U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, DC 20210

RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 3-0300 ANCILLARY MEDICAL SERVICES AND RELATED EXPENSES.

EEOICPA TRANSMITTAL NO. 17-04 January 2017

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise, and replace the text of EEOICPA Procedure Manual (PM) Chapter 3-0300, Ancillary Medical Services and Related Expenses. This version incorporates changes that have arisen since the last publication of Chapter 3-0300, to include the removal of outdated or redundant material and the addition of new material. Sections 4,5,7,8 and 12, contain new material added to this chapter; and sections 6,10, and 11, contain guidance transferred from PM Chapter 3-0200, Medical Bill Processing. Below is a brief summary of the updates and additions contained in this chapter:

- Removes pagination from the Chapter and the Page number column from the Table of Contents.
- Removes the footer on all pages subsequent to the Table of Contents.
- Modifies and abbreviates the description of the claims examiner's role and responsibilities, and removes unnecessary language throughout the chapter.
- Removes Sections 2 (In-Home Health Care), 3 (Attendant Services), 4 (Hospice Care), and 5 (Extended Care Facilities), from the previous publication of this chapter. These topics are now contained in the newly released PM Chapter 03-1000, Home and Residential Health Care.

- Creates a separate section (Section 2), explaining the process for submitting authorization requests for Ancillary Medical Services and Related Expenses, eliminating redundant language throughout the previous version; and, adds language explaining the definition of, and the requirement for, a Letter of Medical Necessity (LMN) when requesting authorization for Ancillary Medical Services and Related Expenses.

- Adds language (Section 3,i.), requiring the claimant to submit a police report documenting the theft of any Durable Medical Equipment (DME) in the event the equipment is stolen.

- Adds new language (Section 4), regarding authorization of oxygen therapy DME and oxygen medical supplies.

- Adds revised language (Section 5), consolidating the authorization of Massage Therapy and Acupuncture Treatments, eliminating repetitive language. This section also adds language placing a limitation on the amount of massage therapy and acupuncture treatments permitted.

- Adds Section 6, Chiropractic Services, providing guidance pertaining to the authorization of chiropractic services (transferred from chapter 3-0200).

- Adds new language (Section 7), providing guidance pertaining to authorization of pulmonary rehabilitation.

- Adds new language (Section 8), providing new guidance pertaining to the authorization of hearing aids.

- Adds new language (Section 9), providing new guidance pertaining to the authorization of organ transplants.

- Adds Section 10, providing guidance pertaining to the authorization of treatment (under Part B and Part E), for mental and psychiatric illnesses (transferred from PM Chapter 3-0200).

- Adds Section 11, providing guidance pertaining to the authorization of experimental treatment(s) (transferred from PM Chapter 3-0200).

- Adds Section 12 providing new guidance pertaining to the authorization of sun protective clothing and annual limitations established by DEEOIC.

- Updates and clarifies the language in Section 13 regarding vehicle modifications and purchases. Also added is clarification regarding the return of a purchased vehicle when it is no longer needed by the claimant.

- Adds language to Section 14, Housing Modifications, regarding payment options available to the claimant and/or the contractor.

- Adds new, consolidated language (Section 18), providing guidance regarding recommended decisions pertaining to Ancillary Medical Services and Related Expense Authorizations, thus eliminating redundant language throughout the chapter.

- Updates Exhibit 1 and adds separate sample development letters for DME, Oxygen Therapy, Medical Supplies, and Ancillary Medical Services.

- Updates Exhibit 2 and adds separate sample authorization letters for DME, Oxygen Therapy, Medical Supplies, and Ancillary Medical Services.

- Provides updated language (Exhibit 5) in a sample letter for authorization of housing modifications.

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Filing Instructions:

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

File this transmittal behind Part 3-0200 in the front of the Unified 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 includes the procedures that the Division of Energy Employees Occupational Illness Compensation (DEEOIC) claims staff use in evaluating and approving requests for ancillary medical services, durable medical equipment (DME) and supplies, and related expenses.

2. Requests for Ancillary Medical Services and Related Expenses. This chapter provides further guidance relating to the review process for requests pertaining to a wide variety of ancillary services and related expenses. A claimant, authorized representative (AR), treating physician, or a provider may request the services and related expenses described in this chapter. Requestors are to make their claims by sending them to the DEEOIC Bill Processing Agent (BPA) via fax, mail, or electronic submission. The assigned Claims Examiner (CE), or a Final Adjudication Branch (FAB) staff person, who receive requests through the OWCP Imaging System (OIS), forwards them to the BPA.

a. The BPA creates an electronic record of the request and initiates a thread to the Fiscal Officer (FO) at the district office where the claimant’s case file resides. The thread from the BPA advises the FO of a pending request for authorization of services. For DME or supplies requests, the thread details will include a statement indicating if any requested DME or supplies are subject to the Office of Workers’ Compensation Programs (OWCP) Medical Fee Schedule.

b. The requestor must submit a Letter of Medical Necessity (LMN), (or an updated LMN in the event that reauthorization for an additional period of time is being requested). A LMN is the written explanation from the treating physician describing the medical need to assist the claimant in the treatment, care, or relief of their accepted work-related illness(s). To ensure that the physician’s opinion derives from a recent physical assessment of the claimant’s medical status, the physician is to document that a face-to-face visit/evaluation occurred between the claimant and the prescribing physician, within six months prior to the date that the physician orders the service. The LMN must clearly identify the type of ancillary

medical service sought, explain why it is medically necessary for the accepted condition, and specify the duration of use. The requestor is to submit any supporting documentation substantiating the medical need for the requested service (i.e.; medical reports, prescriptions, therapy reports, diagnostic reports).

c. Requests submitted for authorization are to include the following:

(1) Claimant information such as name, case file number, date of birth, and telephone number.

(2) Provider, supplier, or requestor information including name, provider address, provider number, Tax ID number, National Provider Number (NPI), telephone number, and fax number.

(3) Prescribing/treating physician contact information including name, address, telephone number, and fax number.

(4) The billing code(s) such as HCPCS and/or Current Procedural Terminology (CPT), code modifier(s), total cost, begin date, and end date.

(5) Diagnosis code(s) for the condition(s) for which the item(s) is being prescribed.

(6) In addition, requests submitted for authorization for DME or oxygen therapy DME and oxygen medical supplies are to include the following:

(i) Supporting documentation that provides the need for DME and/or Medical Supplies (i.e.; prescription, narrative LMN, supporting medical documentation).

(ii) Equipment billing code(s) (HCPCS/CPT), modifier(s), quantity, purchase price and rental price, total cost, begin date, end date, duration of use and frequency.

(iii) The provider will need to bill with the appropriate billing modifier to receive reimbursement. If the billing modifier is missing or invalid, the BPA will deny the bill.

(iv) Prior to payment being made for purchased equipment, the provider is to submit, along with the bill, proof of a transferred title to the claimant, bill of sale, and/or signed invoice by the claimant indicating receipt of the purchased equipment.

d. Upon receipt of an authorization request, not accompanied by appropriate medical evidence, the CE begins development.

(1) The CE sends a development letter to the claimant advising that he or she has received a request, but without the required supporting documentation. The CE's development letter to the claimant must include a clear description of the medical documentation needed to support the request, and grant the claimant 30 calendar days to provide the information. The CE also notifies the claimant that a lack of response or submission of insufficient evidence will result in a denial of the request. Exhibit 1 is a sample development letter for ancillary medical services and Exhibit 3 is a sample letter for DME / Oxygen therapy and related medical supplies. The CE updates the correspondence section of ECS to record the issuance of the development letter, once mailed.

(2) If the CE receives the appropriate medical evidence within the 30-day development period, the CE prepares an authorization letter to the claimant (Exhibit 2 for ancillary medical services or Exhibit 4 for DME/Oxygen therapy and related supplies sample letters).

(3) In situations where the treating physician

does not respond or does not provide clarifying medical rationale to support the request, the CE may refer the matter to a Contract Medical Consultant (CMC) for review.

e. Communicating the decision to the requestor: Upon completion of all appropriate development steps for the requested services, and upon review of all evidence submitted, the CE communicates a decision to approve or deny such services to the requestor. The CE sends an e-mail to the FO, who prepares and sends a thread to the BPA, authorizing or denying the claimed medical services or related expenses. The CE also creates a correspondence entry in the Correspondence screen of the Energy Compensation System (ECS), documenting the decision.

f. Communicating the decision to the claimant: When the CE receives a request for authorization, accompanied by appropriate medical evidence, the CE prepares an authorization letter to the claimant, approving the requested services (Exhibit 2 – Sample Letter for approving ancillary medical services or Exhibit 4 – Sample letter for approving DME, Oxygen Therapy and related supplies). The CE sends a copy of the letter to the supplier/vendor designated by the claimant. The approval letter is to include the following information:

(1) Covered medical condition(s) for which the DME is approved, massage therapy is prescribed, or the condition to be treated with acupuncture.

(2) Authorized billing code(s) relevant to the approval.

(3) Time period (To and From dates) during which the DME rental/purchase is authorized and/or number of frequency and visits approved for massage therapy and acupuncture therapy (i.e.; two visits per week for eight weeks).

