Periodic Roll Review

Periodic Roll Review

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Statutory Provisions

When a case has been accepted, the claimant is entitled to compensation benefits for disability and medical treatment for the medical condition(s) found to be related to employment.

- Sections 5 U.S.C. 8105 (total disability) and 8106 (partial disability) provide that compensation is payable for wage loss caused by a medical condition found to be related to the employment.

- Section 5 U.S.C. 8107 (schedule award) provides that compensation is payable for the permanent loss or loss of use of certain anatomical members, functions, or organs of the body. Except for disfigurement, a schedule award is payable consecutively, but not concurrently, with an award for wage loss due to the same injury.

- Section 5 U.S.C. 8111 provides for additional compensation for the service of an attendant where required; after January 4, 1999, this is paid as a medical expense pursuant to 5 U.S.C. 8103.

Periodic Roll - Definition

- When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation is usually paid on the **periodic roll.** The claimant receives a compensation check every 28 days.
- Once the claimant is placed on the periodic roll, the claims examiner (CE) is responsible for obtaining medical and non-medical evidence to determine continued entitlement, including annual review of cases to ensure that payments are correct and that continuing entitlement is substantiated in the file.

Medical Evidence

During a Periodic Roll Review, the medical evidence is reviewed. The file should contain a physician's rationalized opinion with regard to whether continued disability is causally related to the employee's accepted injury or illness. The following guidelines are used when determining the adequacy of medical evidence in the file:

- For cases in which temporary total disability payments are being paid (**Case Status PR**), medical evidence is required at least once a year.

- For cases in which payments are being made for a loss of wage-earning capacity (**Case Status PW)**, medical evidence is required every two years.

- For more serious injuries in which the CE has determined and the Supervisory Claims Examiner has verified that no wage-earning capacity exists (**Case Status PN**), medical evidence is required every three years.

- For cases on the periodic roll for payment of a schedule award, no medical reports need to be requested. These cases require annual submittal of Form CA-1032 to determine the status of dependents for which augmented compensation is being paid. If the dependent's status is at issue, the case may be reviewed more frequently.

Form CA-1032

- Form CA-1032 is issued to all claimants on the periodic roll on an annual basis. This information is used to decide whether the claimant is entitled to continue receiving compensation benefits, or whether his/her benefits should be adjusted.

- The claimant must completely answer all questions and return the statement within 30 days of the date of the letter or the claimant's benefits may be suspended in accordance with 20 CFR 10.528. Form CA-1032 covers the 15 months prior to the date the claimant signs the form.

- The claimant is provided a warning that a false or evasive answer to any question or the omission of an answer may be grounds for forfeiting his or her compensation benefits and be subject to civil liability. A fraudulent answer may result in criminal prosecution. All statements provided by the claimant on Form CA-1032 form are subject to investigation for verification.

Form CA-1032

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PART A--EMPLOYMENT

Read this section completely before answering the questions below and on the next page. **Report ALL employment for which you received a salary, wages, income, sales commissions, piecework, or payment of any kind.** Such employment includes service with the military forces of the United States, including the National Guard, Reserve component, or other affiliates. Please note that you must report any employment held at the time of injury if you have worked at that employment during any period covered by this form.

Report ALL self-employment or involvement in business enterprises. These include but are not limited to: farming; sales work; operating a business, including a store or a restaurant; any online work/business; and providing services in exchange for money, goods, or other services. The kinds of services which you must report include such activities as carpentry, mechanical work, painting, contracting, child care, odd jobs, etc. Report activities such as keeping books and records, or managing and/or overseeing a business of any kind, including a family business. Even if your activities were part-time or intermittent, you must report them.

Report as your "rate of pay" what you were paid. Include the value of such things as housing, meals, clothing, and reimbursed expenses, if they were received as part of your employment.

Report ANY work or ownership interest in any business enterprise, even if the business lost money or if profits or income were reinvested or paid to others. If you performed any duties in any business enterprise for which you were not paid, you must show as "rate of pay" what it would have cost the employer or organization to hire someone to perform the work or duties you did, even if your work was for yourself or a family member or relative. You need not list ownership or passive investment in any publicly traded businesses. You need not list stocks or bank accounts.

