U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 10.1:

EEOICPA TRANSMITTAL NO. 26-02 September 21, 2026

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this Transmittal to notify staff of the publication of Federal (EEOICPA) Procedure Manual (PM) Version 10.1 (v10.1), which replaces PM v10, effective the date of publication of this Transmittal. Following are the content edits that make up PM v10.1:

- **Chapter 13 – Establishing Covered Employment**

  - Ch. 13.10 has been updated to include the new telephone number for the Social Security Administration (SSA). The language in v10 previously read:

    (7) Inquiries to the SSA are made by calling one of six phone numbers (Modules) depending upon the last four digits of the relevant SSN (see Exhibit 13-1). When calling the SSA, the following information should be available to expedite the inquiry:

    It has been updated in v.10.1 to:

    (7) Inquiries to the SSA are made by calling 1-855-953-8737. When calling the SSA, the following information should be available to expedite the inquiry:

  - In conjunction with the above change, Exhibit 13-1: SSA Contact Numbers, has been removed and the lone remaining exhibit of Chapter 13 has been renumbered accordingly.

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**

  - Ch. 15.8f has been edited to include additional guidance regarding the Direct Disease Link Work Process (DDLWP). The language in v10 previously read:

    f. Direct Disease Linked Work Processes (DDLWP). DDLWP's are links based on scientific literature examining certain job processes associated with certain occupational diseases. The DDLWP's allow the CE to refer cases to a physician without IH review.

    (1) The CE searches SEM as discussed above. DDLWP's will be identified in the "Processes/Activities performed by this labor category" and will

include red text indicating "this work process has direct disease linkages."

(2) The CE reviews the file for reasonable and compelling evidence that indicates the employee performed one of the tasks in the DDLWP. Not all employees in a labor category would have performed all the work processes associated with that labor category.

(3) If the DDLWP is identified in the facility search and the employee performed the DDLWP, the CE can make a factual finding for exposure. Information about the work process, including the period of time that the employee performed the work process, can serve as the basis to obtain a medical opinion for causation without an IH review. For example, a pipefitter was employed at the Y-12 Plant and is diagnosed with COPD. The evidence confirms the employee engaged in the work process of "arc weld stainless steel" during this employment from 1962 – 1975.

(4) Once the CE determines that one or more DDLWP's are appropriate, the CE images the SEM pages that established the link into OIS. The CE also returns to the main menu in SEM and selects the DDLWP's that resulted from the site-specific or "Construction (all sites)" searches. The CE images these pages to document the underlying toxins and scientific references. From the example above, the pipefitter's underlying toxins due to "arc weld stainless steel" would have been stainless steel, stainless steels-precipitation hardenable, and welding fumes.

(5) The CE utilizes the above information in obtaining an opinion from the treating physician. If the treating physician is not a viable option, the CE prepares a referral to a CMC.

It has been updated in v.10.1 to:

f. Direct Disease Linked Work Processes (DDLWP). DDLWP's are links based on scientific literature examining certain job processes associated with certain occupational diseases.

(1) The CE searches SEM as discussed above. DDLWP's will be identified in the "Processes/Activities performed by this labor category" and will include red text indicating "this work process has direct disease linkages."

(2) The CE reviews the file for reasonable and compelling evidence that indicates the employee performed one of the tasks in the DDLWP. Not all employees in a labor category would have performed all the work processes associated with that labor category.

(3) If the DDLWP is identified in the facility search and the employee performed the DDLWP, the CE can make a factual finding that the employee's job encompassed some level of exposure to the identified toxin(s), which-serves as the basis to obtain an IH assessment regarding the nature, frequency and duration of the employee's exposure. For example, a pipefitter was employed at the Y-12 Plant and is diagnosed with COPD. The evidence confirms the employee engaged in the work process of "arc weld stainless steel" during this employment from 1962 – 1975.

(4) Once the CE determines that one or more DDLWP's are appropriate, the CE images the SEM pages that established the link into OIS. The CE also returns to the main menu in SEM and selects the DDLWP's that resulted from the site-specific or "Construction (all sites)" searches. The CE images these pages to document the underlying toxins and scientific references. From the example above, the pipefitter's underlying toxins due to "arc weld stainless steel" would have been stainless steel, stainless steels-precipitation hardenable, and welding fumes.

(5) The CE utilizes the above information in obtaining an opinion from the IH and includes information on the DDLWPs in the Exposure Worksheet (see Exhibit 15-2). The CE then supplies the IH assessment to the treating physician for consideration. If the treating physician is not a viable option, the CE prepares a referral to a CMC.

- Ch. 15.11e has been modified to reflect updated classifications of toxic substance exposure levels. The language in v10 previously read:

e. Exposure levels used by the IH. DEEOIC IH staff will explain their analysis of the available evidence about the employee to assign a characterization of exposure for each targeted toxic substance. The IH will assign a level of employee exposure to each toxic substance as incidental, significant, or more than incidental exposure but less than significant.

(1) Incidental. Incidental exposure means the lowest reasonable level of contact with a toxic substance absent a finding of no exposure. An incidental exposure is one that occurs on an intermittent, infrequent basis, usually without a connection to the normal function of a particular job or work process. The IH will generally describe the exposure as occurring "in passing only."

(2) Significant. A significant exposure is one that occurs at some interval of routine frequency and intensity associated with the work performed by the employee. Based upon the agent under consideration, such exposures may have occurred by inhalation, ingestion, or absorption. The IH categorizes significant exposure further as high, moderate, or low on a case-by-case

basis after reviewing evidence available about the employee. In categorizing the level of exposure, the IH considers and weighs numerous factors including the following:

(a) The employee's labor classification and type of work performed; the presence or absence of exposure monitoring data; frequency of work activities or functions performed; proximity of exposure;

(b) Temporal knowledge (historical information about workplace conditions); the use of personal protective equipment, or the likelihood that workplace controls or mitigation strategies were in place to reduce (not remove) health risks. After considering all these factors or any other available exposure data available about the employee, the IH applies their professional knowledge and judgment to assign a level of significance.

(3) More than incidental, but less than significant. In some instances, employees may be exposed in such a manner that the IH characterizes the exposure as occurring at more than an incidental level but not rising to the level of significant. This categorization applies to situations where the IH interprets the evidence in such a way as to conclude that the employee performed duties in a manner where contact with a toxic substance may have occurred. However, the evidence also documents that the employee's work occurred without any indication of workplace exposure violation or incident, the claimant has provided no substantive evidence of significant exposure, or the totality of evidence provides documentation of proper safety mitigation parameters (e.g., use of personal protective equipment).

It has been updated in v.10.1 to:

e. Exposure levels used by the IH. DEEOIC IH staff will explain their analysis of the available evidence about the employee to assign a characterization of exposure for each targeted toxic substance. The IH will assign a level of employee exposure to each toxic substance as negligible, very low, low, moderate, or high.

(1) Negligible: Negligible exposure refers to a level of exposure to a toxic substance that is so low it poses no appreciable risk to worker health or safety. A negligible exposure is one that is well-controlled and usually occurs on an intermittent, infrequent basis. The IH will generally describe the exposure as occurring "in passing only."

(2) A very low, low, moderate, or high exposure is one that occurs at some interval of routine frequency and intensity associated with the work performed by the employee. Based upon the agent under consideration, such exposures may have occurred by inhalation, ingestion, or absorption. The IH categorizes exposure that is above negligible as high, moderate,

low, or very low, on a case-by-case basis after reviewing evidence available about the employee. In categorizing the level of exposure, the IH considers and weighs numerous factors including the following:

(a) The employee's labor classification and type of work performed; the presence or absence of exposure monitoring data; frequency of work activities or functions performed; proximity of exposure;

(b) Temporal knowledge (historical information about workplace conditions); the use of personal protective equipment, or the likelihood that workplace controls or mitigation strategies were in place to reduce (not remove) health risks. After considering all these factors or any other available exposure data available about the employee, the IH applies their professional knowledge and judgment to assign a level of exposure as very low, low, moderate, or high.

(c) Exhibit 15-4 includes presumptive causation standards for several commonly claimed medical conditions. Generally, a "greater than negligible" exposure (or higher), as determined either by an IH assessment or through application of the exposure presumptions, is sufficient to meet the exposure component of any causative presumption listed in Exhibit 15-4. However, as indicated in the Exhibit, additional criteria also need to be satisfied in order for a claim to qualify for a presumptive causation standard, including but not limited to length of exposure, diagnostic evidence, latency, employment criteria (site/length of employment/position), etc.

- Ch. 15.12 has been edited to include further instructions for handling of claims for cancerous conditions with a Probability of Causation (PoC) under 50%. The language in v10 previously read:

12. <u>Radiation Exposure and NO HP Review</u>. Radiation is a toxic substance under Part E. Dose reconstruction analysis performed by the NIOSH, or the expertise of the HP may be necessary in the development of exposure and causation for a Part E claim.

a. Cancerous conditions. The effect of radiation in establishing a diagnosed cancer, as a covered Part E illness, requires the application of the PoC calculation derived from a NIOSH dose reconstruction.

(1) The CE will develop other non-radioactive toxic exposures while waiting for the dose reconstruction. If this development results in a positive outcome, the CE will accept the cancer claim under Part E without waiting for the dose reconstruction.

(2) If the claim does not result in a positive outcome and the dose reconstruction has not been received, the CE completes a memo to file. The memo explains toxic development is complete, but a decision cannot be issued until the dose reconstruction has been received so radiation exposure can be considered when issuing the decision. If the case involves multiple claimed conditions, the memo is not completed until all toxic development has been completed for all open conditions. This is important since the memo signifies no other development is required and no affirmative decisions can be issued based on the current evidence. The CE images the memo into OIS and enters the appropriate correspondence code into ECS.

b. Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH but will need a review by the NO HP to estimate the extent of occupational exposure to radiation to the effected organ or body part.

(1) Submission of HP referral. The CE prepares a referral package of documents for the HP to assess the likely extent of occupational radiation sustained by the employee. The CE is to prepare a SOAF along with a request for the HP to characterize the level of occupational radiation exposure incurred by the employee that relates to the claimed, diagnosed non-cancer condition. Attached to the SOAF, the CE includes a copy of available radiation exposure records (radiological or dose records) and copies of other pertinent records, including Form EE-3; OHQ; relevant DAR records, such as job/work process description data; records providing a description of work area or location; employee-completed letters about radiation exposure or work duties; affidavits, or other similar documents completed by other sources; any email traffic or documented phone calls between the CE and HP regarding the claim; and any narrative medical letters prepared by a physician that opine as to a potential linkage between the claimed condition and occupational radiation exposure. The CE will transmit the completed referral package to the designated POC within the Technical Procedures Branch in accordance with internal guidance. The CE images the referral package into OIS.

