

For: FSA Offices and RMA Offices in Kansas City

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

Approved by: Deputy Administrator, Management



1 Overview

A Background

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

B Purpose

This notice:

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

C Labor Management 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.

Disposal Date	Distribution
May 1, 2007	All FSA Offices and RMA Kansas City Offices; State Offices relay to County Offices

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1 Overview (Continued)

D Contact

IF located in...	THEN contact...
<ul style="list-style-type: none">• a State Office• RMA Regional Services and Compliance Offices (except Kansas City)	Maria T. Ruiz by either of the following: <ul style="list-style-type: none">• telephone at 202-418-9034• e-mail to Maria_Ruiz@wdc.fsa.usda.gov.
a County Office	the State Office.
<ul style="list-style-type: none">• FSA Kansas City Complex• RMA Kansas City Offices• St. Louis Office	<ul style="list-style-type: none">• Dana Candler, KCHRO, ELRS at 816-926-6117• Toni Sieben, KC-HRO, ELRS at 816-823-3308.

2 LBB Policies

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. The LBB process should be initiated within 1 year from the ending date of leave usage.

The employee must provide all leave documentation including copies of the following:

- applicable work schedule log clearly showing pay periods, dates, and hours etc.
- T&A's
- leave slips
- any medical documentation not on file that can support partial disability.

If an OWCP claim is approved, an employee who uses sick or annual leave may elect to receive compensation instead. Compensation is paid at 2/3 of the employee's base pay if there are no eligible dependents, or at 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 DOL instead of using his/her 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 the employee does not repay the Agency.

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2 LBB Policies (Continued)

B LBB and Taxes

When a 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 their prior year tax form. They may only claim the amount of leave paid as an employee expense, if they itemize deductions. Address questions about tax to IRS.

C LBB and COP

An employee may not repurchase leave used during a period they were eligible for COP.

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 amount paid during the 3 calendar days to be able to repurchase the leave.

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.

3 LBB Procedures

A Required Forms

Complete the following forms for LBB:

- CA-7
- CA-7a
- CA-7b, Parts I through III
- CA-20.

LBB forms are available from the DOL web site at:
<http://www.dol.gov/esa/regs/compliance/owcp/forms.htm>.

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2 LBB Policies (Continued)

B Processing LBB

Process LBB according to the following.

Step	Action
1	<p>The 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, a new CA-20 is required.</p>
2	<p>The 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"> • review CA-7 and CA-7a for accuracy • verify number of hours claimed and dates of disability agree with medical documentation on file. <p>CA-20, CA-7, and CA-7a, payroll T&A's, applicable 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 NFC for their estimate.</p> <p>Transmit completed CA-7a and CA-7b to NFC by FAX to UNIT 2 at 504-426-9757. 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 AO within 5 workdays.</p> <p>Note: 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>

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2 LBB Policies (Continued)

B Processing LBB (Continued)

Step	Action
4	After the estimate is received from NFC, send the package to the employee to complete CA-7b, Part III.
5	If the employee elects not to repurchase the leave, file all documents in the employee's medical folder (SF-66). 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	The completed package for DOL should include CA-7, CA-7a, CA-7b, CA-20 and a cover letter informing the claims examiner that the employee has decided to repurchase the leave.
8	<p>Send the entire package to T&T Management, Inc. (T&TM) at:</p> <p>T&T Management Inc. Attn: OWCP 7833 Walker Drive, Suite 620 Greenbelt, MD 20770 Telephone: 301-446-6080.</p> <p>T&TM will review the information on the forms for accuracy. If there are no corrections to be made T&TM will submit the request to DOL and will continued tracking the claim until DOL provides an answer.</p>
9	If medical evidence supports all hours claimed, then OWCP keys payment in full and issues approval of LBB letter. DOL will send the check to the Agency address on CA-7b, Part II.
10	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.
11	<p>The final package to NFC must include the following:</p> <ul style="list-style-type: none"> • completed AD-343 • LBB approval letter from OWCP • copies of CA-7a • copies of CA-7b, pages 1 and 2 • the employee's check • DOL's check. <p>Fed-Ex the package to:</p> <p>USDA, COLLECTION SECTION (ABCO) 13800 OLD GENTILLY ROAD NEW ORLEANS, LA, 70129 ATTN: MS. BELINDA MYERS (Telephone: 504- 426-4235).</p>
12	Once NFC approves the repurchase of LBB , a Restoration of Leave Buy Back letter will be sent. Follow the instructions provided in the letter.