If you have questions about whether something is material or relevant and should be included, please list that information. Under 5 U.S.C. 8106 (b), an employee who fails to make a report when required or knowingly omits or understates earnings for the period covered by the form forfeits the right to compensation for the period covered by this form.

CRIMINAL, CIVIL AND ADMINISTRATIVE PENALTIES MAY BE APPLIED FOR FAILURE TO REPORT ALL WORK ACTIVITIES THOROUGHLY AND COMPLETELY

1. **Did you work for any employer during the past 15 months?**

   a. Yes or No: _____
   b. If yes, state for each employer:
   Dates of employment: _____
   Description of work done: _____
   Rate of pay: $_____/hr/wk/mo Actual earnings: $_____
   Name/address of employer: _____
   _____

2. **Were you self-employed or involved in any business enterprise in the past 15 months?**

   a. Yes or No: _____

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PART A—EMPLOYMENT (Continued)

b. If yes, state:
Dates of self-employment or involvement in business enterprise: _____
_____
Description of work or business involvement: _____
_____

Rate of pay: $_____/hr/wk/mo Actual earnings: $_____
Name/Address of place of employment or business:
_____
_____

3. **If you answered "No" to both questions 1 and 2,** state whether you were unemployed for all periods during the past 15 months: Yes or No: _____
If no, show dates of employment: _____

PART B--VOLUNTEER WORK

During the past 15 months, did you perform any volunteer work including volunteer work for which ANY FORM of monetary or in-kind compensation was received? Yes or No: _____ If yes, state the kind of work you did and include a description of that work:

_____
_____
What were the beginning and ending dates of the volunteer work?
_____
How often did you perform this work (hours per week, weeks per month, etc.)?
_____

PART C--DEPENDENTS

A claimant who has no eligible dependents is paid compensation at 66 2/3% of the applicable pay rate. A claimant who has one or more eligible dependents is paid compensation at 75% of the applicable pay rate. You must answer the questions below to ensure your compensation is paid at the correct rate.

You may claim augmented compensation for a dependent if you have one or more of the following: (a) a spouse (including a same sex spouse) who lives with you; (b) an unmarried child, including an adopted child or stepchild, who lives with you and is under 18 years of age; (c) an unmarried child who is 18 or over, but who cannot support himself or herself because of mental or physical disability; (d) an unmarried child under 23 years of age who is a full-time student and has not completed four years of school beyond the high school level; (e) a parent who totally depends upon you for support.

You may also claim compensation for a spouse (including a same sex spouse) or dependent who does not live with you if a Court has ordered you to pay support to that person. Finally, you may

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PART C—DEPENDENTS (Continued)

claim compensation for (a) a spouse, (b) an unmarried child under 18, or (c) an unmarried child between 18 and 23 who is a full-time student even if that person does not live with you if you make regular payments for his or her support. YOU MAY NOT CLAIM OR RECEIVE AUGMENTED COMPENSATION FOR AN EX-SPOUSE EVEN IF YOU HAVE BEEN ORDERED TO PROVIDE SUPPORT IN THE FORM OF ALIMONY.

1. Are you married? Yes or No: _____
   If yes, does your spouse live with you? Yes or No: _____
   If no, please provide the date your spouse no longer resided with you: _____
   If your spouse does not live with you, do you make regular payments for his or her support? Yes or No: _____ If yes, describe the support provided:_____
   _____
   _____

2. Do you claim compensation on account of a child? Yes or No: _____
   If yes, complete the following for each child:
   Full Name:_____
   _____
   Date of Birth (and student status if over 18 and under 23): _____
   _____

   Do you claim compensation based on other non-child dependents? Yes or No: _____
   If yes, complete the following for each non-child dependent:
   Relationship to You: _____
   Resides with you? Yes or No: _____
   If this dependent does not live with you, do you make regular payments for his or her support? Yes or No: _____ If yes, describe the support provided:_____
   _____
   _____

   List any other dependents with all information outlined above, including the circumstances of a fully dependent parent, on an extra sheet. Remember to include your name and claim number at the top and to sign and date each extra sheet.

