RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 3-1000, HOME AND RESIDENTIAL HEALTH CARE.

EEOICPA TRANSMITTAL NO. 17-02 DECEMBER 2016

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance for the adjudication of requests from claimants seeking approval for differing types of home and residential health care services (HRHC) including in-home health care, hospice services, and long-term residential care in an assisted living facility or nursing home. The updated language contained in this chapter was removed from Procedure Manual Chapter 3-0300. The updated version of Chapter 3-0300 is being released simultaneously with the release of this new chapter. Changes and updates to the material previously contained in Chapter 3-0300 include:

• Removes pagination from the Chapter and Page Number column in the Table of Contents.

• Removes the footer on all pages subsequent to the Table of Contents.

• Updates the policy pertaining to document retention and storage in the OWCP Imaging System (OIS).

• Updates the language pertaining to face-to-face medical examinations required as part of the physician's medical rationale for prescribing in-home health care.

• Provides new guidance pertaining to the claimant's right to make the final determination regarding the need for, or the level of Home Health Care (HHC) to be provided.

• Provides additional guidance regarding the evaluation of medical evidence and new language pertaining to the use of Second Opinion (SECOP) Medical Examinations.

• Adds new language describing the role of the DEEOIC nurse consultants and medical director.

• Provides additional guidance pertaining to the evaluation of emergency authorization requests for HHC, following a hospital discharge.

• Explains the necessary content of letter decisions to claimants following a determination to reduce or deny care and provides sample language.

• Adds language regarding the issuance of a recommended decision in HHC cases.

• Outlines the process for the evaluation of new medical evidence and the potential impact such new evidence might have upon cases currently authorized, under consideration, or cases that were previously denied.

• Adds new language explaining the need for concurrent authorizations for different types and levels of HRHC services.

• Provides new policy language regarding attendant services provided by family members.

• Provides new policy language and procedural guidance pertaining to DEEOIC's Conflict of Interest policy regarding the role of authorized representatives.

• Updates the language in the sections pertaining to Billing Procedures and Authorizations periods, including an allowance for 12-month authorization periods for assisted living facilities.

• Exhibits: Adds a new Sample Medical Development Letter (Physician) for use in developing medical evidence necessary to adjudicate HHC requests.

• Exhibits: Updates the wording in the Sample Medical Development Letter (Claimant).

• Exhibits: Updates the content of the Billing Codes exhibit.

• Exhibits: Eliminates the follow-up medical development letter (HHC).

• Exhibits: Eliminates the Sample Recommended Decision pertaining to HHC.

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Director, Division of
Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

Remove	Insert
PM Ch. 3-0300	PM Ch. 3-1000

File this transmittal behind Part 1 in the front of the Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees
List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

TABLE OF CONTENTS

1. Purpose and Scope. This chapter describes the procedures for evaluating and approving requests from claimants who are seeking approval for differing types of Home and Residential Health Care (HRHC) services including in-home health care, hospice services, and long-term residential care in an assisted living facility or nursing home. This section also provides procedural guidance with regard to the process for development and authorization of these services.

During the processing of all HRHC claims the Medical Benefits Examiner (MBE), or other designated staff, are responsible for ensuring all documents created during the review process are properly scanned into OIS for recordkeeping purposes and that all appropriate case management updates to the Energy Compensation System (ECS) occur.

2. In-Home Health Care Services (HHC). This section provides clarification with regard to the evidence needed to authorize in-home health care (HHC), which includes skilled nursing services, and attendant services such as home health aides, personal care attendants, etc.

a. Bill Processing Agent. All requests for HHC must be submitted to the Division of Energy Employees Occupational Illness Compensation (DEEOIC) bill processing agent (BPA) via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all relevant documents and requests, and initiates an electronic message (thread) to the national office (NO), advising of a new, pending HHC request.

b. HHC requests are routed, via the BPA, to the Workers' Compensation Assistant (WCA). The WCA reviews the request and forwards the information to the appropriate MBE for review and adjudication.

c. Prior Authorization Required. All HHC requests require prior authorization from a MBE, including authorization for initial in-home assessments.

d. Requests for an in-home assessment of a patient's needs, and/or requests for HHC, can be initiated by a claimant, the claimant's authorized representative, any licensed doctor who is treating the claimant for an accepted condition, or a HHC provider.

e. Telephone Requests. The MBE must document telephone requests for HHC care in ECS. Moreover, the MBE advises the callers that they must submit their requests, in writing, before the authorization process can begin.

