Dear Traveler:

This letter outlines the required guidelines that need to be followed in order for the Alaska Native Medical Center’s (ANMC) Contract Health Services (CHS) program to consider authorizing payment for emergency medical care while traveling outside the State of Alaska. “Emergency” means any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual. You must be an Alaska resident and are required to provide proof that Alaska residency has been maintained. Indian Health Service (IHS) facilities must be utilized when they are available. Prior to departing Alaska, you can verify if there is an IHS facility close to where you will be traveling by checking the web site at “http://www.ihs.gov/FacilitiesServices/AreaOffices/AreaOffices_index.asp”. If an IHS facility is not available, seek care at the closest medical facility.

ANMC CHS must have eligibility documentation (Certificate of Indian Blood or tribal enrollment card issued by a federally recognized tribe) on file. Emergent medical care for outpatient or inpatient services must be reported to ANMC CHS within 72-hours (including weekends and holidays) after receiving medical treatment. The patient or the patient’s family has the ultimate responsibility of notifying CHS by calling (800) 478-1636. When the ANMC CHS office is closed, you can leave a message on our secure voicemail message system. Leave your full name, date of birth and a contact telephone number. CHS staff will return your call the next business day.

ANMC CHS is not an insurance program. Residents of the Annette Island, Tanana Chiefs Conference, Southeast Alaska Regional Health Consortium, or Ketchikan Indian Corporation are covered by their respective CHS program.

Services not covered include:

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<th>Service</th>
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<tr>
<td>Routine obstetrical care.</td>
<td>Medications purchased while traveling.</td>
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<td>Routine or emergent dental care.</td>
<td>Inpatient/outpatient mental health services.</td>
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<td>Routine/non-emergent care and follow-up appointments.</td>
<td>Inpatient/outpatient substance abuse services.</td>
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Travelers must provide medical records, within 30 days, for all out-of-state medical care you receive. This can be accomplished by signing a release of information form from the facility to ANMC. The records will be reviewed by medical professionals to determine if the care you received is emergent. If upon medical review, the medical care received is considered non-emergent, CHS is unable to authorize payment. If payment is approved, it is the patient or patient’s family ultimate responsibility to ensure that CHS receives all claims and applicable insurance information in a timely manner. CHS is unable to authorize payment for delinquent accounts due to untimely submission of claims and/or insurance information. For those traveling outside the United States, traveler is required to pay up-front for the medical care they receive, must still notify CHS within 72-hours from the beginning of treatment, must still provide CHS with the medical records, and can submit receipts to CHS for reimbursement consideration upon returning to Alaska.

For individuals moving outside the State of Alaska, you are encouraged to register and utilize the services available at the closest IHS facility. You can access the list of IHS facilities on-line at the internet address provided above. ANMC CHS cannot guarantee that you will be eligible to receive services at any of these facilities because each area has its’ local policies for determining who is eligible to receive care at that facility. As a mover, ANMC CHS is only able to provide coverage for emergent medical services for 180-days from the date you left Alaska.

Lastly, as a traveler or mover, you are required to provide proof, with date of when you left Alaska should you need financial assistance with medical care. This can be accomplished by your saving and providing those airline tickets or itineraries to CHS if requested.

Please call CHS at 800-478-1636, select option 1 then select the option corresponding to the first letter of your last name should you have additional questions or concerns. Thank you and have a safe trip.

Mailing address: ANMC / I-CHS
4315 Diplomacy Dr.
Anchorage, AK 99508

Physical Location: Inuit Building
4141 Ambassador Dr. #148
Anchorage, AK 99508

Office: (907) 729-2470
or (800) 478-1636
Fax: (907) 729-2483
www.anthc.org/ps/contracthealthsvc

AIBMH Chapter 4 AK Native Medical Center Travel Letter Revised: February 14, 2014 Appendix A
Thank you for asking about Purchased/Referred Care funding for emergent medical services while you are outside of Alaska. Tanana Chiefs Conference may cover you for emergency medical services for 180 days (6 months) from the date you leave Alaska. You may be asked to show proof of the date you departed Alaska.