(4) Statement advising that fees are subject to the OWCP Medical Fee Schedule.

(5) Statement advising that if the rental is converted to a purchase, rental expenses incurred and paid will be deducted from the purchase price and only the difference will be reimbursed.

3. Durable Medical Equipment (DME). A physician must prescribe all DME, supplies, and custom devices. DME serve a medical purpose and can withstand repeated use (e.g.; hospital beds, walkers, and wheel chairs, etc.).

a. A CE must review all requests for the rental and/or purchase of DME to determine their medical necessity. Requests for DME rental or purchase require pre-authorization.

b. In instances where DME, supplies, and custom devices have a total purchase price greater than $500 and the OWCP Medical Fee Schedule does not apply, the CE is to undertake development with the claimant.

(1) The claimant must submit two estimates from two different DME suppliers to include the supplier name and supplier contact information. These estimates must be for exactly the same type of DME, and/or supplies.

(2) Each potential supplier must submit a signed statement describing the DME, supplies, or unadorned item meeting the treating physician’s specifications, and a breakdown of all costs including delivery and installation, and the current Healthcare Common Procedure Code System (HCPCS) code for each DME, supply and/or item needed.

c. Where the purchase of DME, supplies or custom devices are less than $500 or when the OWCP medical fee schedule applies, the CE may approve the purchase request, after appropriate medical evidence is received, without obtaining cost estimates.

d. The CE reviewing a DME request may consider

authorization for rental rather than purchase. In most situations, DME rental is the preferred choice. The CE may authorize the rental of DME for up to six months.

(1) The CE should review the LMN and the provider-submitted rental proposal to ensure that the DME will satisfy the needs of the claimant as outlined by his or her physician. If the CE determines that the rental meets the medical requirements of the physician, he or she is to grant authorization for DME rental for six months (or less depending on the need of the claimant). The CE mails a letter of authorization to the claimant, along with a copy to the chosen DME provider. Additional details on the DME authorization are provided later in this section.

(2) For each DME rental authorization that may extend beyond the initial authorization period, the CE is to enter a reminder in ECS that reauthorization occurs at a six-month interval. The CE must set the reminder to occur 60 days prior to the expiration date of authorized DME rental.

f. In certain situations, the CE may authorize the purchase of DME or supplies. When considering the purchase of DME, the CE is to use discretion to ensure that any authorization granted for the purchase of any DME satisfies the medical needs of the claimant. The CE should not authorize a request for DME based on convenience, comfort, or other non-medical reasons.

DME purchases can only be approved if the CE is able to obtain such an option from an enrolled provider.

(1) Items that should not be rented but considered for purchase include medical/surgical supplies (i.e.; ostomy, incontinence, dialysis, wound care), canes, crutches, and commodes.

(2) The CE may evaluate a DME purchase, when the purchase price of such equipment or item is more cost effective than the rental price. For example, if the price of renting a standard wheelchair is more than the cost to purchase it,

the CE should approve the purchase of the wheelchair rather than renting it.

(3) When reauthorizing rentals, the CE must consider whether the cost to purchase the equipment, minus the rental amount paid, is less than the total cost to authorize another six months of rental. If agreeable with the claimant and the DME provider, the CE may authorize the purchase of such equipment. Otherwise, the CE is to continue to review the claim as a DME rental.

(i) Situations may arise when the CE previously authorized the rental of a DME, then subsequently receives a request for authorization to purchase that same item. Under these circumstances, it may become necessary to convert the rental to a purchase. If the CE receives a request for a purchase, the rental charges were paid for the same DME with no break in service between the rental period and the approved purchase period and the provider who billed for the rental is the same as the provider now requesting the purchase, the CE must request that the provider deduct the rental charges previously paid from the cost of the item being purchased. DEEOIC reimburses all post-purchase requests (from a rental) in accordance with the applicable OWCP Medical Fee Schedule amount.

g. Repair/Maintenance Cost. The CE must authorize the cost for modifications and maintenance to DME equipment when evidence is received validating the need for changes/repair/maintenance of previously approved DME.

h. Replacement. A new request must be submitted if a claimant requires a replacement of previously purchased equipment approved by DEEOIC for purchase. The CE must approve DME for replacement if the equipment is three years or older, inoperable and beyond repair, or the request demonstrates repair costs that exceed the cost to replace the equipment, and that the equipment is no longer covered by

warranty, or if the equipment is lost or stolen. In the event the equipment is stolen, the claimant must

furnish a police report documenting the incident. The CE can consult with the national office Medical Bill Processing Unit (MBPU) for situations involving unique or unusual circumstance.

i. DME add-ons or Upgrades. DEEIOC will consider approval for DME add-ons or upgrades where the evidence substantiates the medical need for the enhancement. Add-ons and/or upgrades are not approved for the claimant's convenience or where such enhancements do not significantly improved DME functionality.

j. Emergency situations. The CE may authorize the rental of DME for a preliminary 30-day period while additional development is undertaken.

(1) If medical documentation from the treating physician supports the need for immediate DME authorization, the CE provides approval for 30 days pending additional development.

(2) The CE sends a letter to the treating physician (with a copy to the claimant) requesting necessary evidence to substantiate that the DME is medically necessary. This should occur within the preliminary 30-day authorization period. The CE may grant extensions in increments of 30 days, not to exceed a total of six months, while awaiting necessary medical evidence.

k. When the CE receives a request for authorization of DME and appropriate medical evidence does not accompany the request, the CE begins development. Refer to Section 2(d) for further guidelines to begin development.

l. When the CE receives a request for authorization of DME, accompanied by appropriate medical evidence, the CE prepares a decision letter to the claimant authorizing the DME. Refer to Section 2(e-f) for further guidelines in communicating a decision.

4. Oxygen Therapy DME and Oxygen Medical Supplies. This section provides procedural guidelines the CE follows when reviewing and authorizing requests for the rental or purchase of Oxygen Therapy DME or Oxygen Medical Supplies.

a. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Supplies to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Supplies include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery systems, cannulas, tubing, regulators, etc. (Exhibit 5 provides definitions and describes the functions of some of the more commonly prescribed oxygen DME.) The CE reviews requests for the rental and/or purchase of Oxygen Therapy DME and Oxygen Medical Supplies to validate their medical necessity. Refer to Section 2(c) to see what is required for authorization.

b. Upon receipt of the request for rental or purchase of Oxygen Therapy DME and/or Oxygen Medical Supplies, the CE evaluates the medical evidence to determine if there is sufficient justification to authorize the request as medically necessary for the treatment or care of an accepted condition. In addition to the guidelines already described in Section 2(g), the claimant must include the following:

(1) Diagnostic testing that supports the physician’s reasons for prescribing Oxygen Therapy DME or Oxygen Medical Supplies, and identifies clear, objective pulmonary deficits including results from an arterial blood gas (ABG) and/or resting/exercise spirometry test, and/or nocturnal oximetry studies. The results are to identify the conditions under which the test(s)/studies were performed; (i.e.; during exercise, at rest, or during sleep). The test(s) are to be performed by a qualified medical professional, and originate from a qualified source such as a laboratory, diagnostic testing facility, hospital, physician’s office or clinic.

c. Additional Information. If the CE determines the evidence is deficient, for example, the physician has not provided a clear description of the needed Oxygen Therapy DME and/or Oxygen Medical Supplies, or has not provided information on the duration or use of the prescribed equipment, the CE initiates development. Refer to Section 2(b) for guidance on development.

d. Upon receipt of appropriate evidence establishing the medical necessity for Oxygen Therapy DME and/or Oxygen Medical Supplies, the CE proceeds to assess whether it is appropriate to authorize a short-term rental, continuous rental, or a purchase of the requested DME.

(1) For authorization of equipment rentals, the DEEOIC will reimburse monthly charges for the approved equipment. A rental period for oxygen equipment is one month (30 or 31 days) and is equivalent to one unit of service. When oxygen equipment is purchased, the DEEOIC will reimburse for a one-time charge, not to exceed the total allowable amount as set forth in the OWCP Medical Fee Schedule.

(2) If the request for oxygen equipment is for a period of 90 days or less, oxygen equipment shall be reimbursed on a monthly rental basis according to the OWCP Medical Fee Schedule. The rental reimbursement amount includes delivery, set-up, education, and training for the claimant, and is not separately reimbursable.

(3) If the request for oxygen equipment is for a period of less than 30 days (partial month), reimbursement occurs on a daily basis. The CE is to authorize units by the number of days that is being requested (e.g.; the request is for dates of service 4/1/2016 – 4/20/2016. The maximum number of units authorized is 20).

(4) If the request for oxygen equipment is for a

period of more than 90 days, the CE is to approve continuous rental, up to one year, or purchase of prescribed oxygen equipment if requested by the DME supplier.

(5) In emergency or urgent situations (such as the claimant being discharged from the hospital to home with urgent oxygen needs), the CE can authorize up to a 30-day rental period for oxygen equipment, while additional development is undertaken. The CE may grant additional extensions of 30-day increments during development, not to exceed a six month period.

e. Authorization Limitations. The CE is to adhere to the following restrictions when evaluating claims for Oxygen Therapy DME and/or Oxygen Medical Supplies.

