Chapter 9

FEDERAL WORKERS' COMPENSATION PROGRAMS

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INTRODUCTION

Much of the content of this chapter was originally published as two articles in a supplement to the *Journal of Occupational and Environmental Medicine* in August 2015 that was devoted exclusively to federal workers' compensation programs.[1,2] Since that work was published, improvements have been made in federal workers' compensation program management. Medical case reviews have been coordinated to ensure that difficult questions regarding work ability and utilization review get addressed for the service leadership. This chapter also expands the earlier work by incorporating the systems analysis approach to evaluating the success of the workers' compensation program.

Federal workers' compensation insurance benefits provide wage replacement as well as medical cost coverage and rehabilitative care. Employees may request disability payments for permanent impairment. Workers who are unable to work must provide medical documentation that their injury is work related and limits their ability to do the essential job functions.

This chapter will review federal workers' compensation program basics for setting up and running the program at the installation and regional levels. Beyond the basics, this chapter will include a discussion of best practices in Federal Employees Compensation Act (FECA) program management and discuss how program metrics can improve the ability to demonstrate program success or show that additional resources are needed to properly run the program. Available FECA data sources will be identified and useful comparison features and tools will be discussed so that local FECA managers can compare their program metrics with other installations, the service, and overall Department of Defense (DoD) FECA program metrics.

FEDERAL WORKERS' COMPENSATION

The first federal workers' compensation law, passed in 1908, included only a quarter of federal workers, those who were considered to work in "dangerous jobs." Only traumatic injuries were covered, and there was a 15-day waiting period to file a claim.[3] FECA, passed in 1916, expanded coverage to all federal employees. The new law added coverage for occupational illnesses, provided wage replacement of up to 66 2/3% of regular pay, and established a compensation fund supported by taxpayers.[4] In 1949, amendments established "schedule award benefits" or fixed payment amounts for various types of permanent partial impairments. In 1960, the Department of Labor was established as the primary payer, and the employing federal agencies were asked to repay the Department of Labor.[5] In 1974 amendments, workers were given the right to choose their treating physician. In addition, the employing agency was required to pay the employee's salary during the first 45 days of the claim for traumatic injuries.[5] As amended, FECA[6] was enacted and codified in Title 5, Chapter 81, of the US Code.[7]

Workers who have their claim accepted may obtain vocational rehabilitation services to help them return to work, and they may request disability benefits amounting to two-thirds of their wages. This amount increases to 75% if the worker has eligible family members.[5] Congress also set up a table of "schedule award benefits" designed to help the Department of Labor pay injured workers for permanent partial disability.[5] The amount and duration of disability benefits varies by the type of partial disability. Under FECA, the employing agency, through the Department of Labor, pays all medical costs associated with the claim. Survivors of employees who are killed on the job are entitled to compensation payments and receive partial funeral costs.[5]

Computer/Electronic Accommodations Program

The Computer/Electronic Accommodations Program (CAP), developed in 1990, is designed to improve accessibility for people with disabilities and cover the costs of assistive technology. The CAP covers the costs to modify computer and telecommunication equipment to enable people with a disability to perform essential job functions. CAP also covers costs of training to use the equipment.

FECA Implementation and the Office of Workers' Compensation Programs

Federal workers may file a claim for wages, medical costs, and vocational rehabilitation benefits when they are injured or develop an occupational disease. They must complete the proper paperwork and submit the forms to the local or regional agency compensation specialist (CS), who then submits them to the Department of Labor's Office of Workers' Compensation Programs (OWCP).[8] The OWCP has published two handbooks about the process, *Questions and Answers About the Federal Employees' Compensation Act (FECA)*[8] and *Injury Compensation for Federal Employees*,[9] as well as additional guidance for federal agencies and employees on its website.[10]

Workers are required by OWCP regulation to file a claim for compensation using the Compensation Act-1 (CA-1) form, Federal Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation[11] within 30 days of the injury. OWCP regulations require federal agencies to process the form promptly, within 2 weeks of the date of the claim's filing. OWCP regulations also call for the employing agency to pay the employee for up to 45 days for any lost wages and for medical expenses up to $1,500.

Workers who have a disease caused by their work, or "occupational disease," have up to 3 years to file a claim per OWCP regulation from the date of notification that their disease was caused by their work. They must file a CA-2 form, Notice of Occupational Disease and Claim for Compensation.[11] They must submit an explanation of how the disease was caused by their work either on the form or in an accompanying statement. The CS forwards the CA-1 and CA-2 to the supervisor, who must review it and complete the section that asks for specific facts in the case. The supervisor will recommend moving forward or controverting the case if the reported events and facts are not supported by witness statements. Per the OWCP's claims manual, the claims examiner must process a traumatic injury claim in 45 days and an occupational disease claim in 90 days.[8]

An OWCP regional office is located in each of the 12 federal regions of the country. Each office has a director, claims examiners, and nurse case managers.[10] The claims examiner performs case management.[10] There may be one medical director or district medical advisor. The employing agency may request a second opinion medical examination when there is a conflict in opinion between the treating provider and agency physician. The OWCP relies on the treating doctor's opinion unless there is incomplete or inconsistent medical information.[10] The district medical advisor may decide if the medical evidence is sufficient or if authorizations for medical procedures are necessary.[10]

An agency has no appeal rights unless a procedural error can be proven, but a claimant may appeal any denied claim. The OWCP nurse case manager reviews and approves proposed medical treatments and facilitates timely return-to-work.[10] The agency CS must be aggressive in contacting the OWCP staff nurse when a case has problems because the OWCP nurses normally do not get involved until after a claim has been accepted.