Services not funded include non-emergency care, care for conditions you had before you left Alaska, dental care, services received in a foreign country (ask about care in Canada), etc.

Some examples of non-emergency health needs, which are not usually covered:

- Urinary tract infections
- Colds
- Sinus infections
- Diarrhea/Vomiting
- Minor rashes
- Medication refills

Here is how to receive funding for your care and other options for you to consider:

⇒ You must use Indian Health Service clinics and hospitals if they are available to you.

Take with you proof that you are an Indian Health Service beneficiary, such as your BIA Certificate of Indian Blood or your tribal enrollment card. Corporation cards may not be recognized as proof of Indian Health Service eligibility.

⇒ In a truly life threatening emergency, get the care you need.

You then have 72 hours to call Purchased/Referred Care and request funding. If you use the ER for healthcare that is not an emergency, YOU may be responsible for the bill. The ER is a place where only specialized emergency care is received.

Examples of emergency that may be treated in the ER:

- Heart attacks
- Serious falls
- Severe bleeding
- Poisonings
- Serious burns
- Serious injuries from car accidents

⇒ You must receive prior funding authorization from Purchased/Referred Care FOR EACH VISIT if additional visits are needed. You may be responsible for paying the bill if you receive care without first having funding approved. When you call Purchased/Referred Care for funding authorization, please have the following information available:

1. Name of the CAIHC doctor or nurse and the date and time you spoke with the person
2. Patient’s name, birth date
3. Nature of the emergency (diagnosis if known)
4. Name, address, and telephone number of the private doctor, clinic, and/or hospital
5. The appointment date and time or the date(s) care was received
6. Name of patient’s insurance company (ies) and policy number(s) or Medicaid number
7. The date you left Alaska and the date you plan to return to Alaska

⇒ Sign the provider’s “Assignment of Benefits” forms.
⇒ Give the provider all your insurance information.

All other payers must be billed before Purchased/Referred Care can make payment as the final payer.

⇒ Sign doctor and hospital “Release of Information” forms. These forms allow the doctor and hospital to send copies of your medical records to CAIHC. Payment cannot be made until these records are received at CAIHC.

I have read and understand the above information. Have a safe and speedy return to Alaska!
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### AFS Areas:
- **GAD** - Galena Zone, Galena  
  Dispatch: (907) 356-5891  
  Toll Free: (800) 237-3644
- **TAD** - Tanana Zone, Tanana  
  Dispatch: (907) 356-5578  
  Toll Free: (800) 237-3652
- **UYD** - Upper Yukon Zone, Fairbanks  
  Dispatch: (907) 356-5553

### DOF Areas:
#### Coastal Region
- **KKS** – Kenai-Kodiak Area, Soldotna  
  Dispatch: (907) 260-4233
- **MSS** - Mat-Su Area, Palmer  
  Dispatch: (907) 761-6240
- **SWS** - Southwest Area, McGrath  
  Dispatch: (907) 524-3368

#### Northern Region
- **CRS** – Valdez-Copper River Area, Glennallen  
  Dispatch: (907) 822-8627
- **DAS** - Delta Area, Delta  
  Dispatch: (907) 895-2107
- **FAS** - Fairbanks Area, Fairbanks  
  Dispatch: (907) 451-2626
- **TAS** - Tok Area, Tok  
  Dispatch: (907) 883-5134
- **SLC** – State Logistics Center  
  Dispatch: (907) 451-2680

### Native Medical Clinics:
- **TCC** – Tanana Chiefs Conference  
  (800) 478-1636
- **ANMC** – Alaska Native Medical Center  
  (800) 770-8251 x 3613
State of Alaska Department of Natural Resources
Division of Forestry

Burn Injury Protocol

Filing Procedures and Responsibilities

The Area must report any event involving death or in-patient hospitalization to the Regional Forester and the Division’s Safety Officer within 8 hours.