f. Approving Initial In-Home Assessment Requests. The MBE must approve any request for an initial in-home HHC assessment, upon receipt of a signed prescription by the treating physician. When an initial HHC assessment request is properly documented with a physician's prescription, the MBE approves the initial request and sends an email to the WCA, who sends a thread to the BPA authorizing the assessment. If the MBE receives a request for an initial HHC assessment without a physician's prescription, the MBE sends a letter to the claimant requesting a signed prescription for the initial assessment. In the letter, the MBE advises that the claimant has 30 days within which to submit a signed physician's request for an initial HHC evaluation. If medical documentation or signed physician's prescription is not received within 30 days, the MBE denies the request.

g. Letter of Medical Necessity (LMN). The LMN is a narrative statement of the physician's opinion regarding the patient's HHC needs and the medical justification for such services. The treating physician must prepare the LMN based upon a clear understanding of the patient's medical history (including the accepted work-related illnesses), reported findings from an in-home assessment, face-to-face examination of the claimant, and consideration of other sources of information (such as family members, or prior nursing notes in the case of a reauthorization of services).

Upon receipt of a LMN, or a hospital discharge summary specifically prescribing HHC services, the MBE must conduct a complete review of the case file medical evidence to determine if there is sufficient and well-rationalized documentation from the physician, describing the medical reasons for HHC, as they relate to the covered medical condition(s). The necessary information that the treating physician must provide in the form of a signed LMN includes:

(1) Medical Rationale. A description of the HHC needs of the patient, as they relate to the patient's covered medical condition(s), based upon a face-to-face medical examination conducted within the past 60 days. HHC exams must be conducted by the patient's treating physician, a physician's assistant, or other medical professional licensed and authorized by state law to conduct such examinations within the physician's practice, or employed by the physician. This should include a detailed description of, and distinction between the patient's medical need for skilled nursing care, personal attendant care, and/or any other type of care, while in the home; and, an explanation as to how the requested care is linked to the covered medical condition(s). The physician must describe the findings upon physical examination, and provide a complete list of all medical conditions, including conditions not accepted by DEEOIC. If a claimant has one or more non-covered conditions, medical evidence must demonstrate how the requirement for in-home health care relates specifically to the accepted conditions. The physician should also describe laboratory or other findings that substantiate a causal relationship between the accepted condition(s) and the need for assistance or skilled nursing care in the home.

(2) Level of care required. The doctor's LMN must specify the appropriate type of

health care professional who will attend to the patient, i.e., Registered Nurse (RN), Licensed Practical Nurse (LPN), Personal Care Attendant (PCA), Certified Nursing Assistant (CNA), or Home Health Aide (HHA). Generally, approved in-home skilled nursing services (RN/LPN) include services such as: administration of prescription medication, wound dressing changes, administration of intravenous medications, assessment of patient's medical condition, and communication with treating physician(s) regarding changes in accepted condition(s). Services provided by non-skilled persons such as home health aides or personal care attendants are typically intended for assistance with activities of daily living which often include: mobility within the household, dressing and undressing, toileting, bathing, and meal preparation.

(3) Extent of care required (hours, days, weeks, etc.). A written medical narrative must describe the extent of care to be provided in allotments of time, to include the duration of each function or operation, and the number of times per hour/day/week a particular function or operation is to be performed or repeated. The LMN must also state the duration of time for which care is being prescribed in days, weeks, or months.

h. Incomplete medical evidence. If, upon review, the MBE finds that the medical evidence is incomplete and/or the file does not contain an appropriate medical rationale to support the type(s) of HHC being prescribed for the patient, the MBE prepares development letters to the prescribing physician (Exhibit 1), and the claimant (Exhibit 2).

(1) Physician Letter. The letter to the treating physician is to include the MBE's request for a narrative medical report addressing the specific

requirements needed to substantiate a clear medical basis for HHC. The letter is also to include a request that the physician estimate the length of time for which the patient will ultimately require HHC services. Lastly, the letter is to reference the fact that DEEOIC cannot process the claimant's HHC request without this additional information. A response from the physician is requested within 30 days. The MBE also faxes a copy of the request letter to the treating physician's office.

(2) Claimant Letter. The MBE's letter to the claimant acknowledges receipt of a request for authorization of HHC services and advises that further medical evidence is required to process the claimant's request. Additionally, the claimant letter contains a copy of the development letter to the prescribing physician, which separately describes the medical evidence requested by DEEOIC. The claimant letter is to include an explanation that without the necessary supporting medical evidence, the request for HHC services cannot be authorized. Finally, the MBE is to request that the claimant contact the prescribing physician's office to make certain that a response to DEEOIC is provided within 30 days.

(3) No response after 30 days. If, after 30 days, there is no satisfactory response from the treating physician, or no response from the claimant, the MBE prepares a second letter to the claimant (accompanied by a copy of the initial letter), advising that no additional information has been received from the treating physician. The MBE advises that an additional period of 30 days will be granted for the submission of necessary medical evidence. The MBE further advises in the letter that if the requested information is not received, DEEOIC must deny the claimant's request for HHC services.