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4 Wage Loss Procedures

A Required Forms

The forms needed to process a wage loss are:

- CA-7
- CA-7a
- CA-20.

B Processing Forms for Wage Loss

Process forms for wage loss according to the following.

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 completed form is sufficient. Otherwise the employee is required to complete a new CA-20. The medical information 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">• review CA-7 and CA-7a for accuracy• verify if hours claimed and dates agree with medical evidence on CA-20 and with payroll T&A's.
4	AO shall send the completed package, including all of the following, to T&TM: <ul style="list-style-type: none">• CA-7• CA-7a• CA-20• copy of the employee's SF-50 at time of injury• cover letter from AO to OWCP requesting compensation for wage loss.
5	Send the entire package to T&TM. T&TM will review the information on the forms for accuracy. If there are no corrections to be made, then T&TM will submit the request to DOL and will continued tracking the claim until DOL provides an answer.
6	If medical evidence supports all of the hours, OWCP keys payment in full and issues the approval letter for wage loss. DOL will send the check to the employee's home or electronic funds transfer to the employee's bank account.

CA-7, Claim for Compensation

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

Claim for Compensation				U.S. Department of Labor	
				Employment Standards Administration Office of Workers' Compensation Programs	
SECTION 1 EMPLOYEE PORTION					
a. Name of Employee:	Last Doe	First Jane	Middle O	OMB No. 1215-0103	Expires: 08/31/2005
b. Mailing Address (Including City, State, ZIP Code) 2400 Wolf St. Transylvania				c. OWCP File Number	
E-Mail Address (Optional)			d. Date of Injury Month Day Year 02/29/2000	e. Social Security Number 123-45-6789	
SECTION 2 Compensation is claimed for:				f. Telephone No./FAX No.	
	Inclusive Date Range From To		Intermittent?		
a. <input type="checkbox"/> Leave without pay			<input type="checkbox"/> Yes <input type="checkbox"/> No	Go to Section 3	
b. <input checked="" type="checkbox"/> Leave buy back	04/20/2000 04/28/2000		<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, commission, volunteer, etc.)					
<input type="checkbox"/> Yes Name and Address of Business: NA					
<input type="checkbox"/> No Go to on 4					
Name		Address		City	State ZIP Code
Dates Worked:			Type of Work:		
SECTION 4 Is this the first CA-7 claim for compensation you have filed for this injury?					
<input type="checkbox"/> Yes Complete Sections 5 through 7 and a Form SF-1199A, "Direct Deposit Sign-up"					
<input type="checkbox"/> 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?					
<input type="checkbox"/> Yes - Complete Sections 5 through 7 or a new SF-1199A to reflect change(s)				<input checked="" type="checkbox"/> 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"/>
For dependents not living with you, complete items a and b below.					
a. Are you making support payments for a dependent shown above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, support payments are made to:					
Name		Address		City	State ZIP Code
b. Were support payments ordered by a court? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, attach copy of court order.					
SECTION 6 a. Was/Will there be a claim made against a 3rd party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?					
<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: /s/ Jane O. Doe			Date (Mo., day, year) 08/17/2000		
Form CA-7 Rev. Nov. 1999					

CA-7, Claim for Compensation (Continued)

Following is an example of a complete 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.

SECTION 8 Show Pay Rate as of _____ Additional Pay Type N/A Additional Pay Type N/A Additional Pay Type N/A
 Date of Injury: _____ Base Pay _____
 Date: 02/29/2000 \$ 29439.00 per year \$ _____ per _____ \$ _____ per _____
 Grade: 6 Step: 5
 Date Employee Stopped Work: _____ Type _____ Type _____ Type _____
 Date: 03/03/2000 \$ 29439.00 per year \$ _____ per _____ \$ _____ per _____
 Grade: 6 Step: 5

Additional pay types include, but are not limited to: Night Differential (ND), Sunday Premium (SP), Holiday Premium (HP), Subsistence

a. Does employee work a fixed 40-hour per week schedule? _____

SECTION 9
 (SUB), Quarter (QTR), etc. (List each separately) Yes No
 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.