(2) HP response. Once a referral is received, the Technical Procedures Branch POC assigns the question to the HP. The HP prepares a formal written response that describes their review of available evidence and applies their subject matter expertise to communicate a well-rationalized opinion characterizing the likely extent of occupational exposure to radiation incurred by the

employee during covered employment. The HP will characterize the exposure to the effected organ, organ system, or body part relating to the non-cancer condition(s) under review. If the diagnosis date is prior to the end of the covered employment, the HP's radiation dose estimate will run through the date of diagnosis as opposed to running through the employment end date. The role of the HP is to characterize the extent of occupational radiation exposure, not to communicate any position about the causal nexus between the extent of estimated occupational radiation exposure and the claimed condition serving as the basis for the referral.

(3) Upon receipt of the completed HP radiation dose estimate, the CE images the response into OIS. The CE must then use the estimate to obtain a well-rationalized opinion from a qualified physician about causal relationship. Per staff procedure, the CE will initially provide the HP dose estimate to the claimant's chosen physician and request a well-rationalized opinion about whether the extent of occupational radiation exposure was at least as likely as not a significant factor in causing, contributing to, or aggravating the claimed non-cancer condition. In the absence of a response, or receipt of an opinion that the CE cannot weigh as being well-rationalized, the CE must forward the matter to a CMC for review.

It has been updated in v.10.1 to:

12. Radiation Exposure Under Part E and HP Review. Radiation is a toxic substance under Part E. Dose reconstruction analysis performed by the NIOSH, or the expertise of the HP may be necessary in the development of exposure and causation for a Part E claim.

a. Cancerous conditions. The effect of radiation in establishing a diagnosed cancer, as a covered Part E illness, requires the application of the PoC calculation derived from a NIOSH dose reconstruction.

(1) The CE will develop other non-radioactive toxic exposures while waiting for the dose reconstruction. If this development results in a positive outcome, the CE will accept the cancer claim under Part E without waiting for the dose reconstruction.

(2) If the claim does not result in a positive outcome and the dose reconstruction has not been received, the CE completes a memo to file. The memo explains toxic development is complete, but a decision cannot be issued until the dose reconstruction has been received so radiation exposure can be considered when issuing the decision. If the case involves multiple claimed conditions, the

memo is not completed until all toxic development has been completed for all open conditions. This is important since the memo signifies no other development is required and no affirmative decisions can be issued based on the current evidence. The CE images the memo into OIS and enters the appropriate correspondence code into ECS.

(3) Upon receipt of a dose reconstruction report with a PoC less than 50%, the CE continues with establishing causation, aggravation, and/or contribution in accordance with Chapter 15.13.

b. Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH but will need a review by an HP to estimate the extent of occupational exposure to radiation to the effected organ or body part.

(1) Submission of HP referral. The CE prepares a referral package of documents for the HP to assess the likely extent of occupational radiation sustained by the employee. The CE is to prepare a SOAF along with a request for the HP to characterize the level of occupational radiation exposure incurred by the employee that relates to the claimed, diagnosed non-cancer condition. Attached to the SOAF, the CE includes a copy of available radiation exposure records (radiological or dose records) and copies of other pertinent records, including Form EE-3; OHQ; relevant DAR records, such as job/work process description data; records providing a description of work area or location; employee-completed letters about radiation exposure or work duties; affidavits, or other similar documents completed by other sources; any email traffic or documented phone calls between the CE and HP regarding the claim; and any narrative medical letters prepared by a physician that opine as to a potential linkage between the claimed condition and occupational radiation exposure. The CE will transmit the completed referral package to the designated POC within the Technical Procedures Branch in accordance with internal guidance. The CE images the referral package into OIS.

(2) HP response. Once a referral is received, the Technical Procedures Branch POC assigns the question to the HP. The HP prepares a formal written response that describes their review of available evidence and applies their subject matter expertise to communicate a well-rationalized opinion characterizing the likely extent of occupational exposure to radiation incurred by the employee during covered employment. The HP will characterize the exposure to the effected organ, organ system, or body part

relating to the non-cancer condition(s) under review. If the diagnosis date is prior to the end of the covered employment, the HP's radiation dose estimate will run through the date of diagnosis as opposed to running through the employment end date. The role of the HP is to characterize the extent of occupational radiation exposure, not to communicate any position about the causal nexus between the extent of estimated occupational radiation exposure and the claimed condition serving as the basis for the referral.

(3) Upon receipt of the completed HP radiation dose estimate, the CE images the response into OIS. The CE must then use the estimate to obtain a well-rationalized opinion from a qualified physician about causal relationship. Per staff procedure, the CE will initially provide the HP dose estimate to the claimant's chosen physician and request a well-rationalized opinion about whether the extent of occupational radiation exposure was at least as likely as not a significant factor in causing, contributing to, or aggravating the claimed non-cancer condition. In the absence of a response, or receipt of an opinion that the CE cannot weigh as being well-rationalized, the CE may forward the matter to a CMC for review.

- Ch. 15.13 has also been edited to, in addition to causation, also discuss aggravation and contribution. The language in v10 previously read:

13. <u>Establishing Causation</u>. Causation is a medical determination that a qualified physician must make regarding whether or not a condition is related to covered employment and exposure to a toxic substance. The standard for establishing causation is "it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness." The CE considers the following when reviewing evidence and developing causation.

a. Part B acceptance. Causation under Part E may be established by an acceptance under Part B. Based on this acceptance, exposure and causation are presumed to already exist. However, the claim must also meet the employment and/or survivor-related eligibility requirements when applicable.

b. Physician's opinion. Unless specified in other programmatic guidance, such as the presumptions listed in the appendix of this chapter, DEEOIC requires a medical opinion on causation from a qualified physician. A claimant may choose to have his or her physician opine on the causal relationship between an exposure to a toxic substance and a diagnosed medical condition. Absent a physician chosen by the claimant to offer an opinion on causation, the CE may utilize the services of a CMC. A causation opinion presented from a qualified physician, including a CMC,

must be well rationalized for a CE to accept as the basis for claim adjudication. As is explained in Chapter 16 - Developing and Weighing Medical Evidence, a "rationalized" opinion means that the statement of the physician is supported by an explanation of how his or her conclusions are reached, including reference to appropriate medical health science literature. Under Part E, a physician may opine on topics for which DEEOIC has not made a finding of a link between exposure and disease, but in so opining a physician must communicate his or her understanding of the different factors considered that justify a particular opinion regarding causation, including providing a scientific basis upon which to base such an opinion. Specifically, a well-rationalized causation opinion from a qualified physician is one that communicates an accurate understanding of an employee's toxic substance exposure; discusses an employee's medical history and pertinent diagnostic evidence; and applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused, or aggravated the employee's claimed condition.

Conversely, a physician's opinion that relies on inaccurate factual findings, especially speculative exposures not supported by the evidence, or opinions that are formed independent of any creditable, substantive medical health science data cannot be considered well-rationalized. The mere presentation of a positive causation opinion from a physician, without any well-rationalized justification, or one that is based upon speculative exposures is not sufficient for establishing a compensable Part E claim.

(1) In these situations, the CE is to provide the physician with any employment or scientific evidence that DEEOIC has obtained to establish an accurate factual presentation of exposure; including exposure analysis worksheets, affirmative SEM search outputs, epidemiological data, or IH assessments.

c. Causation presumptions and development for certain conditions. Certain conditions are associated with certain toxic substances. These links may involve certain labor categories, work processes, timeframes, and/or latency periods. Exhibit 15-4 includes both exposure presumptions, as mentioned earlier, and causation presumptions. This Exhibit incorporates prior DEEOIC guidance from the PM, Bulletins and Circulars which have been amalgamated and summarized into Exhibit 15-4. It is anticipated that this exhibit will be updated as new guidance is developed.

(1) Causation Presumptions. A physician's opinion is not necessary for all identified conditions. The CE reviews the evidence of file

against the specific criteria listed for the specified condition. If the case meets each criterion, the CE may accept the claim.

(2) Development for certain conditions. The Exhibit also assists the CE with causation development and guides the CE on possible circumstances that may result in a positive outcome. A physician's opinion may still be necessary. The guidance in the Exhibit does not represent the only scenarios that may exist to accept a claim. The CE may accept a claim that presents with other fact patterns for the conditions and/or exposures listed.

d. Insufficient evidence to support claim. If the CE is unable to establish causation, the CE provides the claimant with an opportunity to submit additional evidence.

e. Survivorship Part E cases. For Part E cases in which the employee is deceased, guidance is provided in Chapter 20 - Establishing Survivorship.

It has been updated in v.10.1 to:

13. <u>Establishing Causation/Aggravation/Contribution</u>. Causation, aggravation, and contribution are medical determinations that a qualified physician must make regarding whether or not a condition is related to covered employment and exposure to a toxic substance. The standard for establishing causation is "it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness." The CE considers the following when reviewing evidence and developing causation.

a. Part B acceptance. Causation under Part E may be established by an acceptance under Part B. Based on this acceptance, exposure and causation are presumed to already exist. However, the claim must also meet the employment and/or survivor-related eligibility requirements when applicable.

b. Physician's opinion. Unless specified in other programmatic guidance, such as the presumptions listed in the appendix of this chapter, DEEOIC requires a medical opinion on causation, aggravation, and contribution from a qualified physician. A claimant may choose to have his or her physician opine on the relationship between an exposure to a toxic substance and a diagnosed medical condition. Absent a physician chosen by the claimant to offer an opinion, the CE may utilize the services of a CMC. An opinion presented from a qualified physician, including a CMC, must be well rationalized for a CE to accept as the basis for claim adjudication. As is explained in Chapter 16 - Developing and Weighing Medical Evidence, a "rationalized" opinion means that the statement of the physician is supported by an explanation of how his or her conclusions

are reached, including reference to appropriate medical health science literature. Under Part E, a physician may opine on topics for which DEEOIC has not made a finding of a link between exposure and disease, but in so opining a physician must communicate his or her understanding of the different factors considered that justify a particular opinion regarding causation, including providing a scientific basis upon which to base such an opinion. Specifically, a well-rationalized causation opinion from a qualified physician is one that communicates an accurate understanding of an employee's toxic substance exposure; discusses an employee's medical history and pertinent diagnostic evidence; and applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused, or aggravated the employee's claimed condition.

Conversely, a physician's opinion that relies on inaccurate factual findings, especially speculative exposures not supported by the evidence, or opinions that are formed independent of any creditable, substantive medical health science data cannot be considered well-rationalized. The mere presentation of a positive causation opinion from a physician, without any well-rationalized justification, or one that is based upon speculative exposures is not sufficient for establishing a compensable Part E claim.

(1) In these situations, the CE is to provide the physician with any employment or scientific evidence that DEEOIC has obtained to establish an accurate factual presentation of exposure; including exposure analysis worksheets, affirmative SEM search outputs, epidemiological data, NIOSH'S Dose reconstruction report, or IH assessments.

c. Causation presumptions and development for certain conditions. Certain conditions are associated with certain toxic substances. These links may involve certain labor categories, work processes, timeframes, and/or latency periods. Exhibit 15-4 includes both exposure presumptions, as mentioned earlier, and causation presumptions. This Exhibit incorporates prior DEEOIC guidance from the PM, Bulletins and Circulars which have been amalgamated and summarized into Exhibit 15-4. It is anticipated that this exhibit will be updated as new guidance is developed.