DEPARTMENT OF DEFENSE FECA PROGRAM

Unlike other federal agencies, the DoD employs a liaison to work with the claims examiner in each of the OWCP regions.[12] The Defense Civilian Personnel Advisory Service (DCPAS) oversees the liaisons and ensures FECA support to DoD agencies in each region.[12] The services manage their own cases and administer the program on a day-to-day basis.

Most installation commanders require employees to notify their supervisor of an injury within 48 hours of occurrence. Ideally, the supervisor should send the worker to the occupational health clinic to report the injury and tell clinic staff where they will receive treatment. This is the prime opportunity for the occupational health clinic to offer the employee treatment.

The CS uses the Electronic Data Interchange system to review the case information and ensure necessary medical and other information has been obtained per 20 CFR Part 10.330. The installation FECA working group can assist the CS in addressing difficult cases. The occupational medicine physician can assist the CS in the return-to-work process by reviewing work limitations and informing the CS whether the injured worker can safely perform the job functions given the limitations. The CS communicates regularly with injured workers to help them stay connected, monitor their medical recovery, and ensure they are on track for returning to work in a timely fashion.

The CS should investigate any red flags. For example, if the injury occurs shortly after the worker is hired, if the employee was recently disciplined or had preexisting injuries, or if the incident was unwitnessed, then closer scrutiny may be necessary. Injured workers will receive continuation of pay on the agency payroll from day 1 to day 45. From day 46 to the end of the first year, workers are placed on the periodic roll if they are unable to return to work and there is a reasonable chance they eventually will return to work. During this time, workers receive pay and medical care while undergoing periodic examinations. After 1 year, OWCP will order a medical examination. There is less of a chance the injured worker will return to duty if the case is over a year old, and OWCP stops active review and places the employee on the long-term roll. After that the claimant is required to get a physical examination only once every 3 years.[9]

If the treating provider determines the employee may return to duty with limitations, the agency must identify jobs that can accommodate the employee's work restrictions. The employee will be directed to report for work by the claims examiner. The injured employee may appeal the decision to the Employees' Compensation Appeals Board, whose decisions are final and not reviewable.[13]

Authorization for Medical Treatment

When an injured federal employee sees the CS to file the CA-1, he or she also obtains the CA-16, Authorization for Medical Treatment.[11] The CA-16 is issued one time only. The CS or the agency physician completes items 1 through 13 on the CA-16 form. This form is then submitted to the treating provider to pay for treatment of acute traumatic injuries and covers the first 60 days of care. The treating physician can refer the patient to specialists without seeking preauthorization. In an emergency, the CA-16 must be completed within 48 hours after first examination or treatment. The treating physician must provide a written medical report documenting the work relatedness of the injury, the diagnosis and extent of injury, the treatment plan, and any work limitations. The treating provider is also asked to complete the OWCP Form CA-17, Duty Status Report.[11] On the CA-17, the supervisor lists the job requirements on the top of the form, and the provider completes the bottom portion by identifying the employee's work capabilities and job restrictions.

Role of the FECA Working Group

The installation level FECA working group is an ad hoc committee that meets periodically or as needed to discuss problem cases. The FECA working group should include representatives from the safety office, industrial hygiene, occupational health, human resources, and the supervisor and/or commander of the injured employee. The FECA working group must review cases to ensure the facts of the case are accurate, the worker's medical limitations are accommodated (or another worksite is found), and the requested care is medically necessary.[12] The FECA working group should also meet periodically to review FECA program performance. Metrics that must be reviewed include continuation of pay days per case, lost-time case rate, medical costs per claim and per 100 employees, wage replacement costs per case and per 100 employees, and disability retirement awards paid.

The FECA working group should do a root cause or near miss analysis on all incidents to determine the cause and assess whether interventions are necessary to prevent additional injuries. The group can identify jobs with higher risk of injury by reviewing the injury data and finding the most frequent and most costly injuries to target worksites for intervention. If necessary, changes in work processes can be made and safety equipment can be purchased to lower the risk of injury. The safety officer usually leads these investigations.[14]

The FECA working group must have command support. A representative from the FECA committee should attend command-wide safety meetings and brief injury rates and costs to the operational leaders, who often have the greatest control over safety practices followed by employees at the worksite. Senior leaders need to understand how these injury rates and costs impact mission funding and availability of skilled and trained personnel.