(1) Approval for a portable oxygen system (liquid or concentrator) will only be made in combination with a request for a stationary system, or after verification by the CE that the claimant already has a stationary system in the home.

(2) Approval should not be given for more than one delivery system within a claimant's home. A claimant is entitled to one stationary and one portable oxygen system during an authorization period unless there are extenuating circumstances justified by medical rationale (LMN).

(3) Approval for a mechanical ventilator will be coordinated by the DEEOIC Medical Director. The DO will obtain the properly completed LMN, a copy of the hospital admission history and physical, hospital discharge summary, and a detailed report from the claimant's treating physician containing diagnosis, prognosis, proposed treatment regime, and the qualified professional(s) who will monitor the claimant and the ventilator. Once the completed information package is obtained, the CE forwards it to the DEEOIC Medical Director for review and consideration. The CE addresses any such requests to the DEEOIC Medical Director, through the DEEOIC Bill Pay Mailbox. Further

information regarding this mailbox is discussed in PM 2-0200.

f. Upon the approval of either rental or purchase of the prescribed Oxygen Therapy DME and/or Oxygen Medical Supplies, the CE prepares a decision letter to the claimant and the requestor as outlined above in Section 2, e-f, authorizing the equipment and/or supplies. Renewal of an existing authorization requires the claimant to obtain a LMN demonstrating a continuing need for the oxygen therapy DME or oxygen medical supplies.

g. DEEOIC will reimburse for repair, maintenance, non-routine service, modifications necessary to make the equipment operable, and replacement of medically necessary oxygen equipment that a claimant owns. DEEOIC will not provide separate reimbursement for maintenance and service for DME covered under a manufacturer or supplier warranty agreement unless the charges are excluded from the warranty. Reimbursement for repair, maintenance, non-routine service, or replacement of rented oxygen equipment is included in the monthly payment allowance and is not separately reimbursable.

h. All repair, maintenance, and non-routine service requests for authorization must include the following:

(1) Supporting documentation itemizing each repair/maintenance/non-routine service.

(2) The request for authorization is to indicate that the equipment is claimant-owned (non-rented) and out of warranty.

(3) DEEOIC will not authorize separate travel time or equipment pick-up and/or delivery time. Services are reimbursed according to the OWCP Medical Fee Schedule.

(4) DEEOIC allows up to two hours of service within a 120-day period. If a CE receives a repair request for more than two hours of service within a 120-day period, the CE forwards the

request and supporting documentation to the National Office for review through the DEEOIC bill pay mailbox. The CE is to list details of the documented thread, including the document

control number retrieved from the Xerox Transaction Content Management (XTCM) stored image retrieval system and/or attached supporting documentation.

(5) The request for authorization is to indicate whether a temporary replacement or "loaner" will be required. If a temporary replacement or loaner is required, DEEOIC will authorize the temporary equipment on a rental basis for up to a one-month period, not to exceed the estimated repair time.

(i) The temporary replacement request is to include a description of the equipment being dispensed, and is to be the same type of equipment that the claimant uses to treat their illness.

(ii) A new LMN is not required for the repair or temporary equipment as long as the type of equipment and/or the medical necessity is unchanged. DEEOIC will cover the cost for repair up to the OWCP Medical Fee Schedule maximum allowable amount, not to exceed the cost of a replacement.

(6) A new request must be submitted if a claimant requires a replacement of previously purchased equipment approved by DEEOIC for purchase. The CE must approve DME for replacement if the equipment is three years or older, or it is inoperable and beyond repair, or the request demonstrates repair costs that exceed the cost to replace the equipment, and that the equipment is no longer covered by warranty, or if the equipment is lost or stolen. In the event the equipment is stolen, the claimant must furnish a police report documenting the incident. The CE can consult with the national office Medical Bill processing Unit (MBPU) for situations involving unique or unusual circumstance.

i. DME suppliers may not automatically deliver additional oxygen accessories or medical supplies to claimants without a request from the claimant, an

order from the treating physician, or a pre-determined schedule that is medically necessary. Accessories and supplies are comprised of, but not limited to, regulators, wheeled carts, stands, battery packs and chargers, cannulas, tubing, oxygen contents, etc. When authorizing contents and content refills:

(1) For the Rental of a Stationary Gaseous System/Liquid: The content refills are included in the rental price. Therefore, contents are not separately reimbursable.

(2) For the Rental of a Portable Gaseous System/Liquid:
The CE can approve contents for the duration of the rental of a portable gaseous system or portable liquid system. One unit of contents is equal to one month's supply. Therefore, when authorizing contents for the rental period of a portable gaseous system, the CE should only authorize one unit per month.

(3) For the Purchase of a Gaseous System/Liquid:
Purchased systems do not include contents, thus, when authorizing the purchase of a gaseous system or liquid system the CE authorizes contents for a period of one year. Contents are authorized based on one unit per month (i.e.; 12 units = one year). The claimant must provide an updated LMN that supports the need for continued authorization of additional contents.

5. Massage Therapy/Acupuncture Treatments. This section provides procedural guidance with regard to the review and development process leading up to an authorization or denial of a request for Massage Therapy and/or Acupuncture Treatments.

a. The treating physician must prescribe massage therapy and/or acupuncture treatment only for the treatment or care of the claimant's covered medical

condition(s). Along with the signed prescription from the treating physician, the requestor must submit a LMN to reflect that an initial face-to-face visit was held with the claimant. Face-to-face visits are only

required for the initial pre-authorization request. The narrative of the LMN should describe the unique physical and therapeutic benefits that the claimant will derive from massage therapy or acupuncture treatment, and specify the frequency and duration of care to be provided in allotments of time (e.g.; twice a week for eight weeks).

b. When the CE receives a massage therapy and/or acupuncture treatment request unaccompanied by an LMN, the CE begins development. Refer to Section 2(d) for further guidelines to begin development.

c. If the CE receives the appropriate medical evidence within the 30-day development period, the CE prepares a letter to the claimant authorizing massage therapy and/or acupuncture treatment. Refer to Section 2(e-f) for further guidelines in communicating the approval.

d. The initial authorization period may be fewer than, but should not exceed eight weeks, and the CE may approve up to two visits per week, for 16 visits during the initial authorization period. Each visit is equal to a maximum of 1.5 hours. Reauthorization, including obtaining updated medical evidence is required for any request for additional massage therapy or acupuncture treatment after the initial eight-week period. The CE may not authorize more than 60 massage therapy and/or acupuncture treatment visits per calendar year.

e. If, at the end of the initial eight-week authorization period, the CE receives a new request for additional massage therapy and/or acupuncture treatment, the CE must conduct a new evaluation of the medical necessity for continuation of care. If the request is appropriate (updated medical documentation adequately explains the medical necessity for continuing massage therapy and/or acupuncture treatment), the CE grants authorization for the

extension of care within the authorization parameters of no more than two visits per week and a maximum of 60 visits per year.

f. Massage therapists and/or acupuncture providers, must hold a valid massage therapist's license or certification in the state where services are rendered.

g. Massage therapy and/or acupuncture treatment services must be conducted in an appropriate setting (i.e.; medical clinic, medical office) and should be billed daily (i.e.; one date of service per OWCP-1500 line).

(1) The service provider must submit medical notes to the DEEOIC's BPA, along with their bill, describing the particular therapeutic care provided during each visit with the claimant. The notes should describe the effect of the massage therapy, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. The BPA then forwards the medical notes to the district office for review.

(2) The OWCP Medical Fee Schedule does not provide a separate allowance for massage therapy and/or acupuncture supplies (i.e.; tables, equipment). The cost of supplies is factored into the fee schedule amount.

h. If the CE receives a request for in-home massage therapy and/or acupuncture treatment, the claimant must be homebound in order to receive authorization for such services. Medical evidence from the treating physician must demonstrate that the claimant is medically unable to travel to obtain massage therapy and/or acupuncture treatment. Once the CE receives convincing evidence that the claimant is not able to travel for care, and sufficient documentation exists regarding the medical necessity for care, the CE may authorize in-home massage therapy and/or acupuncture treatment.

i. Massage therapy and/or acupuncture treatment is not restricted by medical diagnosis or condition, but is not appropriate when prescribed solely for

prevention of future injury, recreation (spa therapy), and/or stress reduction.

6. Chiropractic Services. The CE may authorize chiropractic services limited to treatment for correction of spinal subluxation, along with the tests performed or required by a chiropractor to diagnose such subluxation. A physician or chiropractor must document a diagnosis of spinal subluxation in his or her LMN as demonstrated by an x-ray before a CE can authorize services, and the spinal subluxation must be related to an accepted condition.