3. You are required to report any changes in dependents as soon as those changes occur. If you are receiving compensation for a dependent and are no longer entitled to receive that compensation, state:
   Date the person stopped being a dependent _____
   Reason the person stopped being a dependent _____
   _____

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PART D--OTHER FEDERAL BENEFITS OR PAYMENTS

Report any benefits you receive from the Office of Personnel Management (OPM), the Social Security Administration (SSA), the Foreign Service, or any other Federal disability or retirement system . DO NOT report benefits received under the FECA.

1. **OPM Benefits.** Report any disability or retirement benefits you receive from the OPM.

   a. Have you been assigned a CSA number? Yes or No: _____
   If yes, write it here: _____

   b. During the past 15 months, have you received a:
   Regular retirement check from OPM? Yes or No: _____
   Disability retirement check from OPM? Yes or No: _____

   Note: When OPM receives your retirement application, they assign a CSA number. It's a seven digit number and will be included on all correspondences from OPM.

2. **Social Security Administration (SSA) Benefits.**

   a. Are you receiving any benefits from SSA? Yes or No: _____

   b. If yes, please select benefit type: _____ Retirement Benefits
   _____ Disability Benefits

   c. If you receive retirement benefits from SSA attributable even in part to your Federal service, your FECA benefits are subject to an offset.

   If you are in receipt of retirement benefits from SSA, please complete the following:
   _____ Your Age
   _____ Your Federal Retirement Coverage (CSRS, FERS, CSRS Offset, Other). If other, explain._____
   _____ Your Monthly Benefit if your retirement is not CSRS

   Note: If you receive SSA disability benefits, those SSA disability benefits may be reduced by SSA due to your receipt of FECA benefits.

3. **VA Benefits.** Report any Veterans Administration (VA) disability award resulting from the injury for which you receive benefits under the FECA.

   a. Do you receive benefits from the VA on account of service in the Armed Forces of the United States? Yes or No: _____

   b. If yes, state your file number: _____
   Also state the kind of disability for which the award was made: _____
   _____

   c. Has the percentage of your VA award increased since the injury for which you are receiving benefits under the FECA?

   Yes or No: _____ If yes, give date of increase: _____

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PART D--OTHER FEDERAL BENEFITS OR PAYMENTS (Continued)

4. **Other Benefits.** Report any Federal Black Lung benefits or any other benefits paid by the Federal government not including benefits under the FECA. If you have received any state benefits such as state workers compensation benefits or Unemployment Compensation during the period covered by this form, please also list such benefits below, as such benefits may be offset or reduced for FECA benefits received.

a. Have you received any other Federally funded or assisted benefits or other state benefits such as described above? Yes or No: _____

b. If yes, provide the following information for each such benefit or payment:

Type of Claim/Award/Benefit: _____
Agency and Address: _____
_____
Claim or File No.: _____
Amount/Value Received _____ Weekly or Monthly? _____
Dates for which benefits received: _____
Do you still receive these benefits regularly? Yes or No: _____

PART E—THIRD-PARTY SETTLEMENT

1. In the past 15 months, did you or an attorney acting on your behalf file a suit or any type of claim (insurance, legal or otherwise) against a third party in connection with an injury or illness for which you receive compensation? Yes or No: _____

2. If yes, state:
Type of suit or claim: _____
Name, address, and phone number of attorney, if applicable: _____
_____
_____

3. In the past 15 months, did you receive any settlement or award from a claim or suit against a third party in connection with an injury or illness for which you receive compensation? This includes any product liability or medical malpractice settlement/award you have received that relates to treatment for your accepted injury or illness. Yes or No: _____

4. If yes, state:
Date of judgment or settlement: _____
Party or parties involved: _____
Type of suit or settlement: _____
Amount of judgment or settlement: _____
Legal fees and Court costs: _____

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PART E—THIRD-PARTY SETTLEMENT (Continued)

Name, address, and phone number of attorney, if applicable: _____
_____
_____

PART F--FRAUD OFFENSES

1. Have you been convicted of any fraud – related offense in connection with the application for or receipt of workers' compensation benefits? Yes or No:_____
If yes, state date of conviction: _____

2. Have you been incarcerated for any period during the past 15 months for any felony offense that resulted in a conviction under state or federal law?
Yes or No:_____ Place of incarceration and dates:_____

PART G--CORRECTIONS

If the name, address, file number, or date of injury shown at the top of the first page of this letter is incorrect, provide the correct information in the space provided below. (Do not complete if the information is correct).