Occupational Health Clinician's Role

The agency occupational health physician must assist the CS by obtaining medical information from the treating provider that the CS needs to send to the OWCP in support of the FECA claim. The agency physician should review the case file, determine the diagnosis, look at medical restrictions, and assist in the work ability determination of the injured employee. This may involve reviewing the medical documentation provided by the treating provider to ensure the medical information provided is sufficient to make the diagnosis, and contacting the treating provider to obtain additional information. The agency physician should be able to quickly address questions that arise about the medical necessity of a requested procedure or treatment. Additionally, the agency physician must advise the treating provider of the medical treatment and pharmacy options available at the base medical facility.

The agency physician must also assist the CS in reviewing job descriptions of positions in which an injured employee may be placed for return to work. The agency physician, with the occupational health nurse, must participate on the FECA committee to discuss difficult cases, review program strengths, and identify areas for improvement. The occupational medicine physician should encourage adoption of a "clinic-first" policy to facilitate timely filing of claims, permit work ability determinations, and facilitate development of the return-to-work plan. The injured employee may also be offered the opportunity to be treated in the occupational health clinic.

Once the injured employee has been cleared by their treating provider to return to work, the agency occupational medicine physician can perform a return-to-work examination and ensure that work restrictions, if any, can be accommodated at the job site by talking with the supervisor and the CS. Further, the examination can confirm that the employee can safely perform the position's essential duties, and that the employee does not pose a risk of injury to themselves or others.

If the treating provider has given the employee work limitations and there is no light duty at the worksite, the agency physician can assist the CS in helping to determine an employee's ability to perform in another position where light duty is available. The occupational medicine physician should routinely look at the dis-

ability guidelines developed by the Reed Group and the American College of Occupational Medicine Clinical Practice Guidelines[15,16] to assess whether diagnostic criteria were met, whether medical care utilization is appropriate, and whether or not the employee is healing normally. If permanent work restrictions do not allow the employee to do essential job functions, the occupational medicine physician must inform the CS and supervisor, and alternatives may need to be explored. Vocational rehabilitation and job retraining may offer the employee an opportunity to continue working for the agency in a different position.

Employees' Choice of Physician

OWCP regulations permit the employee to choose where they are treated for their work injury. An installation commander or supervisor may still require the employee to report to the occupational health clinic for a work ability determination before seeing their own physician, provided the injured worker is not delayed in being seen by their physician. Office of Personnel Management regulations permit the agency physician to examine the injured employee, but the employee's choice of where to be treated must be honored.[17]

The occupational medicine physician is encouraged to offer the injured employee treatment in their clinic because this reduces cost for treatment; referral to a specialist can occur more quickly; and other services such as physical therapy, radiology, and laboratory and pharmacy services are readily available. These efficiencies reduce lost work time for the employee and permit more timely filing of claims forms and the collection of supporting medical information. The CS can more easily coordinate with the occupational medicine physician to determine any work restrictions and coordinate the timely return to work.

TRENDS IN MILITARY WORKERS' COMPENSATION COST AND RATES

The DoD experienced a 600% increase in claims and costs between 1995 and 2005. The Department of Labor pays disability costs to the employee and medical costs to the treating physician. The DoD must then reimburse the Department of Labor. The costs paid by the DoD do not include the indirect costs sustained by agencies and services, such as lost productivity, training of replacement workers, and the effects of the work absence on morale when other workers have to pick up the work of the missing worker. Government Accountability Office audits of the FECA program have estimated that direct and indirect costs for total FECA liabilities are approximately $30 billion.

Injury Statistics

The DCPAS collects data from DoD agencies and the military in a database and tracks the data by year of injury. This data includes the causes of traumatic injury. However, the services and DoD agencies need to do a better job of capturing the cause of injury because "other" and "unspecified" are two of the largest categories. Accurate cause of injury information is needed to identify high-risk jobs that may require interventions to reduce injury risk. Occupational disease information is tracked in a separate DCPAS database.[1]

Initiatives to Reduce Costs

A 2004–2008 initiative by President George W. Bush and the secretary of labor, called Safety, Health and Return to Employment (SHARE),[18] was only partially successful in reducing occupational injuries, illnesses, and fatalities within the federal government. The DoD's efforts at reducing worker's compensation costs achieved the same level of success that other federal agencies achieved.

In 2010 President Obama and the OWCP developed the Protecting Our Workers and Ensuring Reemployment (POWER) initiative[19] and sought to provide funding support to federal agencies to get injured civil service employees back to work. DoD sought funding to pay worker's salaries for modified duty positions to be able to return workers to work. Under this program, CS personnel can use funds to pay for positions that the injured worker can fill with job duties tailored to meet the treating provider's work restrictions. The DoD also initiated efforts to improve the FECA database maintained by DCPAS.