7. Pulmonary Rehabilitation. The CE is required to authorize pulmonary rehabilitation services when prescribed by the treating physician. The treating physician must submit a LMN describing the need for pulmonary rehabilitation and its association to an accepted work-related illness. The LMN must specify the type, amount, frequency, and duration of pulmonary rehabilitation. The LMN must also include measurable and expected outcomes and estimated timetables to achieve these outcomes. Pulmonary rehabilitation must be conducted in an outpatient hospital setting or doctor’s office. A CE may authorize pulmonary rehabilitation for a period of up to six months. Recertification is required for any period beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

8. Hearing Aids. A claimant requesting hearing aid(s) must submit LMN from his or her treating physician. The LMN must contain an explanation for obtaining hearing assistance due to an accepted work-related hearing loss. Services associated with the assessment, provision or fitting of hearing aids must be rendered by a licensed otolaryngologist, otologist, audiologist, or hearing aid specialist. Hearing aids are limited to one per ear every three years. The CE must authorize needed repairs within the three-year period, if the manufacturer’s warranty has expired.

9. Organ Transplants (including Stem Cell). Organ transplants are a complicated and medically challenging treatment option. As a result, a special level of review is required. Once the FO alerts the CE to a request for organ transplant, the CE immediately obtains all relevant documentation from the treating physician relating to medical necessity of an organ transplant. In particular, the CE seeks a LMN describing the justification for the transplant, laboratory and diagnostic test results, CT or MRI scan results, and a transplant protocol. Once the CE has obtained this information, the CE forwards the information to the MBPU, via the DEEOIC Bill Pay Mailbox, requesting review for organ transplant authorization. The MBPU will then forward all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the transplant. The MBPU will then forward the signed memorandum to the jurisdictional office responsible for the claim.

a. With notification of approval, the CE updates ECS Notes with a confirmation of organ transplant authorization. The CE then prepares a letter of authorization to the claimant with a copy to his or her physician. The letter is to provide notification on the organ transplant authorization including:

(1) Covered medical condition(s).

(2) Authorized billing code(s) relevant to the approval.

(3) Statement advising that organ transplants must be performed at a Center for Medicare and Medicaid Services (CMS) approved facility.

(4) Statement advising that fees are subject to the OWCP fee schedule.

(5) Statement advising that an organ donor is not considered an “employee” or “claimant” within the meaning of DEEOIC and is not entitled to compensation for wage-loss or permanent impairment, nor is a donor entitled to benefits for any post-operative complications resulting

from the transplant. Only those medical and related expenses of the donor, which are necessary to secure treatment for the employee, are allowable.

b. In-Patient or Outpatient Setting. Depending upon the transplant center, the condition of the patient, and geographic limitations, transplant procedures may occur on an in-patient or outpatient basis.

(1) Autologous transplants may be performed in either an in-patient or outpatient setting, depending upon the transplant center. This type of transplant requires stem cells that have been gathered and stored, coming directly from the patient.

(2) Allogenic transplants may also be performed in either an in-patient or out-patient setting. Allogenic transplants require that donor-blood stem cells be drawn, stored, and then transplanted into the patient.

c. Choice of Donors.

(1) The first choice of a donor is generally a family member or relative. If the transplant facility approves a related donor, transportation expenses and the cost of required medical procedures for obtaining the organ(s) or blood stem cells are reimbursable. The transplant facility submits bills to the BPA, referencing the employee's (recipient) Social Security Number (SSN), and including the medical documentation/ information pertaining to the donor. Donor travel is reimbursed following the same guidelines established for companion medical travel, and is paid directly to the employee.

(2) If no suitable match is available through a relative, an unrelated donor search must be authorized. The transplant center coordinates with the National Donor Program for the testing of each potential donor. The transplant center submits bills to the BPA for all such tests and procedures. Unrelated donors are not paid for

their donation; the only coverage is for the medical expenses related to the organ donor procedure. These procedures are billed by the

transplant facility, the same as with related donors, referencing the covered employee's SSN on all bills.

d. Long-Term Living Expenses. Transplants involve prolonged outpatient procedures requiring the patient to remain within a short distance of the transplant center. If the CE authorizes a transplant procedure and if the claimant requires extended residency near the facility, the CE must authorize lodging, per diem, companion, and other travel-related expenses on a long-term basis.

10. Mental or Psychiatric Illness Treatment. A CE may accept a mental or psychiatric illness under a Part B or Part E claim as a consequential illness to another accepted illness. In these situations, the CE must obtain a narrative medical report from a licensed clinical psychologist, psychiatrist, or licensed clinical social worker which includes:

a. Diagnosis (with correct ICD10 code) and the initial date of diagnosis.

b. Medical rationale in support of how the mental or psychiatric illness is related to a condition accepted by the DEEOIC under Part B or Part E of EEOICPA.

11. Experimental Treatment. The CE may consider authorizing experimental treatment if the accepted condition is life threatening, conventional therapy has been tried to no avail and a significant body of data supports the view that the experimental procedure is indeed beneficial.

To request experimental treatment, the treating physician must send the treatment protocol, medical rationale, and peer-reviewed documents supporting the treatment to the CE. The CE forwards the information to the MBPU via the DEEOIC Bill Pay Mailbox. The MBPU will forward all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the experimental treatment.

The MBPU will then forward the signed memorandum to the requesting district office.

Upon receipt of the approval from the DEEOIC Medical Director, the CE sends an email to the FO, who prepares and sends a thread to the BPA, authorizing the experimental treatment approved by the DEEOIC Medical Director. The CE also documents the approval in the Notes section of ECS. The CE sends a copy of the approval letter to the provider designated by the claimant to provide the service. The approval letter must contain the following information:

a. Covered medical condition(s).

b. Authorized billing code(s) relevant to the approval.

c. Statement advising that fees are subject to the OWCP fee schedule.

12. Sun Protective Clothing. This section describes the procedures a CE follows when authorizing a claimant's request for reimbursement of sun protective clothing. DEEOIC has established a maximum $400 limit for sun protective clothing per calendar year. Sun protective clothing used for general health or personal reasons is not covered.

a. Sun protective clothing is clothing specifically designed for sun protection and is produced from a fabric rated for its level of ultraviolet protection. Sun protective clothing is clothing that offers at least 30 or more Ultraviolet-A (UVA) and Ultraviolet-B (UVB) sun protection for claimants with accepted conditions of melanoma, other skin cancer or other significant dermatologic condition.

(1) For authorization, the CE obtains the following information:

(i) A LMN from the treating physician describing a medical need for sun protective clothing.

(ii) The claimant must submit a receipt documenting that the clothing was purchased from a sun protective clothing company (i.e.; Solumbra or Coolibar).

(2) Once appropriate documentation is received, the CE approves the reimbursement for the sun protective clothing using the OWCP procedure code Clothing Modifications - CLMOD.

13. Vehicle Modifications and Purchases. This section provides clarification with regard to the evidence needed to approve vehicle modifications and purchases, and provides procedural guidance with regard to the process for review, development, and authorization of such requests.

a. Criteria for Modifications. Upon receipt of a LMN describing a medical need for vehicle modification, and if the claimant's medical needs can be met by modifying or adding accessories/equipment to the claimant's present vehicle, the CE explores that option first, before considering replacement of the existing vehicle. When considering modifications to an existing vehicle, the CE takes into consideration the type of vehicle currently owned, its age, and condition. Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical.

b. Proposals. If the CE determines that the claimant's medical needs warrant vehicle modification, the CE advises the claimant in writing to submit a detailed written proposal containing the following information:

(1) The year, make, model, and body style of the vehicle to be modified, as well as current mileage, description of general mechanical condition, and any modifications currently needed or anticipated. The same applies regardless of whether the vehicle to be modified is new or used.

(2) Detailed written estimates from two licensed automobile dealers, or custom alteration facilities, itemizing the proposed vehicle

modifications necessary to comply with the treating physician's LMN. Estimates must include a breakdown of all parts, labor, and the respective costs associated with each item. The estimates should also state the amount of time required to perform the modifications.

c. Acceptance by the CE. The CE has the latitude to approve an estimate that the claimant favors, if the estimates are reasonably similar in scope and cost.

(1) Approval or Denial. Upon review of the evidence, the CE approves or denies the request by sending a letter decision to the claimant advising of the approval, or reason(s) for denial of the request.

(2) Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant requesting the additional documentation that is necessary to continue with the review process.

(3) Inadequate response. If the claimant does not respond to the development letter, or does not provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a letter decision informing the claimant of the authorization denial.

d. Vehicle Purchase. If the claimant provides a LMN establishing that modifications to his or her currently owned vehicle are not feasible or practical, and that a substitute vehicle is required for the claimant to operate, the CE reviews the case with a supervisor and the National Office Fiscal Officer (NOFO), and may authorize the purchase of a suitable replacement vehicle. Under these circumstances, credit must be taken for the value of the claimant's existing vehicle. Purchase options include the following:

(1) Purchase of a used vehicle, (similar in

quality to the claimant's existing vehicle), equipped to accommodate the claimant's disability and transportation needs.

(2) Purchase of a used vehicle that is suitable for modification as described above.

(3) Purchase of a new vehicle, modified, or suitable for modification, to meet the needs of the claimant, arising from an accepted condition.