The State of Alaska uses the State of Alaska Department of Labor’s “Report of Occupational Injury or Illness to Employer” (Form 07-6100), and the State of Alaska’s “Supervisor’s Accident Investigation Report” (Form 02-932) to document work-related injuries and illnesses. When an employee has been, or claims to have been, injured or becomes ill from work-related causes, Form 07-6100 must be completed and submitted immediately to the applicable Finance Section, Area Admin, or Regional Admin. Failure to file Form 07-6100 within the required time may subject the Area/Region’s operating budget to a penalty equal to 20% of the amount of compensation payable to the injured employee. An employee may file one of these reports at any time. No one has the authority to deny an employee the right to file.

See that copies of the Form 07-6100 and Form 02-932 (Supervisor’s Accident Investigation Report) are faxed immediately to the employee’s home unit. Copies are also provided to the Division of Forestry’s Safety Officer with any personal identifying information such as name, address or social security number blacked out.

At no time should employees comment on the likelihood of a claim being covered other than to inform the injured or ill party of their financial liability if the claim is determined not to be work related.

Final determination of work-related validity is the responsibility of the Adjustor. It is important that an employee is forewarned that they may be liable for any medical costs incurred if the injury/illness is determined NOT to be work-related. After learning an employee has been or claims to have been injured, Form 07-6100 must be completed and submitted immediately to the applicable Finance Section, Area Admin, or Regional Admin. If an employee chooses not to file, the supervisor may file on the employee’s behalf relaying whatever information is available to them.

The agency administrator or designee for the incident will coordinate with the employee’s home unit to identify a Worker’s Compensation liaison to assist the injured employee with worker’s compensation claims and procedures.
Required Treatment for Burn Injuries

The following standards will be used when any firefighter sustains burn injuries, regardless of agency jurisdiction.

After on-site medical response, initial medical stabilization and evaluation are completed: the agency administrator or designee having jurisdiction for the incident and/or firefighter representative (e.g. Crew Boss, Medical Unit Leader, Compensation for Injury Specialist, etc.) should coordinate with the attending physician to ensure that a firefighter whose injuries meet any of the following burn injury criteria is immediately referred to the nearest regional burn center. It is imperative that action is expeditious, as burn injuries are often difficult to evaluate and may take 72 hours to manifest themselves. These criteria are based upon American Burn Association (ABA) criteria as warranting immediate referral to an accredited burn center.

During these rare events, close consultation must occur between the attending physician, the firefighter, the Agency Administrator or designee and/or firefighter representative, the firefighter’s physician (if they have one), and the burn center to assure that the best possible care for the burn injuries is provided.

Burn Injury Criteria

- Partial thickness burns (second degree) involving greater than 10% Total Body Surface Area (TBSA)
- Burns (second degree) involving the face, hands, feet, genitalia, perineum, or major joints
- Third degree burns of any size are present
- Electrical burns, including lightning injury are present
- Inhalation injury is suspected
- Burn injury in someone with preexisting medical disorders that could complicate management, prolong recovery or affect mortality (e.g., diabetes).
- Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit.
- When there is any doubt as to the severity of the burn injury, the recommended action should be to facilitate the immediate referral and transport of the firefighter to the nearest burn center.

Severity Determination

- First Degree (Superficial) Red, sometimes painful
- Second Degree (Partial Thickness) Skin may be red, blistered, swollen, painful to very painful
- Third Degree (Full Thickness) Whitish, charred, or translucent, no pin prick sensation in burned area
Additional guidance regarding federal employees and a list of possible burn care facilities may be found at: http://ameriburn.org/verification_verifiedcenters.php.

Link to the Interagency Standards for Fire & Aviation Operations 2020; see Chapter 7, page 177 for additional burn injuring information.

STATE OF ALASKA
WORKERS’ COMPENSATION NOTICE TO EMPLOYEES

Subject: Notice to employees regarding procedures for Workers’ Compensation (WC) payments, pay, and leave adjustments. This procedure applies to all leave eligible State employees except those covered under the Public Safety Employees Association (PSEA State Troopers, Airport Safety Officers and Correctional Officers who qualify for injury leave).