Improving Workers' Compensation Case Management

In 2016 there were 275,000 DoD civilian employees who received FECA benefits, which cost the federal government $30 billion in direct and indirect costs.[2] In order to reduce costs, the DoD must learn from successful workers' compensation programs how to better manage cases to reduce costs and disability. The DoD should work with OWCP to make it easier for agency physicians to participate in case management. This will improve support for the CS to better address the medical questions that arise in problematic cases. Further, DoD can arrange for physician support for DoD agencies with no access to occupational medicine physicians by contracting for that support with Federal

Occupational Health, a Health and Human Services organization that provides occupational medicine services to the federal government.

Feuerstein[20,21] demonstrated that integrated case management could improve patient job function and reduce symptoms in upper-extremity injuries. Shepherd and LaFleur[22] used targeted injury prevention efforts to reduce injuries at a Navy shipyard. The Navy also saved $46 million by employing occupational medicine physicians to do case reviews.[23] The Army improved its management of FECA cases[24,25] and successfully used contract case managers to effectively lower costs and get employees back to work.[26]

Leadership and worker commitment to the success of the FECA program make all the difference. Morale improves when employees are allowed to participate in health promotion and wellness programs. Training on FECA improves supervisor and worker compliance with the OWCP regulations and reduces costs. OWCP has case management resources that should be employed sooner to effectively reduce costs and prevent worker disability. A nurse case manager should get involved at the start of the case, rather than waiting until the employee has been off for 2 weeks. The case managers need to start at the beginning of the case to assist the injured worker in obtaining treatment and returning to work, and they should stay involved with the case until it is closed.[27] Occupational illness claims must be thoroughly reviewed like other claims to ensure all elements of the case have been successfully managed.

REVIEWS OF MILITARY PROGRAMS

Workers' Compensation Program Systems Analysis

Dr. Bedno[28] used a systems approach to assess the workers' compensation program at two Army installations in 2014. Because workers' compensation cases are complex and involve quantitative and qualitative data collected from multiple sources and perspectives, she employed a case study design that used a mixed methods approach. She assessed the current state of the system for reporting and following up on injuries and illnesses in Army medical centers, including potential barriers and facilitators to reporting. The quantitative portion of the study consisted of analyzing workers' compensation claim data for total costs and types of injuries. The qualitative portion included a document review of policies, procedures, and regulations. Nineteen semi-structured interviews were conducted with key participants in the workers' compensation process, at the installation, region, and headquarters levels.

The results show a significant trend in decreased workers' compensation costs between 2001 and 2013. The workers' compensation claims for new DoD occupational injuries and illnesses in 2013 were less costly than 12 years earlier, but Bedno noted that more improvements are needed. Workers' compensation staff need ways to show where the costs savings have occurred, and having dedicated resources may permit better tracking of efforts to reduce FECA costs.

The qualitative results show that because so many entities are involved in the reporting and management process, there is a tendency for each group to act independently. Based on the interviews and document analysis, identified gaps include data sharing, communication, and teamwork. Not only is there poor communication and lack of data sharing, but also the best or recommended practices are not shared. In most cases, data were not used to show changes in costs or injuries. The responsibility for reporting injuries and illnesses is not well-defined. Further, supervisors and workers need training to understand program basics. Although training on workers' compensation is specified on an annual basis, no regular training was taking place. Leadership (installation- and organization-level) should ensure maximal interaction between involved stakeholders and make sure that everyone attends training annually.

Systems-level improvements are needed, starting with a senior leader commitment to reduce injuries and to make the workplace safer. Military leadership must prioritize occupational injury and illness prevention efforts among their other important issues. Leaders must also devote the necessary resources (eg, personnel, funding) to support this effort. Training on workers' compensation is needed. Flowcharts illustrating the occupational injury and illness process should be used in training (Figure 9-1). Data should be integrated to support all injury prevention initiatives. The responsibility for injury analysis should be delegated within the installation or by region to an epidemiologist, who can assist with targeting injury prevention initiatives based on their analysis. These findings and best practices should be shared with other DoD, federal, and state partners.

Government Accountability Office Audit

The Government Accountability Office (GAO) reviewed the DoD FECA programs in 2010 and reported on the review in 2012.[29] The GAO analysts noted that DoD agencies and services could do a better job of injury prevention and program management.[29] They reported that FECA cases need better case management