(4) Whether a new or used vehicle is purchased, it must be a vehicle of comparable value as the vehicle currently owned and operated by the claimant (i.e.; a vehicle in a price range that closely approximates the level of income and/or standard of living of the claimant). For example, if the claimant owns a mid-priced Chevrolet, Ford, Honda or Toyota, purchase of a Cadillac, Lincoln, or Lexus SUV, would not represent a vehicle of comparable value. Once the baseline cost of a comparable quality vehicle has been established, the claimant may (at his or her option) choose to upgrade the baseline model, by adding additional equipment, with the difference in cost being paid for by the claimant.

(5) After determining the baseline cost of a comparable vehicle, the CE must take credit for (deduct) the wholesale value of the claimant's existing car when determining the allowance to be paid for a replacement vehicle. The wholesale value of the existing vehicle can be determined through a number of internet websites that make this information available free-of-charge. The CE should advise the claimant of the source of their information, once the wholesale value of the claimant's current vehicle has been determined.

(6) Sales Tax. State sales tax should be included in the cost of obtaining a replacement vehicle.

(7) Equipment that is medically necessary for the accepted condition should be factory-installed whenever possible.

(8) Maintenance Costs. The CE authorizes necessary maintenance on the specialized equipment in a modified vehicle, whether installed in a new or used vehicle.

(i) Replacement cost of the specialized equipment, due to normal wear and tear, may be considered as well. Other parts of the vehicle will be maintained at the owner's expense, even if the vehicle purchase was reimbursed by DEEOIC.

(ii) Replacement of the vehicle, and all authorized equipment, can be considered if the claimant can establish that the age, mileage, and condition of the vehicle warrant such replacement. Any residual value remaining in the vehicle to be replaced would be applied as a credit toward the cost of a replacement vehicle.

(9) Proof of Insurance. The claimant bears the cost of obtaining automobile insurance and maintaining current vehicular registration in conformance with the laws of the state within which the claimant resides. Claimants are required to carry comprehensive (fire, theft, vandalism) and collision insurance on any vehicle for which DEEOIC has authorized reimbursement, unless the fair market value of the vehicle and its equipment is less than $2,500. The claimant may select the deductible of the insurance policy but will be responsible for any such deductible should an accident occur.

(10) Vehicle No Longer Needed. If the CE obtains information that a vehicle purchased by DEEOIC is no longer needed, the CE will send an email to the DEEOIC Bill Pay Box Mailbox alerting MBPU of the situation. DEEOIC is entitled to recover the fair market value of the purchased vehicle, less any percentage contribution the claimant made to the overall purchase price of the vehicle and its modifications. The MBPU will

undertake appropriate action to attempt recovery of any funds collectable through sale of a DEEOIC purchased vehicle no longer needed by a claimant.

14. Housing Modifications. This section provides clarification with regard to the evidence needed to approve housing modifications, and provides procedural guidance with regard to the process for review, development, and authorization of housing modifications. The CE considers home modification only when deemed medically necessary due to an accepted condition. A CE's responsibility is to grant authorization to modify an existing structure to accommodate the claimant's medical needs. The treating physician must describe in a LMN the particular home modifications needed to accommodate the claimant's work-related illness.

a. Modifications to Owned Property. Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical, with respect to the quality of construction materials and workmanship.

(1) Modifications may include certain additions where warranted. For example, if a ground-floor recreation room is converted to a bedroom, to accommodate a wheelchair-bound individual, and if no ground-floor bathroom facilities exist, then the addition of a bathroom on the ground floor could be approved. Similarly, if there is no suitable space for conversion of a bedroom on the ground floor, then the addition of a bedroom on the ground floor could be approved, if no other reasonable alternative exists.

(2) Modifications may include certain appliances, such as air conditioning or air filtration equipment, if deemed to be medically necessary by the treating physician, and necessary for the relief of accepted medical conditions. For example, if the claimant suffers from respiratory or cardiac conditions that have been accepted, his or her physician may order

that the claimant be kept in an air conditioned environment, in which case the expense for these modifications would be allowed.

(3) When considering modification requests, the CE should consider whether a portion of a home

can be modified, as compared to a whole-house modification. An example of this would be one or two room air conditioning units, versus installing a whole-house air conditioning system.

(4) Maintenance expenses. The CE approves maintenance expenses for equipment furnished to the claimant, as well as replacement costs, after the normal life expectancy of the appliance.

b. Modifications to Non-Owned Property. Any modifications to property not owned by the claimant, and his or her family, are subject to approval by the landlord or owner. *This is in addition to the preceding guidelines established for owned property.* When presented with a request for modifications to non-owned property, the CE considers the following points:

(1) Rental property may be subject to federal Americans with Disabilities Act (ADA), state, or local statutes that mandate barrier-free accessibility for persons with disabilities. The claimant should discuss any change in housing needs with his or her landlord, who may be able to offer modifications or alternative accommodations better suited to the needs of the individual.

(2) If the landlord is unable or unwilling to pay for modifications, or offer other suitable accommodations, approval must still be obtained from the landlord prior to making any changes or alternations to the non-owned property. Any such changes must be made at the claimant’s expense, and are subject to review and approval by DEEOIC, prior to any reimbursement.

(3) If the landlord/owner will not permit modifications, or if the costs are excessive, and if suitable housing arrangements are available elsewhere, within the same geographic area, it may be more cost-effective to consider paying relocation expenses rather than paying for

modifications at the current location. If changing locations is the most cost-effective alternative, the CE may authorize a subsidy for any increase in rent, if warranted, in addition to the relocation expense. For example, if the claimant lives in an apartment with stairs, and is no longer able to climb stairs due to his or her accepted condition(s), DEEOIC would reimburse the claimant for the most nearly comparable apartment available that offers an elevator and any other accommodations required to fulfill the claimant's medical needs arising from the claimant's accepted condition(s).

(4) The Government is entitled to reimbursement only for the value of special equipment that can be removed and sold separately, once the claimant no longer needs that equipment. Improvements or modifications, and any increase in property value resulting from such changes, accrue to the benefit of the owner.

c. Proposals. If the CE determines that the claimant is eligible for housing modifications, the CE asks the claimant to submit a detailed written proposal for review and consideration. The CE advises the claimant that the proposed housing modifications should be of a quality and grade consistent with the existing architecture and construction materials, not superior to them. Further, the claimant should be cautioned that structural modifications must not compromise the integrity of the existing structure.

Modifications will be no more expensive than necessary to accomplish the required purpose. For example, when remodeling a bathroom, it may be feasible to re-install an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one.

Conversely, modifications must be in keeping with the standard of the décor of the current or pre-illness accommodations. For example, if the claimant's dwelling requires that a sink or commode be changed for handicap accessibility, and if it is necessary to

tear out and replace tile, then the tile in the entire bathroom or kitchen may have to be replaced with similar quality tile in order to maintain the architectural décor of the room.

Proposals must include the following information:

(1) A medical report detailing the physical limitations for which the requested modifications are necessary. This report should be prepared by a physician who is a recognized authority in the appropriate medical specialty.

(2) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical or rehabilitation professional familiar with the needs of the disabled.

(3) If the claimant lives in a rented or non-owned premise, a written statement from the landlord/owner must be obtained, approving and authorizing the specific plans and proposed modifications.

(4) The CE reviews the itemized proposal and determines if the specified modifications are warranted. If the CE identifies technical issues regarding implementation, the CE develops the issue further to identify alternate solutions.

d. Fees and Bids.

(1) Reasonable fees may be paid for the medical or rehabilitation professional's visit to the site, and for the preparation of the detailed report. The same applies to any architectural

drawings that are required for significant structural changes.

(2) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an

Authorized Representative remains the claimant's obligation.

(3) The claimant must provide two or more bids for the proposed changes from licensed and/or certified contractors. The bids submitted must be for exactly the same modifications so that comparison of the competitive bids can be made.

(i) If construction work is required, the bids obtained must be for binding estimates of the cost. No fees will be paid for the bids or estimates.

(ii) If special accessories or devices are required, the CE stipulates that the price quoted by the vendor includes any necessary installation.

(4) The CE reviews the bids to determine that the same workmanship and materials are specified in the competitive bids, and normally selects the lowest cost bid, unless there is a sound reason for a higher-cost alternative, such as increased durability. If the CE selects a bid other than the lowest-cost bid, a memorandum to the file is required, explaining any variance or the justification for accepting a higher bid.

(5) Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant requesting additional documentation that is necessary to continue with the review process.

e. Approval and Payment Options. Upon approval of the request, the CE writes a detailed letter decision to the claimant advising of the approval (Exhibit 6

provides a sample of the home modification approval letter.) The approval letter is to include guidance to the claimant of the payment options available and requests that the claimant respond in writing, indicating his/her preferred payment option. For payment of home modification, the following is necessary:

(1) The claimant submits medical evidence and two proposals for home modifications. Upon review the CE approves the lower cost bid proposal and sends a letter to claimant stating DEEOIC agrees to the approved scope and cost of repairs, and, at the claimant's request, will make direct payment to the enrolled contractor, once the agreed upon work has been completed. The letter states that upon completion of the agreed-upon work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that payment be made to the contractor. The CE sends a courtesy copy of this letter to the contractor.