(1) Causation Presumptions. A physician's opinion is not necessary for all identified conditions. The CE reviews the evidence of file against the specific criteria listed for the specified condition. If the case meets each criterion, the CE may accept the claim.

(2) Development for certain conditions. The Exhibit also assists the CE with causation development and guides the CE on possible circumstances that may result in a positive outcome. A physician's opinion may still be necessary. The guidance in the Exhibit does not represent the only scenarios that may exist to accept a claim. The CE may accept a claim that presents with other fact patterns for the conditions and/or exposures listed.

d. Insufficient evidence to support claim. If the CE is unable to establish causation, the CE provides the claimant with an opportunity to submit additional evidence.

e. Survivorship Part E cases. For Part E cases in which the employee is deceased, guidance is provided in Chapter 20 - Establishing Survivorship.

- Exhibit 15-2, Exposure Worksheet & Instructions, and Exhibit 15-5, Industrial Hygiene Referral Form & Instructions (v10) have been replaced by a new Exhibit 15-2 (v10.1) that combines these two former exhibits into one document, that includes the IH Referral Form, Tabular Questions, Exposure Worksheet, and their instructions. This new exhibit also allows for autofill of the IH Question Tables and Exposure Worksheet and provides increased clarity as to the information that should be provided to the IH with each referral.

- Exhibit 15-4 has been updated to reflect toxic substance exposure level classifications.

- **Chapter 17 – Development of Radiogenic Cancer Claims**

  - Ch. 17.7d has been updated to reflect the current National Institute for Occupational Safety and Health (NIOSH) referral process. In conjunction with this change, Ch. 17.8 has been removed, and the remaining sections of Chapter 17 affected by this change have been renumbered accordingly. The language in v10 previously read:

    d. Referring Case Records to NIOSH. As part of the dose reconstruction process, NIOSH must review certain employees' medical and employment records. All findings made by the CE must be supported by the evidence in the file and documented in the NRSD. When referring cases to NIOSH for a dose reconstruction, the entire case file is electronically transmitted to NIOSH via the Secure Access Management Service (SAMS). Upon receipt, NIOSH sends the DO an electronic confirmation of receipt for each NIOSH referral received via the SAMS portal.

    (1) Schedule. Each DO typically send cases on designated days based on the following weekly schedule:

    Tuesday: Jacksonville
    Wednesday: Cleveland

Thursday: Denver
Friday: Seattle

Occasionally, a terminal claim or a high volume of claims will necessitate the submission of additional NIOSH referrals outside of the schedule noted above.

(2) Following the receipt of the confirmation emails from NIOSH, the DO prepares a manifest of cases and the type of referrals (initial, amended, or supplemental) electronically transmitted that day to NIOSH. The manifest is uploaded to the SAMS portal in the same manner the NIOSH referrals were submitted. NIOSH uses this manifest to reconcile the receipt of each referral submitted via the SAMS portal. For any claims submitted outside of the schedule noted above, a new manifest is prepared and submitted electronically via the SAMS portal for NIOSH reconciliation purposes.

(3) The CE advises the claimant in writing that he or she has sent the case to NIOSH for dose reconstruction (Exhibit 17-3).

It has been updated in v.10.1 to:

d. Referring Case Records to NIOSH. As part of the dose reconstruction process, NIOSH must review certain employees' medical and employment records. All findings made by the CE must be supported by the evidence in the file and documented in the NRSD. When referring cases to NIOSH for a dose reconstruction or an amended or supplemental NRSD, the CE drafts an email to NFO.DEEOIC.NIOSH.REFERRALS@DOL.GOV, copying their supervisor, and attaching a copy of the NRSD. The email subject line should read "NIOSH Referral Case ID XXXX." In the body of the email the CE must include the following information:

Case ID:
Last 4 of SSN:
NIOSH ID (if applicable):
Claimant's Name(s):
Type of Referral: (Initial, Amended, Supplemental, or RECA, if applicable)
Date Range of Records (Amended or Supplemental only):

(1) Contract staff will collect and monitor the emails sent to the above-referenced mailbox, with oversight from designated National Field Operations (NFO) staff. Each day, the contract staff downloads the relevant documents specified in the email (e.g., date range of referral), consolidates them into a single PDF file, and uploads the file to NIOSH via the Centers for Disease Control and Prevention (CDC) Secure Access Management Services (SAMS) portal. The contract staff will record all

NIOSH referrals into a consolidated manifest and each day upload the manifest to SAMS.

(2) Upon receipt of the daily manifest, NIOSH will confirm the Case IDs listed on the manifest match the NRSDs uploaded by the contract staff. If no discrepancies are found, NIOSH will notify DOL by email to NFO.DEEOIC.NIOSH.INQUIRIES@DOL.GOV, using the subject line: "Manifest Confirmation, MM/DD/YYYY." If discrepancies are identified, NIOSH will send an email to the same Inquiries mailbox with the subject line: "Manifest Inquiry, MM/DD/YYYY." In either instance, the date included in the subject line of the email will correspond to the date the manifest was sent to NIOSH. The mailbox is monitored by designated staff, who archive responses from NIOSH that confirm there are no discrepancies in the manifest. The designated staff will review emails from NIOSH regarding inquiries, which may involve manifest discrepancies or other issues identified during the dose reconstruction.

(a) For manifest-related inquiries, the designated staff will investigate and resolve the discrepancy, and work with contract staff, as appropriate.

(b) For other inquiries: The designated staff will forward the inquiry to the assigned CE and copy the CE's manager. The CE will image the email from NIOSH into OIS. The CE will respond to NIOSH via email, with a courtesy copy to their manager, and image a copy of the response into OIS. Unit managers monitor inquiries to ensure CE's respond to NIOSH within three business days.

(3) The CE advises the claimant in writing that he or she has sent the case to NIOSH for dose reconstruction (Exhibit 17-3).

- Ch. 17.10b has also been updated based on the current NIOSH process. The language in v10 previously read:

b. NIOSH CD or Electronic Record. When NIOSH returns a dose reconstruction to DEEOIC, NIOSH will forward all case file documents via CD or as an electronic record, since NIOSH optically scans all documents referred to it for use in performing the dose reconstruction. The CD or electronic record will include the dose reconstruction input file (Excel spreadsheet) used for calculating the IREP PoC. The CE bronzes into OIS or includes as a permanent record of the case file any record received from NIOSH as part of the dose reconstruction process.

(1) Information contained on the NIOSH CD or electronic record will include:

(a) Dose reconstruction files; Computer Assisted Telephone Interview (CATI); dosimetry data; the NIOSH Report of Dose Reconstruction under EEOICPA; NIOSH's PoC calculation; Form OCAS-1; the NIOSH-IREP input file; and pertinent AEC/DOE reports, journal articles or other documents.

(b) Correspondence, including NIOSH letters to claimants, phone conversation notes, and e-mails.

(c) DOE files (data files listed in order of importance on the CD), including DOE dose and work history information and other DOE documents that NIOSH requested, such as incident reports and special studies.

(d) DOL files, including a copy of the case file optically imaged by NIOSH and the OCAS tracking sheets (signatures and dates).

(2) NIOSH will incorporate information from the above sources into the dose reconstruction report. Publicly available documents will be referenced by citation. NIOSH will add documents not publicly available in the record and as noted above, will be included on the CD or as part of the electronic record transferred to DEEOIC.

(3) The CE need not review all of the documents on the CD or electronic record. Those documents that normally will not require review include the DOE documents, the claimant interview, and the NIOSH-conducted closing interview. The CE must always run the IREP separately.

It has been updated in v.10.1 to:

b. Return of Dose Reconstruction from NIOSH. When NIOSH returns a dose reconstruction to DEEOIC, NIOSH will upload the responsive documents to the SAMS portal. This action triggers an email notification to designated contract staff, who then image the incoming dose reconstruction documents into OIS. The imaging of these documents into OIS automatically generates an ECS notification to the assigned CE, who is then responsible for completing all appropriate coding within ECS. The electronic record will include the dose reconstruction input used for calculating the IREP PoC. The CE bronzes into OIS or includes as a permanent record of the case file any record received from NIOSH as part of the dose reconstruction process.

(1) Information contained in the electronic record will include:

(a) Dose reconstruction files; Computer Assisted Telephone Interview (CATI); dosimetry data; the NIOSH Report of Dose Reconstruction under EEOICPA; NIOSH's PoC calculation; Form OCAS-1; the

NIOSH-IREP input file; and pertinent AEC/DOE reports, journal articles or other documents.

(b) Correspondence, including NIOSH letters to claimants, phone conversation notes, and e-mails.

(c) DOE files, including DOE dose and work history information and other DOE documents that NIOSH requested, such as incident reports and special studies; as well as a copy of the case file optically imaged by NIOSH and the OCAS tracking sheets (signatures and dates).

(2) NIOSH will incorporate information from the above sources into the dose reconstruction report. Publicly available documents will be referenced by citation. NIOSH will add documents not publicly available in the record and as noted above, will be included on the CD or as part of the electronic record transferred to DEEOIC.

(3) The CE need not review all of the documents on the CD or electronic record. Those documents that normally will not require review include the DOE documents, the claimant interview, and the NIOSH-conducted closing interview. The CE must always run the IREP separately.

- Ch. 17.12d-f have also been updated based on the current NIOSH process. The language in v10 previously read:

d. The DEEOIC HP serves as the central liaison between NIOSH and DOL on all issues related to dose reconstruction. If the SCE or CES agrees with the CE's findings regarding rework, he or she forwards the CE's e-mail along with the amended NRSD to the DO NIOSH liaison. In turn, the DO NIOSH liaison sends the request along with the amended NRSD to the DEEOIC HP and copies the SCE or CES, and DD. For instances where the CE determines that a rework request does not need to be forwarded to the DEEOIC HP (e.g., non-compensable claim with an accepted cancer not included in the dose reconstruction), the CE is to forward the rework request directly to NIOSH.

(1) The DEEOIC HP reviews the request for rework and determines whether a rework is required.

(2) If the DEEOIC HP needs additional information to make a determination, which may include requesting the case file, he or she contacts the CE.

e. Rework Not Needed. If the DEEOIC HP determines that the submitted information does not change the outcome of the dose reconstruction, he or she sends an e-mail to the DO NIOSH liaison, with a copy to the CE, or SCE, and

DD, explaining the rationale for not continuing the review of the dose reconstruction. When the CE receives this response, he or she ensures the response is entered into ECS and proceeds with the IREP calculation.

(1) Updating Records. The CE is responsible for documenting any change to the case records in OIS. This is true regardless of whether the CE submits the case for a rework review by the DEEOIC HP. The CE is to always document, with memos to file, any analysis that applies to assessing the sufficiency of a dose reconstruction, along with the guidelines used to make that determination.
When the DO makes changes to information used in the NIOSH dose reconstruction, and no rework is required, the DO NIOSH liaison or other designated person sends an e-mail to the appropriate NIOSH PHA. This e-mail indicates what information changed, such as the diagnosis code, cancer name, employment dates, etc.