(4) No response to second request. If the claimant or the physician does not provide a response to the second request for information within the 30-day period allowed, the MBE issues a letter decision to the claimant denying the claim for HHC. The MBE sends an email to the FO, who sends a thread to the BPA advising that the service has been denied.

i. Claimant Has Final Authority. The claimant, or properly designated Authorized Representative (AR), has final decision-making authority regarding the amount or type of HHC they want. If a claimant calls and states that he/she does not require in-home health care, wishes to discontinue care that is currently authorized, or requests a reduction in the amount of care, the MBE takes one of the following actions:

(1) Discontinue Care. Should the claimant wish to discontinue care, the MBE requests that the claimant send DEEOIC a signed letter declining HHC services. Upon receipt of any written statement from the claimant stating that HHC services are not being requested, or no longer wanted, the MBE writes a letter to the claimant, with a copy to the treating physician and any designated HHC provider, confirming that the claimant is declining HHC services and thus the matter is closed. Additionally, the MBE sends an email to the WCA, who sends a thread to the BPA advising that HHC services are denied or terminated, with an effective end-date in the event of termination.

(2) Modification of Care Currently Authorized. If the claimant contacts DEEOIC and requests a reduction in the amount of care being provided, (e.g.; the claimant only wants a home health aide in the home 8 hours a day, and not 24-hours a day), the MBE instructs the claimant to call his/her prescribing physician and request that the physician prepare a new LMN for DEEOIC. The MBE advises the claimant that DEEOIC cannot modify the amount/type of care being authorized

without a letter (LMN) from the physician. Upon receipt of any such letter from the physician, the MBE takes appropriate action with regard to evaluating new medical evidence.

j. Evaluating Medical Evidence. Upon receipt of medical evidence pertaining to either a new HHC request, or an existing HHC authorization, the MBE must determine if the evidence is of sufficient probative value to authorize HHC. To determine the probative value of any medical request for HHC, it is critical that the MBE undertake appropriate analysis of the case file documentation pertaining to HHC services before authorizing such care.

(1) The underlying function of the MBE is to ensure that the covered employee receives the necessary medical care for the accepted medical condition(s) and that any such request for care reasonably corresponds with the medical evidence in the case file. If the physician does not provide sufficient detail concerning the claimant's physical condition, relationship of the prescribed care to the accepted condition(s), or specific medical rationale for HHC, the MBE must prepare and send a letter to the treating physician specifically describing the deficiency in the medical evidence and stating clearly what information is needed.

(2) When evaluating the medical evidence, the MBE must base any determination solely on the weight of medical evidence in the case file. While the MBE can request clarification or seek additional information regarding the medical justification for home health care, it is not appropriate to reduce or modify the type or level of care without the support of medical evidence obtained from a physician.

(3) Nurse Consultants and Medical Director. DEEOIC employs nurse consultants and a medical director, who are available to both the MBE and CE staff, to assist in the evaluation and

analysis of medical evidence. DEEOIC medical staff serve as a technical resource to the district offices in regards to claims-related medical issues and can assist in the determination of appropriate services and procedures that require authorization by DEEOIC.

(4) Second Opinion (SECOP) Medical Examinations. Independent physicians, randomly selected by a third-party contractor, perform SECOP examinations. If the MBE deems the medical recommendations of the treating physician are not supported by appropriate medical rationale and if attempts by the MBE are unsuccessful in clarifying the HHC needs of the claimant via the treating physician, the MBE must immediately arrange for a second medical opinion, or a referee medical opinion, depending on the circumstances. (Refer to Federal (EEOICPA) Procedure Manual Chapter 2-0800, *Developing And Weighing Medical Evidence*, for guidance pertaining to the SECOP/Referee examination process.) The context of any SECOP or referee examination is the medical necessity of HHC for one or more distinct six-month periods.

For SECOP medical examinations required to evaluate HHC renewals, the MBE is to extend the existing HHC authorization until a SECOP medical examination is completed. Under these circumstances, the MBE takes the necessary actions to update the ECS, and notify the WCA (i.e., an update to reflect a 30 or 60-day extension of an existing HHC authorization), while awaiting the findings of a SECOP doctor).

Upon receipt of the SECOP exam results, the MBE considers the reports from both the SECOP doctor and the claimant's treating doctor and determines if one report should be assigned a greater probative value than the other. If the MBE determines that the SECOP medical report is of lesser or equal weight, the SECOP report cannot be used to overturn the opinion of the

claimant's treating doctor. If the MBE determines that the two reports are of equal value, the MBE has the option of accepting the treating physician's report, or seeking resolution by obtaining a referee medical opinion.