(2) Upon receipt of the claimant's attestation and request to pay the contractor, the CE acknowledges the claimant letter and advises that the enrolled contractor should submit Form OWCP-1500, along with a final invoice, in order to receive payment of the agreed upon price. The OWCP Code for HOME MODIFICATION - HSMDF is used, when preparing the Form OWCP-1500.

(3) In certain situations, the CE may authorize payment of a pre-construction deposit if required by the contractor whose bid has been accepted by the CE. In these situations, the contractor is to specify the total cost for specified home modification, along with the amount of any deposit (up to one-third of the total cost) required to initiate work. With CE approval, the contractor may then submit Form OWCP-1500, to receive partial payment for the deposit amount of the estimated cost. The OWCP code for HOME MODIFICATION - HSMDF is used when preparing the

Form OWCP-1500. Upon completion of the work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that final payment be made to the contractor. The contractor submits a separate Form OWCP-1500, requesting payment of the balance of the agreed upon amount.

(4) For guidance regarding problems encountered during the course of home modifications, or for other billing questions, (e.g.; billing difficulties, disputes or other irregularities), the CE should contact the National Office Policy Branch for assistance.

15. Health Facility Membership and Spa Membership. This section describes procedures when a claimant requests authorization for reimbursement of fees to join a commercial health club or spa.

a. Authorization. Membership in a health club or exercise facility, or treatment at a spa, may be authorized when recommended by the treating physician as likely to treat the effects, cure or give relief from a covered illness. All requests for reimbursement of health facility and spa fees require prior authorization from the CE. In all cases where such membership is requested, the CE determines whether the membership is likely to be effective and cost-efficient.

b. Payment. Whenever a request for payment of health club/spa membership is received, the CE obtains the following information:

(1) Information from Physician. The CE obtains the following information from the treating physician:

(i) A description of the specific therapy and or exercise routine needed to address the effects of the covered illness,

including the frequency with which the exercises should be performed.

(ii) The anticipated duration of the recommended regimen (i.e.; weeks, months).

(iii)An opinion as to the actual/anticipated effectiveness of the regimen, treatment,

goals attained/sought, and frequency of examinations to assess the continuing need for the regimen.

(iv) A description/list of the specific equipment and or facilities needed to safely perform the regimen.

(v) The nature and extent of supervision, if any, required for the safety of the claimant while performing the exercises.

(vi) An opinion stating whether exercise can be performed at home, as part of a home exercise program, or a recommendation as to what kind of public or commercial facility could provide the prescribed exercise routine.

(2) Information from Claimant. In addition, the CE obtains the following information from the claimant:

(i) The full name, address, and distance from the claimant's home or work location, of any public facilities (no membership required) and those commercial facilities (membership required) able to accommodate the prescribed regimen.

(ii) If applicable, the specific reason(s) membership in a commercial health club/spa is required when public facilities are available, and or where the doctor indicates the regimen can be performed at home.

(iii) A signed statement from the health club/spa manager stating that the club/spa can fully provide the exercise regimen prescribed by the treating physician, and a breakdown of the fees and charges for various membership options and terms. The statement should describe all facilities, services, and special charges not included in the membership fee.

c. Approval.

(1) The CE must write a letter to the claimant advising of the approval. The letter must include the following:

(i) The date the DO received the request.

(ii) The period of time which the approval will cover.

(iii)The amount approved (i.e.; monthly or annual fee).

(iv) The type of membership approved.

(v) Two copies of a blank OWCP-957.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting additional documentation that is necessary to continue with the review process. In the letter, the CE provides 30 days for receipt of the requested information.

e. Period of Service. The CE may approve health facility membership for up to twelve months. Recertification is required for any period beyond twelve months.

16. Medical Alert Systems. This section describes procedures the CE follows when a claimant requests authorization for medical alert system.

a. Definition. A medical alert system is an electronic device connected to a telephone line. In an emergency, the system can be activated by either pushing a small button on a pendant or pressing the help button on the console unit. When the device is activated, a person from the 24-hour central monitoring station answers the call, speaks to the claimant via the console unit, assesses the need for help, and takes appropriate action. A medical

communication system qualifies as a medical alert system if it includes the following requirements:

(1) An in-home medical communications transceiver;

(2) A remote, portable activator (Personal Pendant);

(3) A central monitoring station staffed by trained attendants 24 hours a day, seven days a week (optional).

b. Authorization. All requests for medical alert systems require prior authorization from the CE. A request for a medical alert system must be documented with a letter of medical necessity from the treating physician, linked to the accepted condition, which includes a statement that the claimant has an acute or chronic condition which can require urgent or emergency care.

(1) Period of Service. The CE may authorize the medical alert system for up to twelve months at a time. The need for such equipment should be recertified by the prescribing physician prior to the expiration of the authorization period.

(2) Billing. Systems that require a one-time connection fee and monthly monitoring fee may be approved, based on the claimant’s needs and the medical justification. The equipment provided is leased and must be returned when no longer needed to avoid further charges. DEEOIC is not

responsible for any additional charges incurred for failure to return equipment or failure to timely return the equipment in a timely manner.

c. Approval.

(1) The CE writes a letter to the claimant advising of the approval. The letter includes the following:

(i) The date the DO received the request;

(ii) The period of time which the approval will cover;

(iii) The amount approved.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting specific documentation that is necessary to continue with the approval process. In the letter, the CE provides 30 days for receipt of the requested information.

17. Medical Expense Reimbursement for Extended Travel. This section describes procedures to be followed for authorizing medical travel requests over 200 miles round-trip, and the process for approving claims for reimbursement, regardless of whether the claimant obtained prior approval for the trip.

a. Authorization. DEEOIC requires pre-authorization for reimbursement of transportation, lodging, meals, and incidental expenses incurred when a claimant travels in excess of 200 miles round trip for medical care of an approved condition. DEEOIC's BPA processes reimbursement claims for claimant travel without pre-authorization when travel is 200 miles or less round trip. **(**Exhibit 7 provides a sample Travel Authorization Letter.)

b. Processing. DEEOIC's BPA processes reimbursement claims in accordance with GSA travel guidelines. Per diem rates for overnight stay and mileage

reimbursement rates are published on the Government Services Administration (GSA) website, and air fare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

c. Prior Approval. Upon acceptance of a medical condition, the claimant receives a medical benefits package from the DEEOIC that includes instructions on how to submit a written request for prior approval of medical travel when such extended travel (over 200

miles round trip) is required. Despite these instructions, it is not uncommon for claimants to submit their request for reimbursement after a trip has been completed, and without having obtained prior approval.

(1) Travel Exceeding 200 Miles. Medical expense reimbursement for travel exceeding 200 miles round trip must be authorized by the CE. Claims that are submitted to DEEOIC's BPA, for reimbursement of travel expenses arising from medical travel in excess of 200 miles roundtrip, will not be processed for payment unless authorization has been provided by the district office.

d. Requests. Upon receipt of a travel authorization request from the claimant, the CE takes immediate action to ensure that the request meets one basic requirement: that the medical treatment or service is for the claimant's approved medical condition(s). The medical provider's enrollment in the DEEOIC program is not a prerequisite to approving medical travel if the claimant chooses to receive medical services from a non-enrolled provider.

(1) Companion. If the travel request involves authorization for a companion to accompany the claimant, the claimant must provide medical justification from a physician. The justification must be in written form, relating the treatment to the accepted condition and rationalizing the need for the companion. If the doctor confirms that a companion is medically necessary, and provides satisfactory rationale, then the CE may

approve companion travel. In the alternative, the CE can authorize the claimant to stay overnight in a hospital or medical facility, and can approve payment for a nurse or home health aide if a companion is not available. The CE must use discretion when authorizing such requests and may approve one of the above alternatives when there is a definite medical need, accompanied by written justification from the physician.

(2) Mode of Travel. The CE may allow the claimant to specify his or her desired mode of travel. It is the CE's role to authorize the desired mode of travel for the time period(s) requested. When a request is received from the claimant that does not identify the mode of transportation, the CE contacts the claimant by telephone and assists in determining the desired mode of travel. (Resource Center staff may assist in this process.)

e. Approval. Once the basic requirements for travel over 200 miles are met, as outlined above, the CE prepares and sends the claimant a travel authorization letter following the guidelines below. The CE may approve an individual trip, or any number of trips within a specified date range, all in one letter to the claimant. Once an initial authorization letter has been sent, future visits to the same doctor or facility may be approved by telephone, and confirmed by a follow-up letter.

f. Authorization Letter. The authorization letter delineates the specifics of the trip being authorized, based upon the mode of travel the claimant has selected. In the travel authorization letter, the CE advises the claimant that travel costs are reimbursable only to the extent that the travel is related to obtaining medical treatment. In the letter, the CE also invites the claimant to contact the nearest Resource Center for assistance prior to or upon completing any trip to complete Form OWCP-957, Request for Reimbursement.

g. Adjudication. When adjudicating claims submitted after the trip has been completed, but for which prior approval was not obtained, the CE follows the same steps as for pre-authorized trips, to the point of sending an authorization package. At that point the CE sends only the authorization (or denial) letter to the claimant, not an entire authorization package.

h. Notifying the BPA. In conjunction with sending the claimant an approval or denial of a travel

request, the CE conveys his/her decision to DEEOIC's BPA via the office's FO, who is the point of contact with DEEOIC's BPA for such issues. The CE prepares an e-mail to the FO, who in turn generates an electronic thread to the BPA. In the e-mail the CE provides the information specified below. The CE must *also* enter the following information into ECS:

(1) Approved dates for a single trip or in the alternative, a date range and number of trips authorized within that time frame.