This allows NIOSH to update its records for the case, which is most critical with respect to changes involving diagnosis codes and PoC values different from those initially generated by the dose reconstruction. Forwarding these changes also allows NIOSH to compile accurate statistics on the types of cancers addressed in EEOICPA decisions that required a NIOSH dose reconstruction.

If a CE performs a new PoC calculation using new information without the need for rework, the DO NIOSH liaison must advise the NIOSH PHA via e-mail and attach the new IREP summary file. For example, in a case with an initial PoC less than 45%, the DEEOIC HP determined that a change in the diagnosis code did not require a rework of the dose reconstruction, but just a different NIOSH-IREP model run. If the new IREP run resulted in a PoC less than 45%, the CE uses the new IREP run and PoC as the value for the dose reconstruction but must advise NIOSH as noted above.

(2) Any future dose reconstruction rework based on additional verified cancer(s) or employment is performed by NIOSH using only DOL-verified information, which may be more restrictive than information used in the previous dose reconstruction (i.e., in some likely non-compensable cases, NIOSH may assume a continuous employment period rather than considering numerous breaks in employment for the purpose of completing a dose reconstruction in a timely manner). Therefore, it is possible in some cases for the subsequent PoC to remain the same, increase only slightly, or even decrease to some degree if the dose reconstruction is reworked in the future.

f. Employment Changes Rework.

(1) If the PoC is 50% or greater and the CE identifies additional DOL-verified employment, a rework is not required.

(2) If the PoC is 50% or greater and the DOL-verified employment is found to be less than that used in the dose reconstruction, the CE submits a request for rework to the DEEOIC HP for review and includes an electronic copy of the dose reconstruction report.

(3) If the PoC is between 40% and 49.99%, and the CE identifies additional DOL-verified employment, the CE submits a request for rework to the DEEOIC HP for review and includes an electronic copy of the dose reconstruction report.

(4) If the PoC is less than 40%, and additional DOL-verified employment is identified:

(a) If all the additional employment falls within the same calendar year and the year is addressed in the dose reconstruction, a rework is not required.

(b) If the additional employment extends into or is wholly within another calendar year not addressed in the dose reconstruction, the CE submits a rework request to the NIOSH.

(5) Some dose reconstructions contain more employment than originally verified by DOL in the NRSD. NIOSH may have DOE dosimetry or employment records for periods not identified by DOL, or the dose reconstruction may use a continuous period rather than considering numerous breaks in employment.

(a) If the case is likely non-compensable, NIOSH may add the additional time period to the DOL-verified employment for the purpose of completing a dose reconstruction (unless it is military, navy nuclear, or non-DOE federal service) in a timely manner.

(b) If the PoC is less than 50% and the dose reconstruction contains employment added by NIOSH, a rework is not required. However, the CE must write a memo to file that DOL did not verify part of the employment period assumed by NIOSH, but that the employment period was assumed correct for completing the dose reconstruction in a timely manner.

Should new information arise to warrant performing the dose reconstruction again (e.g., additional cancer diagnosis, additional employment at another site), only employment verified by DOL will be used, which may be more restrictive than that allowed in the

current dose reconstruction. The CE ensures that he or she includes an explanation of this as part of the narrative analysis included in any forthcoming RD.

If NIOSH has added employment to a claim that is likely compensable, NIOSH contacts the CE with the additional employment information for DOL review and verification. After verification, the CE submits an amended NRSD listing all accepted employment to NIOSH.

(c) If the PoC is 50% or greater and the dose reconstruction contains employment added by NIOSH but not approved by the DO, the CE submits a rework request to the DEEOIC HP.

(6) If a CE identifies military, navy nuclear, or non-DOE federal service employment referenced in the dose reconstruction, the CE submits a rework request to the DEEOIC HP because this may mean that covered employment is not established.

(7) For any PoC, if the CE identifies changes to the employment site(s), the CE submits a rework request to the DEEOIC HP because this may alter the applicable site profile used in assessing occupational radiation exposure.

(8) When a rework is not required, the CE documents the changes to the employment in a memo to file and ensures that the difference(s) between the employment used in the dose reconstruction compared to the DOL-verified employment is noted in the RD. Finally, the CE notifies the NIOSH PHA of the change(s) in employment so NIOSH can update its records.

It has been updated in v.10.1 to:

d. The DEEOIC National Office serves as the central liaison between NIOSH and DOL on all issues related to dose reconstruction. If the SCE or CES agrees with the CE's findings regarding rework, he or she forwards the CE's e-mail along with the amended NRSD to the National Office. In turn, a National Office staff member sends the request, along with the amended NRSD, to the contracted Health Physicist (HP) and copies the SCE or CES, and DD. For instances where the CE determines that a rework request does not need to be forwarded to the HP (e.g., non-compensable claim with an accepted cancer not included in the dose reconstruction), the CE is to forward the rework request directly to NIOSH.

(1) The HP reviews the request for rework and determines whether a rework is required.

(2) If the HP needs additional information to make a determination, which may include requesting the case file, he or she contacts the CE.

e. Rework Not Needed. If the HP determines that the submitted information does not change the outcome of the dose reconstruction, he or she sends an e-mail to the National Office, with a copy to the CE, or SCE, and DD, explaining the rationale for not continuing the review of the dose reconstruction. When the CE receives this response, he or she ensures the response is entered into ECS and proceeds with the IREP calculation.

(1) Updating Records. The CE is responsible for documenting any change to the case records in OIS. This is true regardless of whether the CE submits the case for a rework review by the HP. The CE is to always document, with memos to file, any analysis that applies to assessing the sufficiency of a dose reconstruction, along with the guidelines used to make that determination.

When the DO makes changes to information used in the NIOSH dose reconstruction, and no rework is required, the National Office or other designated person sends an e-mail to the appropriate NIOSH PHA. This e-mail indicates what information changed, such as the diagnosis code, cancer name, employment dates, etc.

This allows NIOSH to update its records for the case, which is most critical with respect to changes involving diagnosis codes and PoC values different from those initially generated by the dose reconstruction. Forwarding these changes also allows NIOSH to compile accurate statistics on the types of cancers addressed in EEOICPA decisions that required a NIOSH dose reconstruction.

If a CE performs a new PoC calculation using new information without the need for rework, the National Office must advise the NIOSH PHA via e-mail and attach the new IREP summary file. For example, in a case with an initial PoC less than 45%, the HP determined that a change in the diagnosis code did not require a rework of the dose reconstruction, but just a different NIOSH-IREP model run. If the new IREP run resulted in a PoC less than 45%, the CE uses the new IREP run and PoC as the value for the dose reconstruction but must advise NIOSH as noted above.

(2) Any future dose reconstruction rework based on additional verified cancer(s) or employment is performed by NIOSH using only DOL-verified information, which may be more restrictive than information used in the previous dose reconstruction (i.e., in some likely non-compensable cases, NIOSH may assume a continuous employment period rather than considering numerous breaks in employment for the purpose of completing a dose reconstruction in a timely manner). Therefore, it is

possible in some cases for the subsequent PoC to remain the same, increase only slightly, or even decrease to some degree if the dose reconstruction is reworked in the future.

f. Rework Needed. If the HP determines that a rework is necessary, he or she e-mails the CE, SCE, CES, DD, and the National Office. In certain non-standard rework requests, the HP also copies the designated NIOSH Division of Compensation Analysis and Support (DCAS) contact person(s) on the e-mail.

(1) The CE takes the following actions:

(a) Forward the amended NRSD as an electronic attachment via e-mail to the NIOSH PHA assigned to the DO.

(b) Send a letter to the claimant (Exhibit 17-5) explaining that the case has been returned to NIOSH for a review of the dose reconstruction.

(c) *Send a copy of this letter to the appropriate NIOSH PHA along with the weekly DO submissions to NIOSH.*

- **Chapter 21 – Impairment Ratings**

  - Ch. 21.9c has been edited to include guidance for situations when a claimant's physician presents an impairment report that communicates information that is contradicted by objective evidence or communicates information that is unclear. The language in v10 previously read:

    c. If the CE identifies a deficiency in a CMC's application of the AMA's Guides, the CE is to initiate follow-up. The CE is to communicate to the CMC question(s) or concerns(s) regarding the appropriate application of the AMA's Guides so that the CMC may provide clarification about the assigned rating. Upon receipt of a response, the CE must weigh whether the supplemental input overcomes the concerns with the initial impairment rating. For a CMC opinion deemed insufficient after further development, the CE refers the matter to the Technical Procedures Branch for review, and possible corrective action, by the CMC Contract Officer Representative.

    For situations where the claimant's physician presents an impairment report that communicates information that is contradicted by other objective evidence in the file (e.g., the severity of activities of daily living dysfunction) or communicates information that is confusing or difficult to decipher, the CE is to make a CMC referral to assess whether the assigned rating represents a reasonable, accurate application of the AMA's Guides based on the available objective evidence and, if not, what alternative whole-person impairment rating is recommended. The CE is to permit the claimant's physician the ability to respond to a CMC assessment

that concludes there is a defect in how the claimant's physician assessed impairment. Once the claimant's physician has been afforded the opportunity to respond to the CMC finding and has chosen to provide a counter argument about the assigned whole-person impairment, the CE is to weigh the competing opinions to decide which has the most probative value regarding the assignment of whole-person impairment. If the opposing opinions are of equal weight, the CE is to obtain a referee opinion, as directed by staff procedure.

It has been updated in v.10.1 to:

c. If the CE identifies a deficiency in a CMC's application of the AMA's Guides, the CE is to initiate follow-up. The CE is to communicate to the CMC question(s) or concerns(s) regarding the appropriate application of the AMA's Guides so that the CMC may provide clarification about the assigned rating. Upon receipt of a response, the CE must weigh whether the supplemental input overcomes the concerns with the initial impairment rating. For a CMC opinion deemed insufficient after further development, the CE refers the matter to the Technical Procedures Branch for review, and possible corrective action, by the CMC Contract Officer Representative.

If the CE identifies a deficiency in a claimant's physician's application of the AMA's Guides, the CE may seek clarification from the physician or make a CMC referral. Clarification to the physician is warranted if the impairment report communicates information that is confusing or difficult to decipher. These interactions should be limited to situations where a simple clarification will allow the CE to proceed with adjudication of the impairment claim (e.g., why a 6-minute walk test was used when the claimant has a knee injury, or why certain values were combined).

If a potential error exists in the claimant's physician's rating (e.g., ratings not based on AMA's Guides, or based on information directly contradicted by objective evidence), the CE is to make a CMC referral to assess whether the assigned rating represents a reasonable, accurate application of the AMA's Guides based on the available objective evidence and, if not, what alternative whole-person impairment rating is recommended. The CE is to permit the claimant's physician the ability to respond to a CMC assessment that concludes there is a defect in how the claimant's physician applied the AMA's Guides. Once the claimant's physician has been afforded the opportunity to respond to the CMC assessment, the CE is to weigh the competing opinions to decide which has the most probative value regarding the assignment of whole-person impairment. If the opposing opinions are of equal weight, the CE is to obtain a referee opinion, as directed by staff procedure.

