)

Following is an example of a completed CA-7b, page 2.

**II. Agency Certification:**

H. Total Amount Due Agency to Repurchase Leave 11. \$ 595.90

I. Estimate of FECA Entitlement (See Line 10) 12. \$ 562.59

J. Balance Due Agency from Employee (Line H minus Line I) 13. \$ 33.31

I hereby certify that the above is consistent with agency payroll records.

The employing agency agrees to allow the employee to repurchase his/her leave. Leave records will be, or have been, changed from "Leave with Pay" to "Leave without Pay" for the period shown on the leave analysis.

I further certify that if this claim is signed by the employee, the employee has made arrangements to pay the agency the balance between the total amount the agency requires to recredit leave and the amount of the FECA entitlement.

( AO Signature ) \_\_\_\_\_  
 (Signature of Agency Official) (Title/Position)

Phone No: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Employing Agency Address for Check: \_\_\_\_\_ ( Respective State Offices Address )  
 \_\_\_\_\_  
 \_\_\_\_\_

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**III. Employee Claim:**

\_\_\_\_\_ K. I hereby elect *not* to repurchase the leave used at this time.

xxx L. I hereby elect FECA compensation to repurchase leave used for medical care or disability resulting from my job-related injury or condition.

I understand that I am responsible for paying my agency the difference between the FECA entitlement and the amount my agency requires to restore my leave, and have done or made arrangements for this.

I understand that if my actual entitlement to FECA compensation is within 10% of the amount estimated above, OWCP will process the leave buy back. If the payrate used in the worksheet above is within 10% of the payrate determined by FECA, and less than the full period claimed is approved, OWCP will process payment for the approved period.

\_\_\_\_\_ (Signature of Claimant) \_\_\_\_\_ (Date Signed)

Page 2