You or your supervisor filed a Report of Occupational Injury or Illness. The State’s insurance adjuster will make a determination as to your eligibility for WC payments. If you qualify, you should receive your first WC payment from the adjuster within 21 days from the date of disability. Subsequent WC payments should be received every 14 days while you remain eligible. Most employees receive approximately 80% of their net weekly wage. Note: Some exceptions are employees who have worked less than 13 weeks, seasonal employees, and individuals who work a second job. Some collective bargaining union agreements may provide additional benefits.

FIRST THREE DAYS AFTER DATE OF WORK-RELATED INJURY/ILLNESS
You will not receive WC payments for this “three-day waiting period”. However, you will be able to use your available leave to remain in pay status with the State of Alaska.

APPROXIMATELY DAY 3 TO 21 AND FORWARD
If you are determined eligible the State’s insurance adjuster will begin making WC payments to you. The WC payments are yours to keep; this is compensation for time loss from work due to injury/illness. You will continue to use your available leave to cover work missed due to injury/illness for the portion that is not covered by WC.

In the beginning there may be a duplication of payments* to you: WC payments and payments for your leave from the State of Alaska. This will require an adjustment to your State of Alaska paycheck and leave account.

Once the State of Alaska has been notified by the adjuster that you are eligible and receiving WC payments, you will be placed in WC leave without pay (LWOP) status with the State of Alaska for the portion of time the WC adjuster is paying you. The portion of time not covered by WC payments will be paid using your available leave with the State of Alaska. The amount of paid leave plus the WC payments should be about the same in total as your usual State of Alaska paycheck.

APPROXIMATELY DAY 29
If your time loss from work due to WC injury/illness extends beyond 28 days, you will be paid retroactively by the WC adjuster for the initial “three-day waiting period”. Because this is also a duplicate payment* it will require an adjustment to your State of Alaska paycheck and leave account.

*ADJUSTMENT PROCESS
The required adjustments will be made to your pay and leave accounts for any duplicate payments. A portion of your leave will be returned to your leave balance and the dollar amount you were paid for that leave will be deducted from your State of Alaska paycheck. Your department Human Resource Office and Technical Service Group will notify you about the timing and amount of deductions to your paycheck.

ADDITIONAL INFORMATION
✓ Time that is not covered by your leave and paid by WC payments will be WC LWOP
✓ WC LWOP will substantially reduce your State of Alaska paycheck
✓ Your leave accrual will be reduced by periods of WC LWOP
✓ Your Merit Anniversary date and leave base date may be adjusted due to WC LWOP
✓ Once your leave is exhausted you will default into full WC LWOP
✓ You may need to make other arrangements for any automated deductions, i.e., loan payments
✓ WC LWOP may affect health insurance eligibility and deferred compensation contributions
✓ WC LWOP may affect your Public Employees’ Retirement (PERS) time. If you wish to buy back your service time reduction contact the Division of Retirement and Benefits at 465-4460

If you have any questions,
Please contact your department’s Human Resource Office/Technical Service Group
AGENCY PROVIDED MEDICAL CARE & OWCP

According to the Interagency Incident Business Handbook, Chapter 10, Section 15

There are two distinct programs for compensation for injury/illness for federal employees. They are federal worker’s compensation program and Agency Provided Medical Care (APMC) program.

Medical treatment for traumatic injury claims are most appropriately processed following the federal worker’s compensation procedures, rather than APMC procedures. This will establish a record for the employee with OWCP and provides the greatest protection and timely service should further treatment be necessary upon return to the home unit.

Injured federal employees do not have a right to treatment under APMC as they do under FECA. It is the agency’s choice whether or not to offer APMC. Per OWCP, the employee’s use of AMPC instead of FECA is voluntary. The COMP/INJR on the incident is responsible to counsel the employee on the difference between APMC and OWCP treatment and allow the employee to choose.