- Ch. 21.14 has been updated to remove the requirement that a recommended decision (RD) pertaining to impairment claims include citation of the American Medical Association (AMA) tables, as this is no longer necessary given the requirement that an

RD include a copy of a pertinent impairment report. The language in v10 previously read:

14. Issuance of RD. The RD for impairment must contain a CE's discussion of the relevant impairment evidence submitted in deciding the claim. Moreover, the CE must explain the sufficiency (or insufficiency) of the evidence justifying the decision outcome. For example, the CE discusses the qualification of the physician to perform an impairment rating. In addition, the CE includes a description of the medical evidence that satisfy the necessary procedural requirements for a valid impairment including MMI, use of AMA Guides, calculation of rating, citation of AMA tables, etc. For any lump-sum award, the CE clearly explains the calculation of the award, including subtractions due to prior lump-sum impairment payments. If coordination and/or offset is required, the CE explains the steps and calculations performed to derive at the award.

If a decision recommends denial of an impairment claim based upon an insufficient evaluation, or if the CE relies on one evaluation over another evaluation(s) in the file, the CE provides a detailed discussion regarding the probative value of the evaluation(s). In the case of competing medical opinions, the CE discusses the weight of medical evidence as to why one report is insufficient, and/or why one report offers more probative value. In other words, the CE has to explain how he or she selected one physician's opinion over another. This is necessary in the event that the employee submits additional impairment evidence to FAB, as any additional impairment evidence submitted has to overcome the weight of medical evidence as assigned by the CE.

It has been updated in v.10.1 to:

14. Issuance of RD. The RD for impairment must contain a CE's discussion of the relevant impairment evidence submitted in deciding the claim. Moreover, the CE must explain the sufficiency (or insufficiency) of the evidence justifying the decision outcome. For example, the CE discusses the qualification of the physician to perform an impairment rating. In addition, the CE includes a description of the medical evidence that satisfy the necessary procedural requirements for a valid impairment including MMI, use of AMA Guides, calculation of rating, etc. For any lump-sum award, the CE clearly explains the calculation of the award, including subtractions due to prior lump-sum impairment payments. If coordination and/or offset are required, the CE explains the steps and calculations performed to derive at the award.

If a decision recommends denial of an impairment claim based upon an insufficient evaluation, or if the CE relies on one evaluation over another evaluation(s) in the file, the CE provides a detailed discussion regarding the probative value of the evaluation(s). In the case of competing medical opinions, the CE discusses the weight of medical evidence as to why one report is insufficient, and/or why one report offers more probative value. In other words, the CE has to explain how he or she selected one physician's opinion over another. This is necessary in the event that the employee submits additional impairment evidence to FAB, as any additional impairment evidence submitted has to overcome the weight of medical evidence as assigned by the CE.

- **Chapter 22 – Wage-Loss Determinations**

  - Ch. 22.10a(7) has been updated to include the telephone number of the SSA. The language in v10 previously read:

    (7) Inquiries to the SSA are made by calling one of six phone numbers (Modules) depending upon the last four digits of the relevant SSN (see Exhibit 13-1). When calling the SSA, the following information should be available to expedite the inquiry:

  It has been updated in v.10.1 to:

    (7) Inquiries to the SSA are made by calling 1-855-953-8737. When calling the SSA, the following information should be available to expedite the inquiry:

- **Chapter 23 – Consequential Conditions**

  - Ch. 23.6a(4) has been added to include lymphedema as an example of a consequential condition that may result from medical treatment of an accepted condition.

- **Chapter 24 – Recommended Decisions**

  - Ch. 24.9b(1) has been edited to comply with guidance at Ch. 25.5 and clarify what is to be included in an RD packet in a recommended denial of a claim. The language in v10 previously read:

    (1) A signed and dated copy of the RD is imaged into the electronic case file and must include all required attachments (HP, IH, TOX, and/or CMC reports) that provided justification or support for the recommended acceptance or the recommended denial of a claim. In the case of a denial, such supporting documentation is also required to be included with the RD provided to the claimant(s). A copy of the impairment report used as the basis of the RD, regardless of whether the claim is being recommended for acceptance or denial, is to be included in the RD packet.

  It has been updated in v.10.1 to:

    (1) The RD is imaged into the electronic case file and must include all required attachments. In the case of a denial, supporting documentation (HP, IH, TOX, and/or CMC reports) are required to be included with the RD provided to the claimant(s). For impairment claims, a copy of the impairment report used as the basis of the RD, regardless of whether the claim is being recommended for acceptance or denial, is to be included in the RD packet.

- **Chapter 26 – FAB Decisions**

  - Ch. 26.3a(3) has been edited to clarify that a certificate of service is to reflect the date the decision is issued, versus the date it was placed in the mail. The language in v10 previously read:

    (3) *Certificates of Service certify that each listed claimant and his or her AR was mailed a copy of the FD and the date it was placed in the U.S. mail. A separate certificate of service is created for each claimant, but a claimant and his or her AR may appear on the same certificate of service.*

  It has been updated in v.10.1 to:

    (3) *Certificates of Service certify the FD was issued to each claimant and his or her AR. A separate Certificate of Service is created for each claimant, but a claimant and his or her AR may appear on the same Certificate of Service.*

  - Ch. 26.4i(2) has also been edited to reflect that a certificate of service is to certify the date on which the decision was issued. The language in v10 previously read:

    (2) A certificate of service, which certifies the Remand Order was mailed on a certain date, is also prepared for each individual recipient, attesting to the date the remand order is sent.

  It has been updated in v.10.1 to:

    (2) A Certificate of Service certifies the Remand Order was issued to each claimant and his or her AR. A separate Certificate of Service is created for each claimant, but a claimant and his or her AR may appear on the same Certificate of Service.

  - Exhibit 26-1 has been updated to clarify that the DEEOIC and U.S. Department of Treasury require submission of Form SF-1199A to allow for direct deposit.

  - Exhibit 26-2, Page 3 of 3, has been updated to include a new Certificate of Service (which clarifies date of issuance versus date of mailing).

- **Chapter 27 – Reopening Process**

  - Ch. 27.5a(3) has been edited to reflect that a certificate of service is to certify the date on which the decision was issued. The language in v10 previously read:

    (3) Certificate of Service. This confirms the mailing date of a Director's Order and lists the name and address of the intended decision recipient. A Certificate of Service is completed individually for each claimant (or his or her AR) who is party to the Director's Order. It must be dated on the date of decision mailing.

It has been updated in v.10.1 to:

(3) A Certificate of Service certifies that the Director's Order was issued to each claimant. A separate Certificate of Service is created for each claimant, but a claimant and his or her AR may appear on the same Certificate of Service.

- In conjunction with the above changes, Exhibit 27-1, Page 5 of 5, has been updated to include a new Certificate of Service.

- Exhibit 27-2, Page 5 of 5, has also been updated to include a new Certificate of Service.

- **Chapter 29 – Ancillary Medical Benefits**

  - Ch. 29.5 has been replaced in entirety and includes additional guidance on requests for Durable Medical Equipment (DME), updates to authorization periods, and provides authorization guidance for seat lift mechanisms, enteral formula, and manual and massage therapy. The language in v10 previously read:

5. Addressing Certain Types of AMB. When reviewing authorization requests for reimbursement for particular types of AMB, it is the role of the MBE to apply the following program guidance when making a decision regarding the claim. The MBE must issue either a written authorization or denial, as is explained later in this Chapter, for each AMB claim registered by the BPA.

a. Durable Medical Equipment (DME). DME is medically necessary equipment and appliances, prescribed by a qualified physician, for a claimant's extended use in treating or mitigating the effect of an accepted medical condition.

(1) DME Purchases Under $500. Where the purchase price of DME, appliances, or custom devices, is less than $500, the MBE may approve the purchase request without obtaining cost estimates.

(2) Purchase of DME in excess of $500. For DME purchases that exceed $500, the MBE must obtain two estimates, from two different DME suppliers, clearly identifying the provider name and contact information. The two estimates must quote a price for the exact same type, model, and/or description of the requested DME and/or appliances. Each prospective supplier must submit a signed statement describing the unadorned DME item that meets the treating physician's specifications. The statement must contain a breakdown of all costs, including delivery and installation, and the current Healthcare Common Procedure Code System (HCPCS) code for the DME item.

(a) An MBE may authorize the rental of DME, if the MBE establishes a necessary and reasonable basis for such, including cost effectiveness of a rental for a limited duration versus the estimates for authorizing purchase. If the MBE determines that the evidence supports the appropriateness of DME rental, the MBE must document the file with a Memorandum describing the justification for allowing a rental in lieu of purchase.

(3) Oxygen Therapy DME and Oxygen Medical Accessories. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Accessories to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Accessories include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery systems, cannulas, tubing, regulators, etc. (Exhibit 29-2) provides definitions and describes the functions of some of the more commonly prescribed oxygen DME). Oxygen related equipment and supplies may be approved for up to 12 months.

(a) MBE authorization requirements.

(i) Upon receipt of a claim and an LMN documenting a substantiated medical need, the MBE may authorize one stationary oxygen system for use in the claimant's home and one portable oxygen system. The assigned MBE must review any request for any additional delivery systems for the claimant to ensure substantial medical justification exists for such a claim. Medical justification for additional delivery system(s) must include sufficient rationale as to how any additional system serves a medical need unfilled by an existing stationary and portable system. Authorization for oxygen accessories must align with the medical need of the claimant.

(ii) For any claim for additional oxygen delivery systems or other supportive oxygen DME, including medical ventilators or oxygen system power back-up systems, the MBE must obtain an LMN from the prescribing physician that provides a well-rationalized justification for the request.

(b) DME Repair/Maintenance Cost. The MBE must authorize the cost for modifications and maintenance to DME equipment when presented with evidence validating the

need for changes/repair/maintenance of previously approved DME. DEEOIC allows up to two hours of service within a 120-day period.

(c) DME Temporary "Loaner" Equipment. DEEOIC will authorize temporary "loaner" equipment when DEEOIC authorized equipment requires repair. Authorized repair periods may not exceed one month. Authorization requests for temporary equipment (loaners), during repair periods, must include a description of the equipment that requires repair, and the rental authorization request must be for the same type of equipment.

(d) Rental of Stationary Liquid Gaseous Systems. The rental price of these systems is to include the cost of content refills. Contents are not separately reimbursable.

(e) Rental of Portable Liquid Gaseous Systems. The MBE can authorize reimbursement, separately, for contents for these systems. One unit of contents is equal to one month's supply and reimbursement is limited to one unit per month.

(f) Purchase of a Liquid Gaseous System. Purchased systems do not include contents. When authorizing purchase of a gaseous or liquid system, the MBE authorizes reimbursement of contents for a period of one year. Authorizations are based on one unit per month (i.e., 12 units = one year).

(g) DME Replacement. The claimant must submit a new request for replacement of previously authorized/purchased DME. The MBE must approve replacement of the DME if it is three years or older, if it is inoperable and beyond repair, if the cost of repairs exceeds the replacement cost of equipment no longer under warranty, or if the equipment is lost or stolen. If the equipment is stolen, the claimant must furnish evidence documenting the theft. The MBE can consult with his/her supervisor for situations involving unique or unusual circumstances that may require referral to the NO MBPU for review.