Name: _____ File Number: _____
Address: _____ Date of Injury: _____
_____

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PART H—CERTIFICATION

I know that anyone who fraudulently conceals or fails to report income or other information which would have an effect on benefits, or who makes a false statement or misrepresentation of a material fact in claiming a payment or benefit under the Federal Employees' Compensation Act may be subject to criminal prosecution, from which a fine or imprisonment, or both, may result. I know that fraudulently concealing or failing to report income or other information in claiming payment or benefit under FECA may result in the forfeiture of compensation for the period covered by this form and may also result in a civil action against me for damages under the False Claims Act or other applicable laws.

I understand that I must immediately report to OWCP any employment or employment activity, any change in the status of claimed dependents, any third party settlement, and any monies or income or change in monies or income from Federally assisted disability or benefit programs.

I certify that all the statements made in response to the questions on this form are true, complete and correct to the best of my knowledge and belief. I have placed "Not Applicable" (N/A) or "None" next to those questions that do not apply to me or my claim.

Signature _____ Date _____

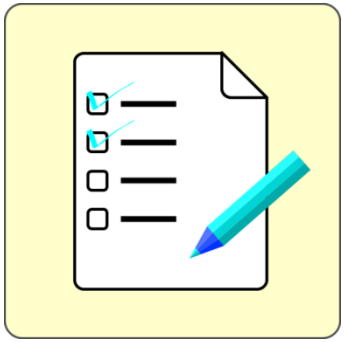
Street Address _____ Telephone _____

City, State and Zip _____

Form CA-1032

The claimant is required to report for the 15 months prior to the issuance of Form CA-1032:

- All employment for which he/she received a salary, wages, income, sales commissions, piecework, or payment of any kind
- All self-employment or involvement in business enterprises
- "Rate of pay" to include all wages or in-kind payment
- Any work or ownership interest in any business enterprise
- Volunteer work
- Dependents
- Other federal benefits received
- Third party settlements
- Fraud or felony offenses
- Corrections or updates in contact information



The claimant is required to sign and date the form certifying that all reported information is correct to the best of his/her knowledge.

Dual Benefits

Dual Benefits

- Annuity Benefits Paid by Office of Personnel Management (OPM)
- Veterans' Affairs (VA) Disability and Death Benefits
- Social Security Act (SSA) Benefits
- Severance and Separation Pay

Annuity Benefits Paid by OPM

Form CA-1032 asks the claimant to report whether he/she is receiving benefits from OPM. A claimant cannot receive **disability or regular** retirement benefits through OPM in conjunction with disability benefits from the Office of Workers' Compensation Programs (OWCP).

VA Disability and Death Benefits

Form CA-1032 asks the claimant to report whether he/she is receiving benefits from VA. If there is an indication that a claimant is in receipt of VA benefits, Claims Examiner (CE) will request additional information from VA to determine whether there has been a new award or an increase in an award that is attributable to the same disability upon which OWCP is paying benefits. This is a “dual benefit.”

Social Security Act Benefits

- Form CA-1032 asks the claimant to report whether he/she is receiving benefits from SSA. It is allowable for both SSA and FECA benefits to be paid at the same time. However, a claimant may not be eligible to receive the entire amounts calculated for both programs for a given date range. In contrast to other dual benefits situations, SSA and OWCP benefits are addressed through mandatory reductions of payments. These are commonly known as "offsets."

- SSA benefits paid for disability are reduced based on the amount of compensation payable from OWCP. This reduction is calculated and deducted by the SSA, not OWCP.

- However, under the Federal Employees' Retirement System (FERS), a portion of a claimant's SSA entitlement may be the result of the employee's federal employment. Therefore, the portion of the SSA benefit due to the federal employment would constitute a dual benefit requiring development and offset.

Form CA-1032 Suspension

Form CA-1032 Suspension

OWCP regulations provide that if timely reports of earnings are not made when requested on Form CA-1032, the right to compensation for wage loss is suspended until the report is received.