A determination regarding the weight of medical evidence and a conclusion regarding the HHC needs of the claimant must clearly identify one or more six-month periods of HHC. Once the period(s) of HHC covered by second opinion decision expires, the MBE treats any subsequent request for HHC as a new request.

k. Emergency Authorizations. In certain emergency circumstances, the MBE may authorize HHC for a preliminary 30-day period while additional development is undertaken. In order to obtain approval for an emergency authorization, the physician or hospital staff contacts DEEOIC's BPA and advises the BPA that a claimant requires care of an emergency nature (e.g., the claimant is being released from the hospital and requires immediate in-home care).

The BPA obtains any pertinent medical documentation and assesses the emergency nature of the request. A mere discharge following hospitalization is not a sufficient basis to authorize emergency HHC. The hospitalization discharge documentation must clearly describe the emergent medical need for HHC related to an accepted condition. It must also specify the level, extent, and duration of HHC required at the emergency level of care. Upon receipt of an emergency HHC authorization request, the BPA immediately contacts the WCA, advises the nature of the emergency, and provides electronic copies of all documentation obtained. The WCA forwards the information to the MBE for review. The BPA does not make a decision regarding the request, but simply obtains the pertinent documentation and advises of the emergency request.

(1) Upon receipt of supporting medical documentation, the BPA sends the information to the WCA, who sends the information to the MBE for

review. The MBE must carefully evaluate these situations to ensure the medical documentation clearly indicates that the patient's care and well-being are dependent upon HHC services for a DEEOIC accepted medical condition. If the BPA has not already obtained medical documentation to support this need, the MBE requests the attending physician discharge summary and discharge plan stating the level of care needed in the home. If necessary, the MBE may call the hospital or attending physician for clarification of the need for emergency care and discuss needed medical evidence.

(2) If discharge information from a treating physician supports the need for immediate authorization; the MBE provides an emergency 30-day approval pending additional development. When granting an emergency HHC authorization, and for each 30-day temporary extension (while awaiting medical evidence), the MBE notifies the claimant and provider, in writing, of the initial and subsequent periods of authorization. The MBE sends an email to the WCA advising of any authorizations, and the WCA forwards the information to the BPA in the form of a thread.

(3) Upon initial approval of 30-day emergency care, the MBE sends a letter to the treating physician, with a copy to the claimant, requesting the necessary medical evidence to substantiate that the approved level of care is medically necessary to give relief for the accepted medical condition(s). This should occur within the initial 30-day authorization period. The MBE may grant extensions in increments of 30 days, while awaiting the necessary evidence to document that the level of care is medically warranted and necessary. These extensions should generally not exceed a total of 90 days.

(4) Some emergency authorization requests may not warrant approval. In some situations, the evidence supplied may not justify the emergency

request. After careful review of the evidence supplied, the MBE sends a letter to the claimant, with a faxed copy to the requestor, if other than the claimant. In the letter, the MBE explains the deficiency that exists in the medical evidence necessary to support the request for emergency care. The MBE further advises that a LMN is required, clearly describing the patient's discharge circumstances that support the need for a specific level of in-home health care. In addition, the MBE sends an email to the WCA, who updates the thread request indicating the emergency authorization request is under development.

1. Authorization Letters to Claimants. If the MBE determines that the medical evidence, or the emergency request, warrants approval of the HHC being prescribed, authorization may be granted for up to 6 months (up to 90 days for emergency requests). The MBE prepares a letter decision notifying the claimant and the home health care provider of the authorization being approved, and delineating the following information. (See Exhibit 3 for a sample authorization letter):

(1) Covered medical condition(s) for which care is authorized.

(2) Level and duration of the type(s) of in-home care to be provided, i.e., RN 1 hour per day and Home Health Aide 8 hours per day, 7 days a week for a period of 6 months.

(3) Authorized billing codes relevant to the level and duration of the care authorized (see Exhibit 4 for a description of the pertinent codes).

(4) Period of authorization with specific start and end dates.

m. Approval Actions by the MBE. Upon sending the authorization letter to the claimant and provider, the

MBE completes the authorization process with the following steps:

(1) Create Authorization: The MBE sends an email to the WCA, who initiates an electronic thread to the BPA to authorize the specific level(s) of care, billing codes (with units), and time period of the authorization.