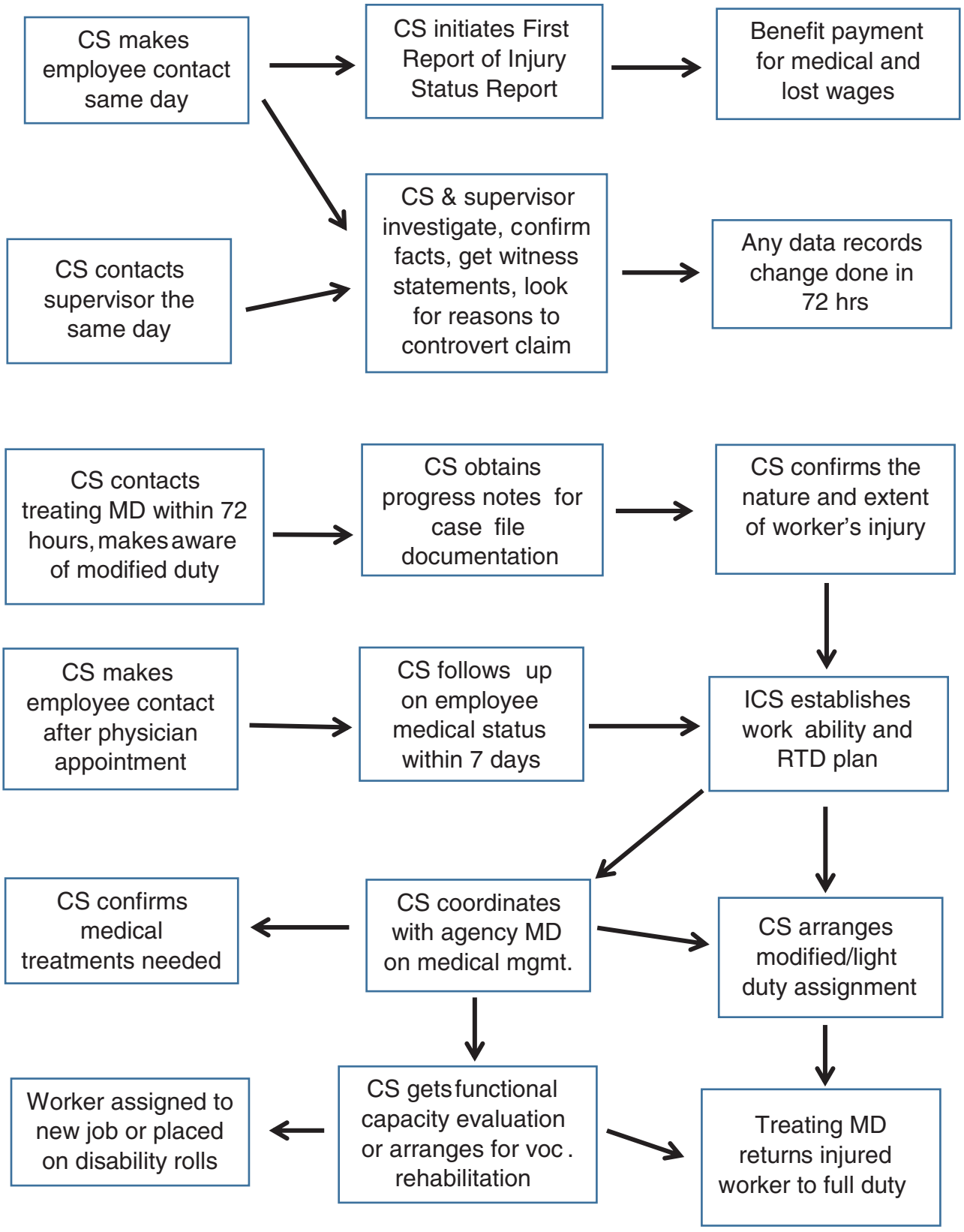

Figure 9-1. Worker's Compensation Claim Management process.
CS: compensation specialist
RTD: return to duty

and that questionable cases should be controverted. Additionally, DoD needs better management controls to ensure Department of Labor charges are valid and required medical documentation is provided by the treating provider to support the claim.[29] GAO also encouraged the continuation of best practices that reduce the risk of fraud. Experienced staff must be employed to manage short- and long-term cases to identify fraud, and private investigators should assist in fraud investigations.

Other GAO recommendations are as follows. The DoD needs to share information between the agencies and services to reduce duplicate payments and improve the job reassignment process.[29] The CS should check with Social Security to ensure workers are not working a second job while receiving disability benefits.[29] Further, agency physicians need to be consulted and actively engaged in the case management process by providing medical expertise when there are unresolved medical questions such as work ability, appropriateness of the treatment plan, and whether the employee can safely return to the job with the work limitations given by the treating provider.

GAO indicated that agency physicians need to ensure treating providers in the medical community get training on the Department of Labor medical documentation requirements of FECA.[29] GAO also stated that the DoD must prosecute fraud cases, but the Department of Justice must assist in this effort by encouraging the US attorney for each region to prosecute cases of obvious fraud, even if the cases do not have a high dollar value in terms of the medical and disability costs.[29] In addition, GAO indicated that the DoD needs to hire more CS staff. This would allow them to reduce their caseload and better manage the cases they are responsible for overseeing. GAO recommended that any cost savings that accumulate from better DoD management practices should be shared with installation commanders to help fund personnel, injury prevention, data collection and analysis, and criminal investigation initiatives.

FECA MANAGEMENT CHALLENGES

The POWER initiative[19] put the spotlight on the problem of increasing injury claims and costs, and the DoD responded well by reducing FECA costs. However, the DoD bill for FECA stood at $682 million in direct costs for 2014. The DoD's integrated approach across functional areas requires the CS to take the lead role in coordinating with program stakeholders to achieve program success. This is difficult to do from a regional or headquarters level when the rest of the stakeholders are on the local installation. This regional approach limits the interaction between the CS and the FECA working group, including the agency physician.