When Suspension Occurs

- If no Form CA-1032 is returned within 30 days of being issued and there are no extenuating circumstances, compensation is suspended until a completed 1032 is received by OWCP.

- If Form CA-1032 has been returned but is missing information or is incomplete, CE advises claimant and provides an additional 30 days.

- NOTE: Suspension will occur if Form 1032 is incomplete 30 days following a second request.

Suspension

- Once CE has decided to proceed with a suspension, a letter is issued to claimant advising him/her of the terms of the suspension. The suspension decision includes appeal rights.

- No preliminary notice is required when suspending benefits for failure to submit a timely response to Form CA-1032 request because this language is included on original Form CA-1032 sent to claimant.

How does a suspension decision affect benefits?

Once suspension decision has been issued:

- Claimant remains entitled to medical benefits during the period of suspension.
- Suspension will continue until completed form is returned.
- No deductions for health benefits and/or life insurance will be made during period of suspension.

Reinstatement of benefits following a suspension?

Once the claimant returns the completed Form CA-1032:

- Compensation benefits will be reinstated retroactive to date that benefits were suspended as long as information supports continuing entitlement to benefits.

- Retroactive deductions for health benefits and/or life insurance will be made.

Questions

When the medical evidence indicates that disability is expected to continue for more than 60-90 days, compensation is usually paid on the periodic roll. When a claimant is on the periodic roll, they will receive a compensation check:

a) Every Friday
b) Every 14 days
c) Every 28 days
d) The first day of every month

Questions

Once a claimant is placed on the periodic rolls, they will not have to submit medical evidence for the life of the claim.

a) True

b) False

Questions

Form CA-1032 is issued to all claimants on the periodic roll on an annual basis to decide whether the claimant is entitled to continue receiving benefits. If the form is not returned to OWCP, the claimant's benefits:

a) May be suspended
b) Will continue

Questions

A claimant can receive disability or regular retirement benefits through OPM in conjunction with disability benefits from the Office of Workers' Compensation Programs.

a) True
b) False

Questions

If OWCP issues a suspension decision based on a claimant not returning a Form CA-1032, all of the following actions may occur except:

a) The claimant is not authorized to talk to his/her claims examiner during the period of suspension.
b) The claimant remains entitled to medical benefits during the period of suspension.
c) The suspension will continue until the completed form is returned.
d) No deductions for health benefits and/or life insurance will be made during period of suspension.

Questions

Once a claimant returns the completed Form CA-1032, compensation benefits and deductions for health benefits and/or life insurance will be reinstated:

a) As of the date the claimant signed Form CA-1032
b) As of the date OWCP received Form CA-1032
c) Retroactive to the date that benefits were suspended
d) 30 days after received of Form CA-1032

Take Away Tips

1) When a case has been accepted, the claimant is entitled to compensation benefits for disability and medical treatment for the medical condition(s) found to be related to employment

2) Once a claimant is placed on the periodic roll, OWCP is responsible for obtaining medical and non-medical evidence to determine continued entitlement, including annual review of cases to ensure that payments are correct and that continuing entitlement is substantiated in the file.

3) During a Periodic Roll Review, the medical evidence is reviewed. The file should contain a physician's rationalized opinion with regard to whether continued disability is causally related to the employee's accepted injury or illness.

4) Form CA-1032 is issued to all claimants on the periodic roll on an annual basis. This information is used to decide whether the claimant is entitled to continue receiving compensation benefits, or whether his/her benefits should be adjusted.

Take Away Tips

5) A claimant cannot receive disability or regular retirement benefits through OPM in conjunction with disability benefits from OWCP.

6) It is allowable for both SSA and OWCP benefits to be paid at the same time. However, a claimant may not be eligible to receive the entire amounts calculated for both programs for a given date range. SSA and OWCP benefits are addressed through mandatory reductions of payments commonly known as "offsets."

7) OWCP regulations provide that if timely reports of earnings are not made when requested on Form CA-1032, the right to compensation for wage loss is suspended until the report is received.

8) Once the claimant returns the completed Form CA-1032 compensation benefits will be reinstated retroactive to date that benefits were suspended as long as information supports continuing entitlement to benefits.