(2) ECS Reminder. The MBE creates a reminder note to review the HHC authorization 60 days prior to the expiration of the authorized period (or within 30 days of the letter for emergency authorization requests).

n. Insufficient Evidence. After appropriate development as outlined above, if the MBE reviews the medical evidence in the file and determines that there is insufficient evidence to warrant authorization of HHC, the MBE sends a detailed letter-decision to the claimant (with a copy to the HHC provider) advising of DEEOIC's determination. A letter decision is also required any time medical evidence is received that warrants a reduction in the level of HHC services currently being authorized. Letter decisions to either reduce or deny HHC must include a copy of any SECOP or Referee report if that report serves as the basis for the decision to reduce or deny the requested level of care. The narrative content of the letter decisions must clearly explain how the MBE evaluated the medical evidence, and must provide a rationale for his/her determination. Further, all letter decisions must clearly identify the six-month period(s) being addressed by the decision. The letter-decision must include a sentence at the end with language as follows:

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

o. Issuing a Recommended Decision. In the event that the claimant does request a Recommended Decision (RD), the MBE prepares and issues the decision.

p. Receipt of new medical evidence. Upon receipt of new medical evidence during development of a new HHC request, during a currently authorized period of HHC, after an authorized period of HHC has expired, or following a denial of a HHC request, the MBE must review that new evidence to determine if any action is required. New medical evidence could potentially result in one of the following scenarios:

(1) Approval of the HHC request currently under consideration, (including six-month reauthorization), or approval of an HHC request previously withdrawn or denied.

(2) An increase in the current level of authorized services. In this instance the MBE must terminate the current authorization and begin a new six-month HHC authorization period.

(3) A reduction in the current level of authorized services, but only if ordered by the treating physician who initially prescribed the care, or, based on a SECOP medical exam and report. When a decrease in care is warranted, the MBE must terminate the existing authorization and begin a new six-month authorization period.

(4) A denial of the current level of authorized services. (Examples of this would be in cases where HHC was authorized on an interim basis while awaiting results of a SECOP exam, or where a temporary emergency authorization was granted while awaiting additional medical evidence.)

If the claimant's treating physician provides new medical evidence supporting a reduction in, or a termination of care, that reduction or termination is communicated to the claimant by letter. There is no need to include language regarding the claimant's right to request a recommended decision.

q. Letters advising of a reduction or termination of services must be copied to the HHC provider and must specifically advise the claimant that the reduction or termination will occur 15 days from the date of the letter. The letter must provide an explanation of any new level of authorized services.

r. No overlapping HHC authorizations. It is important for the MBE to understand that only one six-month HHC authorization period can exist at any given time. Regardless of differing types of service(s) authorized, there can be no overlapping dates. If the medical evidence dictates a change in the care currently authorized, the authorization must be closed, with an end-date, and a new authorization begun.

For example: If the claimant was authorized 8 hours a day of skilled nursing and 8 hours a day of home health aid (HHA) care, for a six-month period, and if the treating doctor prescribed an increase in the HHA care, to 16 hours a day, the entire authorization would be terminated and a new authorization period would be approved for both the skilled nursing and the increased level of HHA care.

s. Reauthorization of HHC Services. The following actions are taken by the MBE during the course of an existing authorization:

(1) 60 Days prior to the expiration of a HHC authorization the MBE reviews the case record to determine if new medical evidence exists in support of a reauthorization of services.

(2) If new evidence exists (face-to-face medical exam, updated medical report, etc.) supporting a reauthorization of services, the MBE follows the guidance under "p" and re-evaluates the case for consideration of a new 6-month period of care.

(3) In the absence of new medical evidence supporting a reauthorization, the MBE sends a letter to the treating physician, with a copy to

the claimant. The letter advises of the upcoming expiration date and emphasizes the need for updated medical evidence, if continuing HHC services are necessary.

(4) Following a request for updated medical information, prior to a six-month reauthorization, if no response is forthcoming, the HHC authorization expires and the MBE takes appropriate action to close the HHC claim. However, if the provider or the claimant submits a request for a continuation of services, the MBE evaluates the request, and any accompanying medical evidence.

3. Attendant Services Provided by Family Members. A claimant's spouse, or relative, may provide authorized attendant care services if properly credentialed. Requirements for licensing, certification, or training, vary from state-to-state. There are two ways an individual can qualify for reimbursement by DEEOIC as a provider of HHC services:

a. A qualified individual can enroll with DEEOIC (OWCP.dol.acs-inc.com), as a HHC provider and can be authorized for reimbursement for a maximum of 12 hours per day.

b. The employee's spouse or relative can be employed by a DEEOIC enrolled medical provider of HHC services. In this instance, licensing, certification and training become the responsibility of the enrolled provider.

4. Conflict of Interest Policy. DEEOIC has developed a Conflict of Interest Policy regarding the role of authorized representatives. (Refer to Federal (EEOICPA) Procedure Manual Chapter 2-0400.) Conflicts of interest can arise when a duly authorized representative (AR) has direct financial interests as a result of his or her role, aside from the permitted fee enumerated under the EEOICPA. Because the "role" of an AR is so important, DEEOIC will consider the AR to have a prohibited "conflict of interest" if that individual could directly benefit financially from

their client's EEOICPA claim due to something *other than the* statutorily limited fee for representing a client in connection with his or her EEOICPA claim.