(h) DME Add-ons or Upgrades. An MBE may consider approval for DME add-ons or upgrades where the evidence substantiates medical need for the enhancement.

(i) Travel Time. An MBE may not authorize separate reimbursement for travel time for pickup and/or delivery of DME. These costs are incorporated in the OWCP Fee Schedule and are not separately reimbursable.

(ii) Emergency requests. The MBE may approve an emergency authorization for rental of DME, for a 30-day period, while undertaking necessary development.

b. Hearing Aids. The MBE may authorize hearing aids to address the effect of accepted, work-related hearing loss when a licensed otolaryngologist, otologist, or audiologist provides a well-rationalized LMN. The MBE's authorization should encompass reimbursement for the costs of evaluation, fitting, and the hearing aid unit or units. The MBE may authorize one hearing aid per ear for purchase every three years. During any three-year authorization period, the MBE may authorize costs relating to the repair of damaged hearing aids. If a claimant seeks replacement of a hearing aid prior to the expiration of the three-year period, the MBE has the discretion to determine if a reasonable and medically compelling justification exists for a new authorization. Reasons for a new authorization, prior to the expiration of the three-year period, include, but are not limited to documented loss, an unrepairable unit, or a prescription change.

c. Rehabilitative Therapy Services. DEEOIC defines these as therapeutic services, for which a provider charges a fee to render care, that are outside the scope of routine and customary medical care generally provided by a qualified physician. The prescribed rehabilitative therapy must be considered safe and effective by the medical community and intended to improve the health of the patient, as it relates to an accepted medical condition. A properly licensed or credentialed specialist, whose credentials meet relevant state requirements, must perform the services.

(1) Types of Rehabilitative Therapy:

(a) Physical Therapy (PT). PT is the treatment of injuries or disorders using physical methods, such as exercise and massage. The goal of physical therapy is to relieve pain and to help the patient attain maximum functional motor potential.

(b) Occupational Therapy (OT). OT involves treatment that helps develop adaptive or physical skills that will aid the claimant in performing the ordinary tasks of daily living.

OT focuses on the use of hands and fingers, coordination of movement, fine motor skills, and self-help skills such as preparing meals and dressing.

(c) Speech Therapy (ST). ST is the treatment of defects and disorders of speech and swallowing.

(d) Pulmonary Therapy. Pulmonary therapy is a supervised program that includes exercise training, health education, and breathing techniques for people who have certain lung conditions or lung problems due to other conditions.

(e) Medical Massage Therapy. Medical massage therapy is manual manipulation of the soft tissues of the body to treat the effect of a diagnosed medical condition.

(f) Acupuncture Treatment. Acupuncture involves the insertion of very thin needles, through the skin, at strategic points in the body. It is most commonly used to treat pain, and/or to stimulate nerves, muscles, and connective tissue, which a physician prescribes as medically necessary treatment for an accepted medical condition.

(2) Evaluating Claims for Rehabilitative Therapy. When evaluating claims for reimbursement of rehabilitative therapy services, the MBE considers several factors in making a determination of medical necessity. The physician's LMN must provide a well-rationalized justification for, and a written description of, the particular type of rehabilitative therapy they have prescribed, along with a discussion of the specific quantity, frequency, and duration of the therapeutic service. DEEOIC considers rehabilitative therapy services medically appropriate only if a qualified physician provides an appropriate medical rationale explaining how the prescribed rehabilitative therapy will lead to an expected, measurable improvement in one or more activities of daily living, within a reasonable period.

(a) The MBE may authorize an initial evaluation request upon receipt of a physician-signed prescription and indication that the evaluation is regarding an accepted work-related condition(s).

(b) Authorizations for services may be for a lesser period but must not exceed 3 months (90 days). The assigned MBE may approve up to three visits per week, for each therapy discipline. Each visit is equal to a maximum of 1.5 hours

(6 units). PT, OT, or ST services are limited to one hour (4 billable units) when the provider bills with combined codes. The MBE may not authorize therapy for any one discipline for more than 60 visits per calendar year.

(c) Rehabilitative therapy providers must conduct services in an appropriate setting (i.e., in a clinic, professional office, or other similar location). The MBE cannot authorize reimbursement requests for in-home rehabilitative therapy unless the employee is homebound, and the treating physician has provided evidence that the employee is medically unable to travel outside the home. Provider travel, to and from an employee's residence, is not a billable service.

(3) When submitting reimbursement requests, providers of rehabilitative therapy services must submit appropriate clinical notes to the BPA, along with their bill, describing in detail the particular therapeutic care provided during each visit, and the time spent providing that care. The therapy notes must document compliance with the LMN. The notes should describe the effect of rehabilitative therapy specific to unique features of *the employee, including any specific improvements in functionality or in achieving relief from the symptoms of an accepted medical condition. The MBE may weigh information communicated in therapy notes when evaluating reauthorization requests. Moreover, the MBE may refer claims to the Program Integrity Unit, for investigation of those situations where an applicable therapy provider does not provide an employee-specific description of the services provided, lists vague or non-descriptive services, or conducts therapy services that do not comply, or align with the prescribing physician's LMN.*

d. Chiropractic Services. The MBE may authorize reimbursement for chiropractic services, limited to treatment for correction of spinal subluxation and the tests performed or required by a chiropractor to diagnose such subluxation. A physician or chiropractor must document a diagnosis of spinal subluxation in the LMN, arising from an accepted condition and supported by an x-ray before the MBE can authorize reimbursement of chiropractic services.

e. Enteral Formula. Enteral formula is a nutritional supplement for patients who are unable to get sufficient nutrients in their diet. Patients prescribed enteral formula consume it by mouth or through a feeding tube. The MBE may authorize reimbursement for enteral formula when provided with a well-rationalized justification for its need. The physician's LMN must

provide a description of the type of formula the patient requires, along with information detailing the specific quantity, frequency, and duration of use. The physician may also provide guidance on how the patient receives the formula (orally or via feeding tube).

It has been updated in v.10.1 to:

5. <u>Addressing Certain Types of AMB</u>. When reviewing authorization requests for reimbursement for particular types of AMB, it is the role of the MBE to apply the following program guidance when making a decision regarding the claim. The MBE must issue either a written authorization or denial, as is explained later in this Chapter, for each AMB claim registered by the BPA.

a. Durable Medical Equipment (DME). DME is medically necessary equipment and appliances, prescribed by a qualified physician, for a claimant's extended use in treating or mitigating the effect of an accepted medical condition.

(1) DME Purchases Under $500. Where the purchase price of DME, appliances, or custom devices, is less than $500, the MBE may approve the purchase request without obtaining cost estimates.

(2) Purchase of DME in excess of $500 and Not Subject to Fee Schedule. The MBE is required to obtain two cost estimates. These estimates must be sourced from two completely independent DME suppliers. Each supplier must be entirely separate in ownership, operations, and corporate affiliation; and under no circumstances may the suppliers be related entities or sister companies.

Both estimates must reflect pricing for the identical item—matching in type, model, and detailed description of the DME and/or appliance requested. The MBE must obtain from each supplier a signed statement describing the unmodified DME item that meets the treating physician's specifications. The statement must contain the current Healthcare Common Procedure Code System (HCPCS) code for the DME item, and a breakdown of all costs, including delivery and installation. The statement must further affirm that the supplier operates independently and maintains no ownership ties or affiliations with the other supplier providing the competing estimate. Upon receiving the two required quotes, DEEOIC may conduct an assessment of the quotes to determine their reasonableness.

(a) An MBE may authorize the rental of DME, if the MBE establishes a necessary and reasonable basis for such, including cost effectiveness of a rental for a limited duration versus the estimates for authorizing purchase. If the MBE determines that the evidence supports the appropriateness of DME rental, the MBE must

document the file with a Memorandum describing the justification for allowing a rental in lieu of purchase (except items utilized in oxygen therapy, which is covered separately below).

DEEOIC will reimburse repair, maintenance, non-routine service, modifications necessary to make the equipment operable, and replacement of medically necessary equipment that a claimant owns. DEEOIC will not provide separate reimbursements 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 equipment is included in the monthly payment allowance and is not separately reimbursable.

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

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

(ii) An indication that the equipment is claimant-owned (non-rented) and out of warranty.

(iii) An indication as to 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. 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.

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. DEEOIC allows up to two hours of service within a 120-day period. If an MBE receives a repair request for more than two hours of service within a 120-day period, the MBE forwards the request and supporting documentation to the NO for review through the DEEOIC bill pay mailbox. The MBE is to list details of the documented thread, including the document control number retrieved from the medical bill processing system and/or attached supporting documentation.

A new LMN is not required for 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.

A new request must be submitted if a claimant requires a replacement of previously purchased equipment approved by DEEOIC for purchase. The MBE may approve DME under the following circumstances: for replacement if the equipment is five years or older; when it is inoperable and beyond repair; when repair costs exceed the cost to replace the equipment; or when the equipment is lost, stolen, and no longer covered by warranty. A copy of the warranty is required to be submitted to allow the MBE to assess whether the item is covered under warranty and what the warranty covers. In the event the equipment is stolen, the claimant must furnish a police report documenting the incident. The MBE may consult with the MBPU for situations that fall outside these procedures.

(3) Oxygen Therapy DME and Oxygen Medical Accessories. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Accessories to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Accessories include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery systems, cannulas, tubing, regulators, etc. (Exhibit 29-2 provides definitions and describes the functions of some of the more commonly prescribed oxygen DME). Oxygen related equipment and supplies may be approved for up to 12 months.

(a) MBE authorization requirements.

(i) Upon receipt of a claim and an LMN documenting a substantiated medical need, the MBE may authorize one stationary oxygen system for use in the claimant's home and one portable oxygen system. The assigned MBE must review any request for any additional delivery systems for the claimant to ensure substantial medical justification exists for such a claim. Medical justification for additional delivery system(s) must include sufficient rationale as to how any additional system serves a medical need unfilled by an existing stationary and portable system. Authorization for oxygen accessories must align with the medical need of the claimant.

(ii) For any claim for additional oxygen delivery systems or other supportive oxygen DME, including medical ventilators or oxygen system power back-ups, the MBE

must obtain an LMN from the prescribing physician that provides a well-rationalized justification for the request.

(b) DME Repair/Maintenance Cost. The MBE must authorize the cost for modifications and maintenance to DME equipment when presented with evidence validating the need for changes, repair, and/or maintenance of previously approved DME. DEEOIC allows up to two hours of service within a 120-day period.

(c) DME Temporary "Loaner" Equipment. DEEOIC will authorize temporary "loaner" equipment when DEEOIC authorized equipment requires repair. Authorized repair periods may not exceed one month. Authorization requests for temporary equipment (loaners), during repair periods, must include a description of the equipment that requires repair, and the rental authorization request must be for the same type of equipment.

(d) Rental of Stationary Liquid Gaseous Systems. The rental price of these systems is to include the cost of content refills. Contents are not separately reimbursable.