APMC

Agency Provided Medical Care (APMC) is a program under which agencies pay for limited first aid costs for minor injuries or illnesses that involve only one treatment. The coverage is separate from the provisions of the Federal Employee’s Compensation Act (FECA). APMC is not intended to pay for medical treatment beyond first aid and is not to interfere with employee’s rights under FECA for treatment of work related injuries and illness.

The use of APMC is appropriate for injury/illness first aid cases involving only one APMC visit which occurs on the day of the injury/illness. One follow-up visit is permissible if it occurs during non-duty hours and the employee is agreeable to this. APMC can only be used while the employee remains at the site of the incident. Injury/illness cases treated under APMC cannot have lost time charged to sick leave, annual leave or Continuation of Pay (COP). If using AMPC procedures, FS-6100-16, APMC Authorization and Medical Report will be completed. If a follow-up appointment, after duty hours if needed, another FS-6100-16 is issued.

Use of APMC for traumatic injuries must be limited to first aid type of treatment and may not include authorization for therapy, stitches, x-ray or other non-first aid treatments.

APMC may be used to authorize first aid treatment only for illnesses such as respiratory infections, colds, sore throats, and similar conditions associated with exposure to smoke, dust and weather conditions, etc. APMC is appropriate as an interim measure until the employee can arrange for private medical attention, at the individual’s expense, or file a claim under FECA and await OWCP’s approval to incur medical expenses.

APMC should not be authorized for non-work related injuries or illnesses. Do not authorize APMC for dental treatment, e.g., toothache due to cavity, where there is question whether it related to a work related injury. However, where it is deemed necessary by the incident agency, a payroll deduction is made to cover the cost.

Contract employees may not utilize APMC services. State authorities vary, check with the State’s incident business coordinator.
FECA
The Federal Employee’s Compensation Act (FECA) provides compensation benefits to civilian employees of the United States for disability due to personal injury or disease sustained while in performance of duty. The Office of Worker’s Compensation Programs (OWCP) administers the FECA. Included in coverage are those under a permanent, seasonal, temporary appointment or casual hire. All related medical care including first aid; physician services; surgery; hospitalization; drugs and medicine; orthopedic; prosthetic; and other appliances and supplies; are covered under FECA.

Generally, federal employees are covered under FECA while in travel status away from their home unit unless they are engaged in non-work related activities or deviate from the authorized course of travel for personal reasons.

OWCP has authorized agencies to issue CA-16, Request for Examination and/or Treatment, to medical facilities/providers authorizing medical treatment for work related traumatic injuries. This form can only be issued once by the agency and provides treatment up to 60 days, or until OWCP rules otherwise on the case.

OWCP rarely allows agencies to authorize medical treatment related to an occupational disease or illness. The employee is responsible for the cost of treatment and can file a claim (CA-2, Notice of Occupational Disease and Claim for Compensation) with OWCP for adjudication of the claim. A CA-1 or CA-16 should not be issued for occupational disease or illness. There is no entitlement to Continuation of Pay (COP) for an occupational disease or illness (CA-2).

If it is expected that treatment by a medical provider occurs after the date of injury, follow-up treatment is necessary after the individual is released from the incident and/or loss of time occurs the claim must be processed by FECA.

Form Distribution
Federal agencies are required to submit workers’ compensation claims documents to OWCP within 10 days of the date signed by the employee. In order for home units to comply, the COMP/INJR faxes and mails the original injury/illness forms, supporting documentation and medical treatment records to the individual’s home unit compensation specialist within two days of receipt of the CA-1/CA-2. This allows the home unit to review the information, contact the incident if clarification is necessary, meet OWCP reporting requirements and ensure injured workers receive timely and quality service. A temporary copy may be retained by the Compensation/Claims Unit.

Travel to and from a medical provider and/or time spent receiving medical treatment is compensable as work hours if it falls within the normal guaranteed work schedule (8, 9, 10 hours). FECA does not allow payment of overtime for either of these activities.