With regard to HHC services, a DEEOIC enrolled provider of medical services will be considered to have a prohibited conflict of interest if, in addition to being the client's authorized representative, they are also being paid by DEEOIC, directly or indirectly, as a provider of authorized medical services to that individual. Because there is an obvious conflict of interest in these circumstances, DEEOIC will not recognize the enrolled provider as an AR. Under these circumstances, DEEOIC will inform the claimant of the need to designate another person as authorized representative, who does not have such a conflict.

5. Hospice Care. This section provides clarification with regard to the evidence needed to authorize in-home hospice care services.

a. Hospice care is generally requested and authorized when a physician has determined that an individual has a terminal illness and has no more than six months to one year of life remaining. When a treating physician determines that in-home hospice care is required for an accepted condition and prescribes these services for a claimant, it remains the role of the claimant's treating physician to determine and prescribe all medical services and care, required by the patient for the accepted condition(s).

b. All requests for in-home hospice care require prior authorization from the MBE and must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. Upon receipt, the BPA creates an electronic record of the request and generates a thread advising that a new hospice request is pending CE approval.

6. Extended Care Facilities. This section provides clarification with regard to the evidence needed to authorize placement in an extended care facility. When a treating physician determines that extended care is

required for an accepted condition and provides a LMN to that effect, the CE may authorize the services.

a. Care in a nursing home, skilled nursing facility, or an assisted living facility may be authorized when the claimant does not need acute care but does require medical services and assistance with activities of daily living.

b. All requests for extended care require prior authorization from the MBE and must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of a new and pending request for extended care. The FO forwards the request to the MBE for review and adjudication.

7. Billing Procedures and Authorization Periods. This section provides guidance with regard to billing protocol and authorization periods relevant to all types of ancillary medical services (e.g. home health care, hospice care and extended care facilities).

a. Authorization Period. All types of care (with the exception of Assisted Living Facilities) may be authorized for a period not to exceed six months. Assisted living may be authorized for a period not to exceed 12 months. Recertification is required for each successive six-month, or 12-month period, or part thereof, and should be completed before the current authorization expires, to allow uninterrupted care. The MBE should make every effort to complete recertification before a current authorization expires.

b. Billing Procedures. The provider submits Form OWCP-1500, which must be accompanied by supporting documentation (e.g. nursing notes, attendant care notes, and itemization of charges with dates and hours of care). Exhibit 4 lists and describes the various billing codes used by DEEOIC, when approving HHC services.

SAMPLE MEDICAL DEVELOPMENT LETER (PHYSICIAN)

Physician Name
Street Address
City, State Zip

Patient Name:
Patient Date of Birth:
DEEOIC Case ID:

Dear Dr. _____:

This letter is in reference to your patient, _____, who has been awarded medical benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), for the following accepted, work-related conditions: *[Insert Medical Conditions.]*

Non-covered conditions which are noted in your patient's records, and for which benefits are not provided, *[Insert non-covered conditions.]*

You recently wrote to the Division of Energy Employees Occupational Illness Compensation (DEEOIC) on *[Insert Date of Physician Letter]*, prescribing the following home health care services:

- *[Insert description of services prescribed by the doctor]*

WHAT DEEOIC IS REQUESTING FROM YOU:

DEEOIC can only authorize home health care services deemed medically necessary for the accepted medical conditions listed above. After a review of your narrative letter and your patient's medical records, we are seeking clarification from you regarding the medical necessity for the home health care services you have prescribed, as they relate to your patient's accepted condition(s). If home health care is medically necessary for the treatment of these conditions, we require a narrative letter, describing in detail the specific medical, and/or ancillary services required by your patient, and an explanation as to how these services are causally related to the DEEOIC accepted conditions. Medical evidence should include findings upon physical exam (a face-to-face exam conducted within the past 60 days is required), laboratory and other test results, and any other supporting documentation related to your examination and findings.

Your narrative letter must clearly differentiate between skilled nursing services and non-skilled home health services, and provide specifics as to the frequency and duration of the care your patient requires, i.e.; number of hours a day, days a week, and the time period for which these services are needed. Skilled and non-skilled services should be separately delineated as follows:

(a) Skilled Nursing Care: A description of the specific medical services to be performed by a licensed professional such as a RN/LPN including the frequency that

each of these services is to be performed in a 24-hour period (or in a calendar week, if the frequency is less than once a day), and the period of time for which you are prescribing these services.