(e) Rental of Portable Liquid Gaseous Systems. The MBE can authorize reimbursement, separately, for contents for these systems. One unit of contents is equal to one month's supply and reimbursement is limited to one unit per month.

(f) Purchase of a Liquid Gaseous System. Purchased systems do not include contents. When authorizing purchase of a gaseous or liquid system, the MBE authorizes reimbursement of contents for a period of one year. Authorizations are based on one unit per month (i.e., 12 units = one year).

(g) Stationary Oxygen Concentrators. The MBE may authorize a request to purchase or rent an oxygen concentrator. However, the MBE may not authorize a request to purchase a previously rented oxygen concentrator. Instead, the item should continue to be rented, or alternatively, the claimant may be offered a new unit after 5 years.

(h) DME Replacement. The claimant must submit a new request for replacement of previously authorized/purchased DME. The MBE may approve replacement of the DME if it is five years or older, if it is inoperable and beyond repair, if the cost of repairs exceeds the replacement cost of equipment no longer under warranty, or if the equipment is lost or stolen. If the equipment is stolen, the claimant must furnish evidence documenting the theft. The MBE

may consult with his/her supervisor for situations that fall outside these procedures that may require review by the NO MBPU..

(i) DME Add-ons or Upgrades. An MBE may consider approval for DME add-ons or upgrades where the evidence substantiates medical need for the enhancement.

(j) Travel Time. An MBE may not authorize separate reimbursement for travel time for pickup and/or delivery of DME. These costs are incorporated in the OWCP Fee Schedule and are not separately reimbursable.

(k) Emergency requests. The MBE may approve an emergency authorization for rental of DME, for a 30-day period, while undertaking necessary development.

b. Hearing Aids. The MBE may authorize hearing aids to address the effect of accepted, work-related hearing loss when a licensed otolaryngologist, otologist, or audiologist provides a well-rationalized LMN. The MBE's authorization should encompass reimbursement for the costs of evaluation, fitting, and the hearing aid unit or units. The MBE may authorize one hearing aid per ear for purchase every five years. During any five-year authorization period, the MBE may authorize costs relating to the repair of damaged hearing aids. If a claimant seeks replacement of a hearing aid prior to the expiration of the five-year period, the MBE has the discretion to determine if a reasonable and medically compelling justification exists for a new authorization. Reasons for a new authorization, prior to the expiration of the five-year period, include, but are not limited to documented loss, an unrepairable unit, or a prescription change.

If a request is submitted prior to the five-year mark, the MBE considers such requests on a case-by-case basis. Such requests require supporting documentation, including applicable medical records, the hearing aid warranty information for the previously authorized hearing aids, a detailed statement indicating why replacement is necessary, and a statement attesting to the fact that repair is either not possible or less cost-effective than the purchase of replacement hearing aids. There is a maximum of one unit.

Reimbursement of batteries are limited to 30 units per 180 days from the first dispense date of service. Authorizations for hearing aid fittings, repairs or modifications, conformity evaluations, and dispensing fees require preauthorization, as these costs are typically included in the cost of new hearing aids, whether supplied by an audiologist or purchased over the counter. If the claimant purchases hearing aids directly from a hearing aid supplier, the claimant may only be reimbursed at the fee schedule price.

c. Seats Lift Mechanisms. Seat lift mechanisms are intended to assist in transitioning from a seated to a standing position. While a recliner is a comfort or convenience item and not medically necessary, a seat lift mechanism may be deemed medically necessary when it is required to assist a claimant with mobility limitations. As such, requests for reimbursement for recliners equipped with a lift mechanism require medical documentation that supports the medical need for such, and are limited to one unit every five years, based on standard industry pricing.

When it is unclear whether the medical evidence establishes the need for a seat lift mechanism, the MBE may seek clarification from a medical officer or nurse to provide advice to allow the MBE to make an informed decision whether to authorize the request or undertake further development.

d. Enteral Formula. Enteral formula is a nutritional supplement for patients who are unable to get sufficient nutrients in their diet. Coverage for in-home enteral nutrition is limited to reimbursement for prescribed enteral products administered via a feeding tube, subject to documented clinical findings that meet the criteria for medical necessity.

The MBE may authorize reimbursement for enteral formula administered via feeding tube when provided with a well-rationalized justification for its need related to the accepted condition(s). This requires a face-to-face assessment with the treating physician within 6 months of the LMN. The physician's LMN must provide a description of the type of formula the patient requires, along with information detailing the specific quantity, frequency, and duration of use. Requests for enteral formula are approved for up to 6 months.

Over the counter, oral nutritional supplements (e.g., Boost®, Ensure®, etc.) not delivered via nasogastric, nasoduodenal, naso-jejunal, gastrostomy or jejunostomy tube are only covered under the following circumstances:

(1) Burn patients

(2) Claimants currently undergoing treatment (i.e., chemotherapy, radiotherapy, surgical resection) for:

(a) Blood cancers (leukemia, lymphoma, multiple myeloma)

(b) Solid organ malignancies (breast, bone, colorectal, or lung cancer)

(3) Conditions associated with impaired digestion and/or absorption of an oral diet by the small bowel that qualify as medically necessary, including:

(a) Inflammatory bowel disease

(b) Surgical resection of the small bowel

(c) Cystic fibrosis

(d) Chronic pancreatitis

(e) Advanced liver disease.

When it is unclear whether the medical evidence meets the above criteria for these specific circumstances, the MBE may seek clarification from a medical officer or nurse to provide advice to allow the MBE to make an informed decision whether to authorize the request or undertake further development.

e. Ramps. Home entrance access ramps may be approved for the safety of the claimant when provided a well-rationalized LMN from the treating physician justifying the need. A request for a ramp may encompass both DME (the ramp itself), as well as any necessary home modification to install the ramp (i.e., attaching it to the home). In such instances, DME providers may supply the ramp, but any installation requiring modification to the home must be completed by an entity licensed to provide such modifications. Specific guidance regarding home modifications is provided later in this Chapter.

f. Generators and Surge Protection. DEEOIC may reimburse costs for a generator or surge protector for approved furnished DME when provided a well-rationalized LMN from the employee's treating physician. Such requests must be commensurate with the operational requirements of the furnished DME. Whole-home generators and surge protectors are not allowable when a smaller unit is suitable to operate the furnished device(s). Whole-home generators are classified as home modifications and should be adjudicated in accordance with home modification procedures that follow later in this Chapter.

g. Rehabilitative Therapy Services. DEEOIC defines these as therapeutic services, for which a provider charges a fee to render care, that are outside the scope of routine and customary medical care generally provided by a qualified physician. The prescribed rehabilitative therapy must be considered safe and effective by the medical community and intended to improve the health of the patient, as it relates to an accepted medical condition. A properly licensed or credentialed specialist, whose credentials meet relevant state requirements, must perform the services.

(1) Evaluating Claims for Rehabilitative Therapy. When evaluating claims for reimbursement of rehabilitative therapy services, the MBE considers several factors in making a determination of medical necessity. The physician's LMN must provide a well-rationalized justification for, and a written description of, the particular type of rehabilitative therapy

prescribed, along with a discussion of the specific quantity, frequency, and duration of the therapeutic service. DEEOIC considers rehabilitative therapy services medically appropriate only if a qualified physician provides an appropriate medical rationale explaining how the prescribed rehabilitative therapy will lead to an expected measurable improvement in one or more activities of daily living, within a reasonable period. DEEOIC may not authorize rehabilitative therapy when prescribed for illness prevention, recreation (spa therapy), or stress reduction.

The MBE may authorize an initial evaluation request upon receipt of a physician-signed prescription and indication that the evaluation is regarding an accepted work-related condition(s). Rehabilitative therapy providers must conduct services in an appropriate setting (i.e., in a clinic, professional office, or other similar location). The MBE cannot authorize reimbursement requests for in-home rehabilitative therapy unless the employee is homebound, and the treating physician has provided evidence that any departure of the employee from his/her residence must incur considerable and taxing effort. Provider travel, to and from an employee's residence, is not a billable service.

(2) Types of Rehabilitative Services:

(a) Physical Therapy (PT). PT is the treatment of injuries or disorders using physical methods, such as exercise and massage. The goal of physical therapy is to relieve pain and to help the patient attain maximum functional motor potential.

(b) Occupational Therapy (OT). OT involves treatment that helps develop adaptive or physical skills that will aid the claimant in performing the ordinary tasks of daily living. OT focuses on the use of hands and fingers, coordination of movement, fine motor skills, and self-help skills such as preparing meals and dressing.

(c) Speech Therapy (ST). ST is the treatment of defects and disorders of speech and swallowing.

(d) Pulmonary Therapy. Pulmonary therapy is a supervised program that includes exercise training, health education, and breathing techniques for people who have certain lung conditions or lung problems due to other conditions.

(e) Acupuncture Treatment. Acupuncture involves the insertion of very thin needles, through the skin, at strategic points in the body. It is most commonly used to treat pain, and/or stimulate nerves, muscles, and connective tissue, which a physician prescribes as medically necessary for the treatment of an accepted condition.

(i) Authorizations for the rehabilitative therapy services listed above (PT, OT, ST, pulmonary therapy, and acupuncture therapy) must not exceed 3 months (90 days). The MBE may approve up to three visits per week, for each therapy discipline. Each visit is equal to a maximum of 1.5 hours (6 units). PT, OT, or ST services are limited to one hour (4 billable units) when the provider bills with combined codes. The MBE may not authorize therapy for any one discipline for more than 60 visits per calendar year.

(3) Additional Types of Rehabilitative and Therapeutic Services:

(a) Manual Therapy. Manual therapy is a type of physical therapy that uses skilled, targeted movements to restore function and mobility and reduce pain. Manual therapy must be prescribed by a licensed physician or qualified healthcare provider and performed by a state licensed physical therapist. Manual therapy is not covered as a stand-alone service and must be provided along with other covered physical therapy services during the same visit. It is also not covered for illness prevention, recreation (spa therapy), or maintenance therapy.

Manual therapy may be authorized when considered likely to cure, give relief, or reduce the degree or period of one of the accepted conditions listed below, or when an accepted condition is causing:

(i) Adhesive capsulitis

(ii) Burn wound treatment

(iii) Chronic ankle instability

(iv) Knee osteoarthritis

(v) Low back pain

(vi) Postoperative pain

(vii) Neck pain of four or more weeks duration

(viii) Osteoarthritis

(ix) Lymphatic drainage after surgery for treatment for cancer

Manual therapy is not considered medically necessary for long-term treatment. As such, its allowable authorization shall not

exceed 24 visits per calendar year. The MBE may authorize payment for manual therapy only as a component of a physical therapy treatment plan for a maximum of 1 visit per week for an initial 90-day period. Each individual manual therapy treatment session, as part of PT, may not exceed 15 minutes in duration. Such visits must be in a clinical setting and may only be provided in-home when the claimant is homebound. Reauthorization requests for manual therapy are required from the medical provider every 90 days, not to exceed 180 days.