(2) Approved mode of transportation.

(3) Starting point and destination, (e.g.; claimant address and provider address, city & state at a minimum).

(4) Authorization for rental car reimbursement, if appropriate.

(5) Companion travel if approved.

i. Approval Package. The approval package must include the following:

(1) Two copies of the detailed authorization letter.

(2) Two copies of a blank OWCP-957.

(3) A prepaid express mail envelope, addressed to DEEOIC's BPA, for the claimant's use.

18. Ancillary Services or Expense Authorization Recommended Decision. When a CE decides to deny authorization for a claimed ancillary service or expense discussed in this chapter, the CE sends a letter decision to the claimant. The letter decision is to include a narrative explanation as to why the evidence is insufficient to warrant authorization. The CE is to send a copy of the letter decision to the provider, if applicable.

a. The letter decision is to include the following language:

> *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.*

Upon issuance of the denial letter, the CE creates correspondence in ECS documenting the issuance of the decision letter denying the ancillary medical service.

b. Recommended Decision. Should the claimant request a Recommended Decision regarding denial of an ancillary medical service or related expense, the CE completes the Recommended Decision process in accordance with existing DEEOIC procedure. In particular, the CE ensures that the narrative content of the Explanation of Finding includes a well-written discussion of the justification for the denial of authorization. The FAB is responsible for independently evaluating the recommendation of the CE, along with the file evidence, and deciding whether to finalize the recommended decision.

Sample Ancillary Medical Services Development Letter

Date:

Claimant: (or Auth Rep/Provider) *Case ID:*
Street Address *Accepted Condition(s):*
City, State, Zip

Dear *[Enter Claimant or Auth Rep]*:

I am writing to you concerning your benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). We have received a request for authorization for the *[Enter type of ancillary medical service requested].* In order to properly evaluate and respond to this request, we need additional information from you.

Please provide our office with the following information:

(*Request only that information that is necessary to process the claim. Feel free to modify the following, if necessary.)*

- *Prescription from your treating physician (should include diagnosis code(s) for the condition for which the item(s) is being prescribed).*
- *Letter of Medical Necessity or other medical documentation (describe the general information a LMN is to provide.*
- *Claimant information such as name, case file number, date of birth, and telephone number.*
- *Provider or vendor information such as name, provider address, ACS provider number, Tax ID number, national provider identification number, telephone number, and fax number.*
- *Treating physician contact information such as name, address, telephone number, and fax number.*

- *DME information such as diagnosis code, HCPCS/CPT, modifier, quantity, purchase price, rental price, total cost, begin date, end date, and duration of use.*

You have 30 calendar days to provide the additional information. Your lack of response or submission of insufficient evidence will result in a denial of the request.

In the interest of expediting the approval of your request for *[Enter type of Ancillary Medical Service]*, please fax the requested information to the DEEOIC Bill Processing Agent at (800) 882-6147, within 30 days, or contact me if you have questions regarding this request.

Thank you for your assistance.

Sincerely,

[Enter POC CE Name and Signature]
[Enter POC CE Telephone and Fax Numbers]

cc: *[Enter as appropriate]*

SAMPLE ANCILLARY MEDICAL SERVICES AUTHORIZATION LETTER

Date:

Claimant Name (or Auth Rep)
Street Address
City, State, Zip

Re: Case ID *[Enter Case ID Number]*

Dear *[Enter Claimant or Auth Rep Name]*:

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

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) recently received a request for authorization for *[Enter the ancillary medical service]* for the following covered medical condition(s):

List the covered condition(s):

After a thorough review of your case file, including communication with your treating physician (*if applicable*), the following authorization is granted:

[Enter type of ancillary medical service and billing code(s)] for the period of *[Enter to and from date]* from [*Enter vendor name].*

Note that the DEEOIC requires that the approved vendor noted above be enrolled as a provider in our medical bill payment system to be reimbursed. Vendors may call toll free 1-866-272-2682 for program enrollment information or for answers to payment questions.

All fees for the ancillary medical service is subject to the OWCP Fee Schedule.

If you have any questions or concerns regarding this authorization, please call your claims examiner at (XXX) XXX-XXXX.

Sincerely,

[Enter CE name]
DEEOIC Claims Examiner

cc: *[Enter supplier name]*

Sample Development Letter (DME, Oxygen Therapy Equipment and/or Oxygen Medical Supplies)

Date:

Claimant: (or Auth Rep/Provider) *Case ID:*
Street Address *Accepted Condition(s):*
City, State, Zip

Dear *[Enter Claimant or Auth Rep]*:

I am writing to you concerning your benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). We have received a request for authorization for the *[rental/purchase]* of a *[Enter type of DME, Oxygen Therapy Equipment and/or Oxygen Medical Supplies requested].* In order to properly evaluate and respond to this request, we need additional information from you.

Please provide our office with the following information:

(*Request only that information that is necessary to process the claim. Feel free to modify the following, if necessary.)*

- *Prescription from your treating physician (should include diagnosis code(s) for the condition for which the item(s) is being prescribed).*
- *Letter of Medical Necessity or other medical documentation (describe the general information a LMN is to provide.*
- *Claimant information such as name, case file number, date of birth, and telephone number.*
- *Provider or vendor information such as name, provider address, ACS provider number, Tax ID number, national provider identification number, telephone number, and fax number.*
- *Treating physician contact information such as name, address, telephone number, and fax number.*

- *DME information such as diagnosis code, HCPCS/CPT, modifier, quantity, purchase price, rental price, total cost, begin date, end date, and duration of use.*

- Diagnostic testing that supports the physician's reasons for prescribing oxygen therapy DME or oxygen medical supplies, and identifies clear, objective pulmonary deficits including results from an arterial blood gas (ABG) and/or resting/exercise spirometry test, and/or nocturnal oximetry studies. The results are to identify the conditions under which the test(s)/studies were performed; (i.e.; during exercise, at rest, or during sleep). The test(s) are to be performed by a qualified medical professional, and originate from a qualified source such as a laboratory, diagnostic testing facility, hospital, physician's office or clinic.

Note that add-ons and/or upgrades to Oxygen Therapy Equipment and/or Oxygen Medical Supplies will be considered for approval if evidence substantiates a medical need for the enhancement. However, add-ons and/or upgrades to Oxygen Therapy Equipment and/or Oxygen Medical Supplies are not covered when they are intended primarily for the claimant's convenience and do not significantly enhance functionality.

You have 30 calendar days to provide the additional information. Your lack of response or submission of insufficient evidence will result in a denial of the request.

In the interest of expediting the approval of your request for *[Enter type of DME, Oxygen Therapy Equipment and/or Oxygen Medical Supplies]*, please fax the requested information to the DEEOIC Bill Processing Agent at (800) 882-6147, within 30 days, or contact me if you have questions regarding this request.

Thank you for your assistance.

Sincerely,

[Enter POC CE Name and Signature]
[Enter POC CE Telephone and Fax Numbers]

cc: *[Enter as appropriate]*

Sample Authorization Letter (DME, Oxygen Therapy Equipment and/or Medical Supplies)

Date:

Claimant Name (or Auth Rep)
Street Address
City, State, Zip

Re: Case ID *[Enter Case ID Number]*

Dear *[Enter Claimant or Auth Rep Name]*:

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

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) recently received a request for authorization for the *[Enter purchase or rental]* of a *[Enter the Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies]* for the following covered medical condition(s):

List the condition(s)

After a thorough review of your case file, including communication with your treating physician (*if applicable*), the following authorization is granted:

Rental of *[Enter type of Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies and billing code(s) for the period*] of *[Enter to and from date]* from [*Enter vendor name].*

If the rental is converted to a purchase, the purchase reimbursement price must be less than the paid rental price.

Purchase of *[Enter type Durable Medical and/or Oxygen Therapy Equipment and/or Medical*

Supplies and billing code(s)] from *[Enter vendor name]*.

Note that the DEEOIC requires that the approved vendor noted above be enrolled as a provider in our medical bill payment system to be reimbursed. Vendors may call toll free 1-866-272-2682 for program enrollment information or for answers to payment questions.

Reimbursement claims must be submitted with the appropriate modifier to receive payment for Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies.

All fees for the rental/purchase of Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies are subject to the OWCP Fee Schedule.

Add-ons and/or upgrades to the Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies are considered for approval if evidence substantiates a medical need for the enhancement. However, add-ons and/or upgrades to Durable Medical and/or Oxygen Therapy Equipment and/or Medical Supplies are not covered when they are intended primarily for the claimant's convenience and do not significantly enhance the equipment/supplies functionality.