The data in the OWCP's Agency Query System, which provides CS information about claim demographics, case status, and claim costs, should be linked to data maintained by the Defense Manpower Data Center so that more accurate injury rates and costs can be tracked for each installation and unit, and commanders and supervisors can access their injury rate and cost data. This would keep FECA on the installation commander's radar and improve local injury prevention efforts.

DCPAS has published FECA policy and procedures in one DoD instruction.[12] It calls for tracking compensation claims and costs, providing training, and assigning a DoD liaison to each OWCP district office. The DoD Safety and Occupational Health Working Group must encourage more aggressive efforts in the adoption of FECA best practices and facilitate injury prevention initiatives at the headquarters, agency, and service level.

Quarterly FECA working group meetings at the headquarters, subordinate command, and local command level should be adopted as a best practice. The FECA working group must engage to better manage the FECA program at the installation level because there is no CS to lead the effort locally. The FECA working group can work with supervisors to identify light-duty positions for employees who need to return to work. The FECA working group must track injury rates and costs over time and provide feedback to supervisors regarding the impact of injuries on costs and worker productivity. The FECA working group can target high-risk jobs for changes in work practices or protective equipment usage that will lower injury risk. DCPAS must encourage CS staff to more accurately code the nature and the cause of injury data (40% of all claims have no cause or nature of injury recorded).

DEPARTMENT OF LABOR PROGRAM MANAGEMENT EFFORTS

The POWER initiative, which lasted from 2010 to 2014, achieved many of its performance targets. Federal agencies increased collection and analysis of data on the causes and costs of injuries and illnesses.[19] FECA managers in federal agencies realized that workers on the long-term rolls for longer than a year pose a

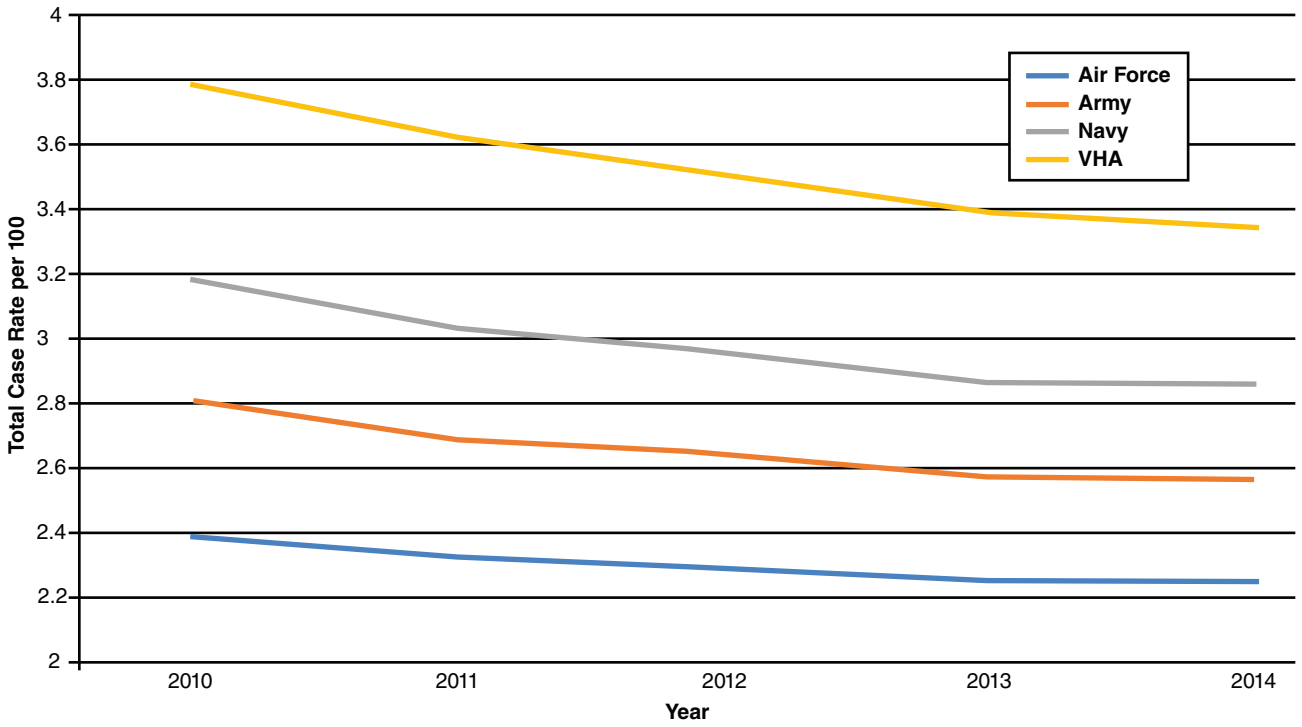

Figure 9-2. Department of Defense results for Protecting Our Workers and Ensuring Reemployment (POWER) goal 1, reducing total case rates, 2009–2014.
VHA: Veterans Health Administration
Data source: US Department of Labor, Office of Workers' Compensation Programs. POWER performance, Department of Defense. https://www.dol.gov/owcp/dfec/power/getxls.htm?id=1340000. Accessed August 8, 2017.