(b) Non-Skilled Home Health Services: Services of a general nature - - assistance with activities of daily living - - such as bathing, personal hygiene, feeding, and assistance with ambulation, are generally performed by home health aides (HHA), personal care attendants (PCA), or certified nursing assistants (CNA). The need for non-skilled services must be separately described, along with the number of hours each day, or week, for which you are prescribing care.

Thank you for your assistance in providing this requested information. Please respond within 30 days to the address on the letterhead.

The DEEOIC does not endorse or sponsor any home health care provider. Any nursing assessment or other documentation presented from a home health provider is the product of that provider and should be evaluated carefully in conjunction with your knowledge of the patient's physical findings and medical history.

Physicians may bill DEEOIC for report preparation using CPT Code 99080, in addition to billing for customary medical services (e.g., office visits, diagnostic testing, laboratory services, etc.) provided during the physical examination as long as they relate to an accepted condition. Supporting documentation (e.g., medical reports, evaluation reports, assessment reports, progress report/notes, clinical notes and diagnostic testing results) must be submitted with the completed OWCP-1500 to DEEOIC's bill processing agent. Reimbursement for services will be in accordance with the OWCP fee schedule.

To receive payment for services, you must be enrolled as a DEEOIC provider. For more information on how to become an enrolled provider, please contact the DEEOIC bill processing agent at 1-866-272-2682 or at http://owcpstaff.dol.acs-inc.com. DEEOIC requires that providers meet basic qualifications, which includes maintaining appropriate licensure, to be enrolled. If you have any questions regarding this request, please contact me at 1-888-XXX-XXXX.

Sincerely,

[Insert Name]
Claims Examiner
cc: [*Insert Patient Name]*

Attachments: *[Individually describe any medical records or other documents attached]*

SAMPLE MEDICAL DEVELOPMENT LETTER (CLAIMANT)

(Date)

Employee Name
Employee Address
City, State Zip

Employee:
Case ID:

Dear (*Insert Employee Name*):

We recently received a claim requesting that home health care services be provided to you under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). You have previously been awarded medical benefits, which may include home health care services, for the following work-related conditions: *[Insert Accepted Medical Conditions]*

After a careful review of your claim, we have determined that additional medical evidence is needed in order to evaluate your request. We have written to your doctor requesting the additional information that we require. A copy of our letter is attached.

Please contact your doctor's office to confirm that they received our request, and that a response will be provided. If you believe that our request should be directed to a doctor other than the one identified in this attached letter, please contact me right away.

Ultimately, it is your responsibility to make certain that we receive the medical information needed in support of your request. We are asking that you and your physician provide us with a response within the next 30 days.

If you have any questions, or need to contact me regarding this letter, please call me at 1-888-XXX-XXXX.

Sincerely,

(*Insert Name*)
Claims Examiner

Encl. Letter to Physician

If you have a disability (a substantially limited physical or mental impairment); please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Exhibit 2

SAMPLE AUTHORIZATION LETTER

Date:

Claimant Name (or Authorized Representative)
Street Address
City, State, ZIP

Re: Claim Number *(Insert Claim Number)*

Dear :*(Insert Claimant or Authorized Representative Name)*:

This letter is in reference to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

We recently received a request for authorization of in-home medical care for the following covered medical conditions:

Pulmonary Fibrosis
Silicosis
Chronic Obstructive Pulmonary Disease (COPD)

After a thorough review of your case file including communication with your treating physician [*if applicable*] the following authorization is granted for the period of December 4, 2006 through June 4, 2007:

Registered Nurse [Billing Codes T1030 (per diem) and S9123 (hourly)] to administer medication and conduct physical evaluation 1 hour per day, every 5 days.

Home Health Aid or equivalent [Billing Codes S5126 (per diem) and S9122 (hourly)], 16 hours per day, seven days per week, to assist with ambulating, bathing, general personal hygiene, food preparation and feeding, and oxygen canister replacement.

You are free to select any licensed provider willing to perform the authorized services; however, the DEEOIC requires that the provider be enrolled in our medical bill

payment system. Providers may call toll free 1-866-272-2682 for program enrollment information or for answers to payment questions. If you have any questions or concerns regarding this authorization please call your claims examiner at (XXX) XXX-XXXX.

Sincerely,

(Insert CE Name)
Claims Examiner

cc: Provider

If you have a disability (a substantially limited physical or mental impairment); please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications

Billing Codes

T1001: Nursing Assessment/Initial Evaluation: A physician's written report and a Claims Examiner's prior authorization is required before the in-home assessment is conducted. Typically only one (1) in-home initial evaluation is authorized for a claimant. Once an authorization is approved by the DEEOIC, an assessment can be performed.