If you have any questions or concerns regarding this authorization, please call your claims examiner at (XXX) XXX-XXXX.

Sincerely,

[Enter CE name]
DEEOIC Claims Examiner

cc: *[Enter supplier name]*

OXYGEN DELIVERY SYSTEMS

GASEOUS OXYGEN SYSTEM – This consists of an oxygen tank with a regulator/flowmeter. This is a compressed gas system. A regulator/flowmeter is attached to the tank via an oxygen wrench. The flow rate is controlled by adjusting the knob on the regulator/flowmeter. Oxygen tanks, no matter how large or small, are all portable.

OXYGEN CONCENTRATOR – An oxygen concentrator is a device which takes ambient or room air and divides the air into oxygen and nitrogen. The nitrogen is discarded and the oxygen is stored, concentrated, and delivered to the patient at 90-95% purity. A stationary concentrator is most typically utilized inside the patient's home. A stationary system runs on electricity. A stationary system has a regulator/flowmeter built into the device. A stationary system typically has a single delivery port and, depending upon the model, can deliver up to 8 liters per minute (LPM) of oxygen to the patient. A portable oxygen concentrator is most typically utilized outside the patient's home. A portable system runs on a battery that must be recharged periodically. The battery recharger runs on electricity. Typical battery life for a portable oxygen concentrator is approximately 4 hours.

LIQUID OXYGEN SYSTEM – Liquid oxygen systems consist of a stationary unit or reservoir which stores a large volume of liquid oxygen and a portable unit which can be refilled from the stationary unit. Neither the stationary or portable units require electricity.

MECHANICAL VENTILATOR – Mechanical ventilation may be defined as a life-support system designed to replace or support normal ventilator lung function. Mechanical ventilation serves only to provide assistance for breathing and does not cure a disease process. Mechanical ventilators require electricity and a skilled professional (M.D., D.O., PA, NP, RN, or RRT) to monitor the patient and the ventilator settings.

Sample Home Modification Letter

[*Date*]

[*Claimant Name or AR Name*]
[*Street Address*]
[*City, State, Zip*]

Employee: [*Insert Employee Name*]
Case ID: XXXXX

Dear [*Insert Employee or AR Name*]:

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

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) recently received an authorization request for home modifications related to your accepted medical condition(s).

Along with your request we also received a copy of your letter of medical necessity, prescribing [*Insert brief description of modifications prescribed by letter of medical* necessity]. Additionally, we received the two, detailed contractor estimates, describing the scope and cost of the proposed modifications.

After a careful review of your request, we have determined that the evidence submitted is sufficient to authorize your request for home modification. The request is **approved** subject to the following conditions:

- The DEEOIC is approving modifications based upon the proposal submitted by: [*Insert Name and Address of Contractor and Date of Proposal, for the approved bid.*]
- The total approved cost for all work, including materials, labor, profit and overhead is the amount of

[*Insert Approved Dollar* Amount] as stated in the proposal.

- Upon completion of the approved modifications, you must submit a signed letter to DEEOIC advising that all of the approved work has been completed, and that the work has been completed in a satisfactory manner. Along with your letter you must submit a completed OWCP Form 915 (Claim For Medical Reimbursement), a final invoice for the charges billed, and proof of payment to the contractor.
- If you want DEEOIC to pay the contractor directly, it will be necessary for the contractor to enroll in our medical bill processing system in order to receive payment. Contractors seeking additional enrollment information can call our toll-free number (866-272-2682) for answers to billing questions. Once the approved work has been completed, it will be necessary for you to write us advising that all work has been completed in a satisfactory manner, and that you are requesting DEEOIC to make payment directly to the contractor, for the pre-approved amount.
- Once DEEOIC has approved a written proposal for medically necessary modifications, you have the option of contracting for additional modifications, or for materials and appliances that represent an upgrade from the medically necessary standard prescribed. You may do so with the understanding that DEEOIC will only reimburse you for the cost of medically necessary modifications approved in writing. Reimbursement for the approved amount will be made to you upon completion of all work, and upon receipt of the following:
  - A letter from you stating that all work, as detailed in the approved modification proposal, has been completed to your satisfaction.
  - A final invoice from the contractor itemizing the cost of the completed work.
  - Proof of payment to the contractor <u>for an amount no less than</u> the amount approved for reimbursement by DEEOIC.

- The DEEOIC neither endorses nor sponsors any entity providing services to beneficiaries of our program.

If you have any questions or concerns regarding this authorization please call me at [*Insert Telephone Number*].

Sincerely,

[*Enter CE Name*]
Claims Examiner

Copy To: Authorized Representative

Copy To: Contractor

Sample Travel Authorization Letter

Date:

Claimant Name (or Auth Rep):
Street Address
City, State, Zip

Dear Claimant Name (or Auth Rep):

This letter is in reference to your request for medical travel authorization under the Energy Employees Occupational Illness Compensation Program Act. You *(or you and your companion)* are **authorized** to travel for medical treatment with *(Insert name of doctor or medical facility) in (City / State).* Outlined below are the itemized travel allowances approved for your trip:

- Dates of Trip: *(Insert authorized travel dates)*
  [Or in the alternative]
- Multiple Trips Authorized *(Insert Authorized travel date range)*
- Trip Origin & Destination: *(Insert starting City/State and ending points)*
- Authorized mode of travel *(Insert approved mode: auto, air, etc.)*
- Meals & Incidental Expenses (M&IE) See below.
- Lodging (single or double occupancy) See below.
- Airfare allowance See below.
- Mileage allowance for personal vehicle *(Insert appropriate mileage rate or N/A)*
- Companion approved to travel: *(Insert name of companion or N/A]*
- Rental car reimbursement *Indicate "YES" or N/A]*

Companion Travel: If you have been authorized a companion to accompany you on this trip, you will be reimbursed at twice the daily M&IE rate and lodging will be based upon double-occupancy, unless otherwise approved. If travel is by commercial airline, then the companion airfare will be reimbursed as well. The expenses for your companion will

be paid to you, not to the companion, or any other party.

Travel Changes: We understand your travel may not happen as originally planned. If you encounter a change in your travel plans (such as an extended stay) that may result in additional expenses, please contact me or the DEEOIC Resource Center identified below at your earliest convenience to let us know the specific changes. We will be glad to assist you with any adjustments to your authorization so you won't encounter any delays in your reimbursement.

How to File for Travel Reimbursement: Reimbursement requests must be submitted using the enclosed Form OWCP-957. Only travel costs that are directly related to obtaining medical treatment for your accepted condition(s) will be reimbursed. Receipts are required for all lodging, airfare, rental car (if authorized), and gasoline purchases (for approved rental car only). Any other expenses under $75.00 do not require receipts. The OWCP-957 form includes an instruction sheet; however, I would like to provide you with some additional information to help you with your reimbursement request:

M&IE: Itemization of expenses and submission of receipts is ***not*** required for meals and incidental expenses (MIE). The MIE expenses are reimbursed as a fixed-rate, daily allowance, regardless of what you actually spend, and are determined by the Government Services Administration (GSA) published rate for the geographic location of your stay on any given day.

By GSA rule, reimbursement for the first and last days of travel is 75% of the daily fixed-rate for MIE.

Lodging: Daily lodging rates are also based on applicable GSA rates for the location of your stay and may change due to seasonal fluctuations so be sure to check the current rates. State and local lodging taxes are not included in the daily lodging rate and will be reimbursed separately. All receipts must be submitted.

Rental Car: When a rental car has been approved, reimbursement will be based upon an economy-sized vehicle, unless otherwise approved. Gasoline purchases for the rental car are reimbursable. All receipts must be submitted.

Airfare: Airfare reimbursement will be based upon the actual cost incurred, but not to exceed the cost of a refundable coach or economy class fare (Y-Class airfare). All receipts must be submitted.

GSA Rates: The daily allowances for MIE and lodging are determined by GSA, for specific cities and geographic areas around the country, and they vary by region. These rates are revised occasionally by GSA. For more information on these GSA-published rates, please visit the GSA Website at: www.gsa.gov ; or contact your nearest resource center for assistance.

Where to Send Your Reimbursement Forms: Send a copy of this authorization letter, along with your itemized Form OWCP-957, along with any required receipts, to our bill processing agent. For your convenience, I have enclosed a pre-paid envelope and an extra copy of this authorization letter. Please send your information to:

(Insert Name and Address of the DEEOIC Bill Processing Agent)

Where to go for Help: For assistance in completing your travel reimbursement form, or in determining applicable MIE and lodging rates, or if you need other assistance related to this travel authorization or reimbursement process, please contact your nearest DEEOIC Resource Center, or call me. Below is the address of your nearest Resource Center.

Insert complete RC address
Telephone Number

Additional information and forms are also available on our website at: https://www.dol.gov/owcp/energy/. Please have a safe trip and let me know if you have any other concerns that are not addressed in this letter.

I can be reached, toll free, at: (Insert toll free number).

Sincerely,

John Doe
Claims Examiner

Enc: OWCP-957 (2 blank forms)
Prepaid envelope addressed to bill processing agent
Copy of Authorization Letter (2 copies)