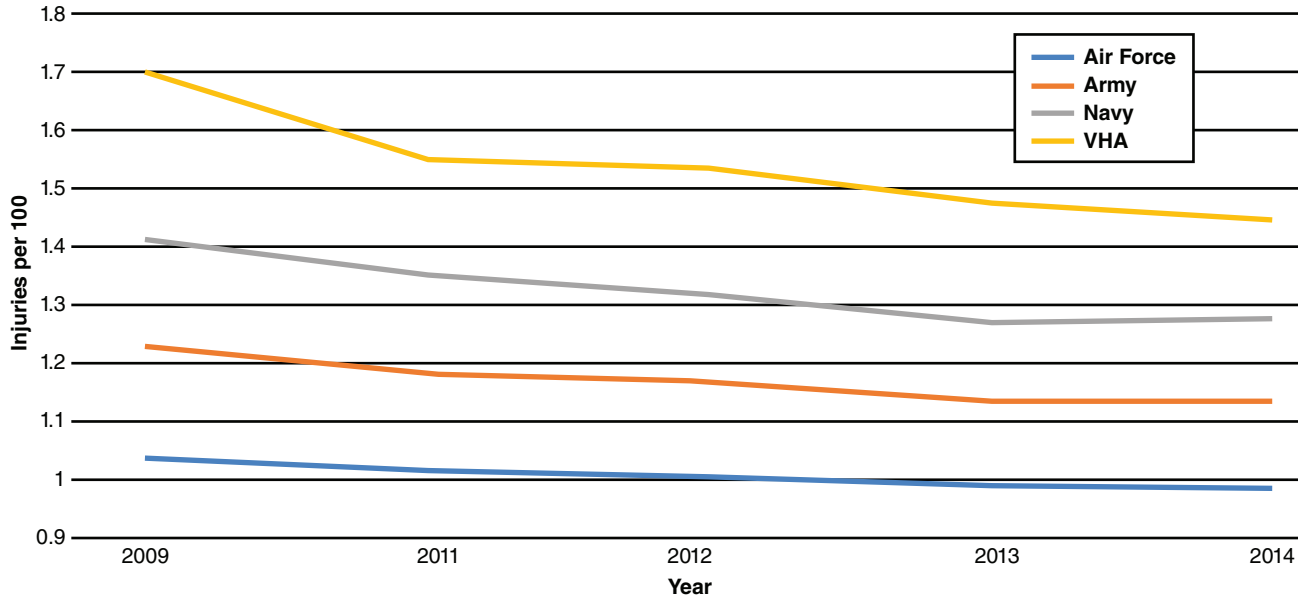

Figure 9-3. Department of Defense results for Protecting Our Workers and Ensuring Reemployment (POWER) goal 2, reducing lost time injury and illness case rates, 2009–2014.
VHA: Veterans Health Administration
Data source: US Department of Labor, Office of Workers' Compensation Programs. POWER performance, Department of Defense. https://www.dol.gov/owcp/dfec/power/getxls.htm?id=1340000. Accessed August 8, 2017.