		FOR EXAMPLE ONLY								
		S	M	T	W	TH	F	S		
WEEK 1	From <u>5/14</u> to <u>5/20</u>		8	4	6	6			WEEK 1	From <u>02/27</u> to <u>03/04</u>
WEEK 2	From <u>5/21</u> to <u>5/27</u>		8		6	6		4	WEEK 2	From <u>03/05</u> to <u>03/11</u>

b. Did employee work in position for 11 months prior to injury? Yes No
 If No, would position have afforded employment for 11 months but for the injury? Yes No

SECTION 10 On date pay stopped, was employee enrolled in:
 a. Health Benefits under the FEHBP? No Yes Code VNZ c. Optional Use Insurance? No Yes Class _____
 b. Basic Life Insurance? No Yes d. A Retirement System? No Yes Plan FERS (Specify CSRS, FERS, Other)

SECTION 11 Continuation of Pay (COP) Received (Show inclusive dates):
 From 03/03/2000 To 04/16/2000 Intermittent? Yes — Complete Time Analysis Sheet, Form CA-7a
 No

SECTION 12 Show pay status and inclusive dates for period(s) claimed:
 Sick Leave From 04/20/2000 To 04/20/2000 Intermittent? Yes No If intermittent, complete Form CA-7a, Time Analysis Sheet.
 Annual Leave From 04/20/2000 To 04/28/2000 Yes No
 Leave without Pay From _____ To _____ Yes No If leave buy back, also submit completed Form CA-7b.
 Work From _____ To _____ Yes No

SECTION 13 Did employee return to work? Yes No
 If Yes, date 05/01/2000
 If returned, did employee return to the pre-date-of-injury job, with the same number of hours and the same duties?
 Yes No If No, explain: Job essentially same however, put on temporary light duty.

SECTION 14 Remarks: _____

SECTION 15 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 ____/____/____
 Name of Agency _____ (Agency Official)

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.

<p>Leave Buy Back (LBB) Worksheet/ Certification and Election</p>	<p>U.S. Department of Labor Employment Standards Administration Office of Workers' Compensation Programs</p>
<p>Employee Statement - Please carefully read instructions on pages 3 and 4 <i>before</i> filling out this form.</p>	
<p>A. Name of Employee: <i>(Last, First, Middle)</i> Doe, Jane O.</p>	<p>B. OWCP File Number:</p>
<p>C. Social Security Number: XXX-XX-XXXX</p>	
<p>D. Period for Which Compensation is Claimed to Repurchase Leave</p> <p>From: <u>4</u> / <u>20</u> / <u>00</u> To: <u>4</u> / <u>28</u> / <u>00</u></p>	
<p>I. Agency Estimate of FECA Entitlement:</p>	
<p>A. Weekly Base Payrate <i>(excluding overtime)</i></p> <ul style="list-style-type: none"> • 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 _____ / _____ / _____ \$ _____ <p>Enter the greatest amount and the effective date of that amount on line 1. 1. <u>566.13</u></p> <p style="text-align: right; margin-right: 100px;"><u>01</u> / <u>02</u> / <u>00</u> <i>(effective date)</i></p>	
<p>B. Additions to Base Pay: 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.</p> <ul style="list-style-type: none"> • Night Differential 2. <u>N/A</u> • Sunday Premium 3. <u>N/A</u> • Subsistence/Quarters 4. <u>N/A</u> • Other <i>(Specify)</i> 5. <u>N/A</u> 	
<p>C. Total Weekly Payrate <i>(Add lines 1 through 5)</i> 6. <u>566.13</u></p>	
<p>D. Compensation Rate <i>(Circle either 2/3 or 3/4)</i> 7. <u>2/3</u> <u>3/4</u></p>	
<p>E. Total Hours Claimed on CA-7a 8. <u>53</u></p>	
<p>F. Total Hours Worked per Week 9. <u>40</u></p>	
<p>G. Formula <i>(for FECA Entitlement)</i></p> <p style="text-align: center;"> $\\$ \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$ </p>	
<p>Page 1</p>	<p>Form CA 7b June 1996</p>

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.

_____/s/ AO _____ (Signature of Agency Official) _____ (Title/Position)

Phone No: _____ Date Signed: _____

Employing Agency Address for Check: _____ (Respective State Offices Address)

M. Employee Claim:

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

 X 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)

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