T1017: Targeted Case Management (15 minutes = 1 Unit): This service requires prior authorization from the DEEOIC Claims Examiner for a Registered Nurse to perform targeted case management. This is limited to the clinical impact of a claimant's accepted work-related condition on his/her current medical status. The skill level of a Registered Nurse is required for this targeted case management activity. The Claims Examiner's authorization will specify the number of hours authorized for a case management visit. Each unit of a T1017 code is equal to 15 minutes; therefore, if a nurse case manager is at the claimant's home for an assessment for one hour, the proper number of units to bill for this T1017 code is 4 units.

T1019: Personal Care Attendant (PCA) (15 Minutes = 1 Unit): This service requires prior authorization from the Claims Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist claimants with activities of daily living (i.e. bathing, feeding, dressing, etc.) Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

Each unit of a T1019 code is equal to 15 minutes; therefore, if an attendant provides services for one hour, the proper number of units to bill for this T1019 code is 4 units. Under no circumstances should this code be authorized for more than 7 hours and 45 minutes (31 units) of care per day.

T1020: Personal Care Services (PCA) Per Diem (8 hrs.): This service requires prior authorization from the DEEOIC Claims Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist claimants with activities of daily living (i.e. bathing, feeding, dressing, etc.) Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

12-hour care: For personal care services approved for 12 hour care, the bill must be submitted with one unit of a T1020 code, which covers the 8-hour period of provided services, and 16 units T1019 which cover the 4-hour period of provided services.

Under no circumstance should a per diem code be used for less than 8 hours of care.

T1030: Nursing Care, in-home, by Registered Nurse (RN), Per Diem (8 Hours): This service requires prior authorization from the DEEIOC Claims Examiner for a Registered Nurse to perform in home health care (per 8 hour shift). An RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an RN for an 8 hour shift(s).

24-hour care: If this code is approved for 24 hour care, the bill must be submitted with 3 units of a T1030 code which covers the 24 hour period of provided services, regardless of the number of RNs assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1030 code.

Under no circumstances should a per diem code be used for less than 8 hours of care.

T1031: Nursing Care, in-home, by Licensed Practical Nurse (LPN) Per Diem (8 Hours): This service requires prior authorization from the DEEOIC Claims Examiner for a Licensed Practical Nurse to perform in-home health care (per 8 hour shift). An LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an LPN for an 8 hour shift(s).

24-hour care: If this CPT code is approved for 24 hour care, the bill must be submitted with 3 units of a T1031 code which covers the 24 hour period of provided services, regardless of the number of LPNs assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1031 code.

Under no circumstances should a per diem code be used for less than 8 hours of care.

S5126: Attendant: Home Health Aide (HHA), Certified Nurse Assistant (CNA), Per Diem (8 Hours): This service requires prior authorization from the DEEIOC Claims Examiner. A HHA/CNA can only be authorized for care if there is sufficient medical rationale from a physician documenting the medical necessity of the service for the accepted work-related condition. If a HHA/CNA is authorized and a RN/LPN is utilized, bills should be submitted with the S5126 code.

24-hour care: If this CPT code is approved for 24 hour care and the care is provided, the bill must be

submitted for 3 units which cover the 24 hour period of provided services, regardless of the number of HHA/CNAs assigned. For example, if two HHA/CNAs are utilized for two 12 hour shifts, the service provided still covers the authorized three 8 hour shifts and the bill should reflect 3 units of the authorized S5126 code.

Under no circumstances should a per diem code be used for less than 8 hours of care.

S9122: Home Health Aide (HHA) or Certified Nurse Assistant (CNA) Hourly Code (less than 8 hour care): This service requires prior authorization from the DEEOIC Claims Examiner for a HHA or CNA to perform in home health care (per hour code only). A HHA or CNA can be approved if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a HHA or CNA. Under no circumstances should an hourly code be authorized for more than 7 hours (units) of care per day.

S9123: Nursing Care in-home Registered Nurse (RN) Hourly Code (less than 8 hour care): This service requires prior authorization from the DEEOIC Claims Examiner for a RN to perform in home care (per hour code only). A RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a RN. Under no circumstances should an hourly code be authorized for more than 7 hours (units) of care per day.

S9124: Nursing Care in-home License Practical Nurse (LPN) Hourly Rate (less than 8 hour care): This service requires prior authorization from the Claims Examiner for a LPN to perform in home care (per hour code only). A LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a LPN. Under no circumstances should an

hourly code be authorized for more than 7 hours (units) of care per day.

S9126: Hospice Care, in the home, Per Diem (8 Hour Shifts): This service requires prior authorization from the DEEOIC Claims Examiner. Hospice care is generally requested and authorized when an employee is determined to be terminally ill.