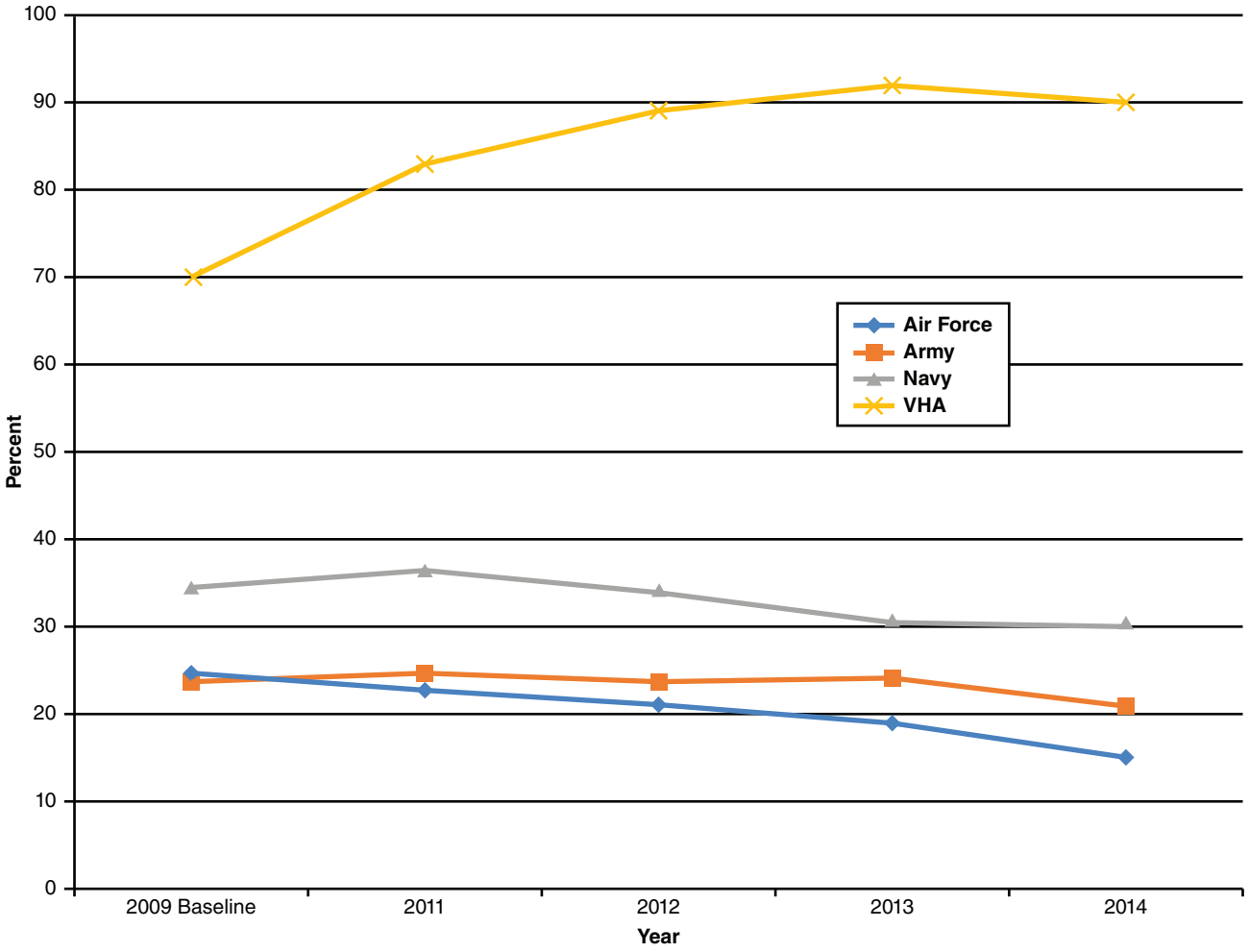

Figure 9-4. Department of Defense results for Protecting Our Workers and Ensuring Reemployment (POWER) goal 6, reducing lost production day rates, 2009–2014.
VHA: Veterans Health Administration
Data source: US Department of Labor, Office of Workers' Compensation Programs. POWER performance, Department of Defense. https://www.dol.gov/owcp/dfec/power/getxls.htm?id=1340000. Accessed August 8, 2017.

problem in terms of getting employees back to work. Therefore, high-risk jobs must be identified and targeted for injury prevention efforts before workers get injured. Front-line supervisors and workers in these high-risk jobs can be given improved training on safety procedures and monitored for adherence to safe practices and proper use of personal protective equipment. Thus, the employees and their agencies become the beneficiaries of safe and healthy workplaces.

The DoD achieved most of the targets for the POWER goals. The FECA metrics for each federal agency were published on the Department of Labor OWCP Division of Employees Compensation website.[30] The Army, Navy, and Air Force all met the POWER goals. The total claim rate and costs for the Army, Navy, and Air Force decreased significantly (Figures 9-2, 9-3, and 9-4).

The Department of Labor began, as part of the POWER initiative, an annual Return-to-Work Council meeting, designed to bring together senior level managers in the federal government who worked at the best and worst performing federal agencies with the aim of helping all agencies meet POWER goals. The council encouraged successful agencies and organizations to share their best practices as a model that the worst 14 could adopt. Ultimately, the Department of Labor wanted to see these agencies lower their medical and disability costs and reduce their injury rates.[31]

SUMMARY

Available data from the Department of Labor shows that the DoD has done an excellent job managing the workers' compensation program over the last 10 years. However, there are still opportunities for improvement in terms of injury prevention and case management activities. Data collected by DCPAS should be disseminated to the services so that case management efforts can be improved and injury prevention efforts can be better targeted to at-risk worker populations. The DoD has been successful over the past decade in significantly reducing both claims and costs by engaging all members of the FECA team to do their share in supporting FECA efforts in a collaborative way that prevents injuries, lowers costs, and improves case management. While the costs have been reduced, DoD still spends over $600 million annually on FECA cases, and more improvements are possible.

The newest systems approach affords managers another way examine the FECA program's execution and look for ways to improve it. This chapter highlighted some best practices that should be continued, such as use of the DoD nurse liaison at each regional office to help CSs coordinate with the claims examiner. Also, the DCPAS should make FECA data available to the FECA working group so that the safety and occupational health team can target injury prevention efforts to lower injuries and reduce long-term disabilities due to work related injuries and illnesses. The occupational medicine physician can assist the FECA working group by serving as medical consultant for questions about work ability, medical necessity for requested procedures and treatments, and coordination with the treating provider to obtain needed medical information, as well as by helping collect and analyze injury data and sharing the results of the analysis with the group and local installation leaders.

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