When it is unclear whether the medical evidence meets the above criteria, the MBE may seek clarification from a medical officer or nurse to provide advice that allows the MBE to make an informed decision whether to authorize the request or undertake further development.

(b) Massage Therapy. Massage therapy consists of hands-on manipulation of soft tissue, such as muscles, tendons and ligaments and must be performed by a state licensed massage therapist or physical therapist. Massage for general relaxation, stress reduction, preventive care, or maintenance therapy is not covered. It may be authorized when considered likely to cure, give relief, or reduce the degree or period of one of the accepted conditions listed below, or when an accepted condition is causing:

(i) Lower back pain

(ii) Postoperative pain

(iii) Neck pain of four or more weeks duration

(iv) Symptoms of anxiety, depression, and fatigue associated with ongoing chemotherapy and/or radiation therapy as a result of cancer treatment.

(v) Lymphatic drainage after surgery for treatment of cancer

The MBE may authorize payment for massage therapy for an initial period not exceeding 90-days. The allowable authorization shall not exceed 12 total visits per calendar year.

When it is unclear whether the medical evidence meets the above criteria, the MBE may seek clarification from a medical officer or nurse to provide advice that allows the MBE to make an informed decision whether to authorize the request or undertake further development.

(c) Respiratory Therapy. Respiratory therapy is for the treatment of patients with breathing problems and must be prescribed by a licensed physician or qualified healthcare provider and performed by a state licensed respiratory therapist. It may be authorized when considered likely to cure, give relief, or reduce the degree or period an accepted respiratory or cardiopulmonary condition, or when an accepted condition is causing respiratory or cardiopulmonary symptoms. The allowable authorization shall not exceed 60 total visits per calendar year.

(c) Chiropractic Services. The MBE may authorize reimbursement for chiropractic services, limited to treatment for correction of spinal subluxation and the tests performed or required by a chiropractor to diagnose such subluxation. A physician or chiropractor must document a diagnosis of spinal subluxation in the LMN, arising from an accepted condition and supported by an x-ray before the MBE may authorize reimbursement of chiropractic services. The allowable authorization shall not exceed 60 total visits per calendar year.

(4) When submitting reimbursement requests, providers of rehabilitative and therapeutic services must submit appropriate clinical notes to the BPA, along with their bill, describing in detail the particular therapeutic care provided during each visit, and the time spent providing that care. The therapy notes must document compliance with the LMN. The notes should describe the effect of rehabilitative therapy specific to the employee, including any specific improvements in functionality or in achieving relief from the symptoms of an accepted medical condition. The MBE may weigh information communicated in therapy notes when evaluating reauthorization requests. Moreover, the MBE may refer claims to the Program Integrity Unit, for investigation of those situations where an applicable therapy provider does not provide an employee-specific description of the services provided, lists vague or non-descriptive services, or conducts therapy services that do not comply, or align with the prescribing physician's LMN.

h. Organ Transplants and Experimental Treatments. Both procedures are complex and medically challenging treatment options that require a special level of review for reimbursement authorization submitted through the BPA and routed to the MBE.

(1) Evidence Necessary for Review of Requested Organ Transplant (including stem cell transplants). Upon receipt of a request for an organ transplant, the MBE immediately obtains all relevant documentation from the prescribing physician supporting the medical necessity of an organ transplant related to an accepted condition. This should include relevant

laboratory and diagnostic test results, CT or MRI scan results, and a transplant protocol with information on the type of transplant, such as:

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

(b) Autologous stem cell transplants may be performed in either an in-patient or an outpatient setting. This type of transplant uses stem cells, gathered in advance from the patient, and stored for use in the transplant procedure.

(c) Allogenic stem cell transplants may also be performed in either an in-patient or an outpatient setting. Allogenic stem cell transplants use stem cells from a person, other than the patient, that are stored and then transplanted into the patient.

(d) Types of Donors for "living donations," where a living person donates an organ (or part of an organ) for transplantation to another.

(i) Directed Living Donations. This type of donation involves donations from family members or relatives where the donor specifically names the person who will receive the donation. If the transplant facility approves a related donor, expenses incurred by the donor for transportation, 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 recipient (employee's) SSN, along with medical information regarding the donor. The MBE authorizes reimbursement of donor travel expenses follow the same guidelines established for companion travel on extended medical trips).

(ii) Non-directed living donations. If no suitable match is available through a directed living donation, the claimant's transplant center coordinates with the United Network for Organ Sharing to determine the availability of a suitable, matching organ. In such cases, the transplant center submits bills to the BPA for all necessary tests and procedures. Unrelated donors are not paid for their donation. Coverage is only for medical expenses related to the organ donation procedure. The transplant facility bills those expenses in the same manner as with related donors, referencing the covered employee's SSN on all bills.

(2) Obtaining Evidence for Evaluation of Requests to Participate in Experimental Treatments (also known as Investigational Protocols or Clinical Trials). Experimental treatment is a treatment that is not generally accepted by the medical community as having a proven efficacy. Experimental treatments can offer a claimant access to innovative therapeutic care; however, it may concurrently come with significant risk. As such, special consideration is needed to assess the medical necessity of treatment options that a physician deems as experimental or falling outside normal treatment modalities for the accepted work-related illness. In most instances, experimental treatment is appropriate when the accepted condition is life threatening, conventional therapy has been unsuccessful, and a sufficient body of medical data supports that the experimental procedure may be beneficial. To request reimbursement authorization for participation in an investigational protocol, the treating physician must provide the DEEOIC with an LMN, which includes medical rational supporting the claimant's participation in a specific clinical trial.

(3) DEEOIC Medical Officer Review. Once the MBE has collected the necessary evidence supporting the medical need for an organ transplant or experimental treatment, the MBE forwards all supporting medical information to an MBAU Supervisor for review. The MBAU Supervisor reviews the information for accuracy and completeness, and routes it to the DEEOIC Medical Officer, through the DEEOIC Bill Pay Mailbox. Upon receipt, the Medical Officer reviews the request and returns the case to the MBPU with a memorandum either approving or denying the organ transplant or experimental treatment request. The MBPU will notify the MBE of the referral outcome.

(a) Approval by DEEOIC Medical Officer. Upon approval by the Medical Officer for organ transplant or experimental treatment, the MBE updates ECS Notes and prepares a decision letter of authorization to the claimant, with a copy to the prescribing physician, containing the following information and special limitations pertaining to organ transplants and experimental treatment plans. The decision letter serves as the acceptance of the organ transplant as a consequential condition to a previously accepted work-related illness. After the MBE issues the decision letter, the MBE will provide email notice to the CE regarding the organ transplant acceptance. Once notified, the CE must complete the coding in ECS related to the organ transplant approval as a consequential condition. The MBE issued authorization decision must include the following information:

(i) Covered medical condition(s).

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

(iii) Statement advising that all medical expenses are subject to the OWCP fee schedule.

(iv) Statement that all organ transplants must occur at a Center for Medicare and Medicaid Services (CMS) approved facility in order to receive authorization for reimbursement.

(v) Statement advising that the person donating an organ is not considered an "employee" or "claimant," within the scope of DEEOIC policy and is not entitled to compensation for wage-loss or permanent impairment. Further, an organ donor is not entitled to benefits for any post-operative complications resulting from the transplant. Only those medical and related expenses, incurred by the donor, which are necessary to secure treatment for the employee, are reimbursable.

(vi) Long-term living expenses for organ transplant patients. Transplants often involve prolonged outpatient procedures requiring the patient to remain within a short distance of the transplant center. When the MBE authorizes a transplant procedure which requires extended residency near the facility, the MBE authorizes lodging, per diem allowance, companion travel expense, and other travel-related expenses, based on medical information supporting the length of stay.

(b) Disapproval by DEEOIC Medical Officer. In the event that the DEEOIC Medical Officer does not agree with the medical necessity for the requested organ transplant procedure or opines that the medical evidence is insufficient to support the proposed experimental treatment for an accepted condition, the Medical Officer returns the case to the MBPU with a memorandum explaining his/her decision. Depending upon the opinion of the Medical Officer, the MBE takes one of the following actions:

(i) If the Medical Officer requests further medical information, the MBE proceeds with development to obtain the information needed for an opinion from the Medical Officer.

(ii) When the Medical Officer provides an opinion that the medical evidence does not support the medical need for an organ transplant or experimental treatment, the MBE treats

the matter as a conflict of medical opinion between the prescribing physician and the DEEOIC Medical Officer. The MBE must assess the competing opinions to determine the one that the MBE can assign the weight of medical evidence to decide the claim. If the MBE assigns equal weight to the opposing opinions, the MBE is to obtain a referee medical opinion.

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

(1) 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.

(a) 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. Additions to a home may only be considered when no other reasonable alternative exists to accommodate the claimant's medical needs based on the accepted medical condition(s). As such, the MBE may develop the issue further to identify alternate solutions and require a certification from a licensed contractor that no other reasonable alternative to the proposed home modifications exist.

(b) Modifications may include certain appliances, such as air conditioning or air filtration equipment, if deemed medically necessary by the treating physician, and if necessary for the relief of accepted medical conditions. For example, if the claimant suffers from accepted respiratory or cardiac conditions, 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.

(c) When considering modification requests, the MBE should consider whether a portion of a home could 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.

(d) Maintenance expenses. While maintenance expenses and replacement costs for equipment furnished to the claimant are covered (as outlined above), general home maintenance not related to furnished equipment (i.e. air duct cleaning, HVAC servicing, lawn care, tree trimming, etc.) and general preventative maintenance on furnished equipment is not covered.

(2) Modifications to Non-Owned Property. Any modifications to property not owned by the claimant, or 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 MBE considers the following points:

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

(b) The claimant must obtain written approval from the landlord prior to making any changes or alterations to the non-owned property.

(c) 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 authorization for relocation expenses, rather than paying for modifications at the current location. If changing locations is the most cost-effective alternative, the MBE 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 medical condition(s).

(3) 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.

(4) Proposals. If the MBE determines that the claimant is eligible for housing modifications, the MBE asks the claimant to submit a detailed written proposal for review and consideration. The MBE 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 reinstall an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one. Modifications must be in keeping with the standard of decor 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 to maintain the architectural décor of the room.

Proposals must include the following information:

(a) 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.

(b) 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.

(c) 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.

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

(5) Fees and Bids.

(a) Reasonable fees may be paid for a 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.

(b) No fee will be paid to attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an AR remains the claimant's obligation.

(c) 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 from a licensed contractor. No fees will be paid for the bids or estimates.

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

(d) The MBE 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 MBE 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.

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

(6) Approval and Payment Options. Upon approval of the request, the MBE writes a detailed letter decision to the claimant advising of the approval. (Exhibit 29-3 provides a sample of the home modification approval letter.) The approval letter is to include guidance to the claimant explaining the

payment options available and requests that the claimant respond in writing, indicating the preferred payment option. For reimbursement authorization of home modifications, the following is necessary:

(a) The claimant submits medical evidence and two proposals for home modifications. Upon review, the MBE approves the lower-cost bid proposal and sends a letter to the 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 MBE sends a courtesy copy of this letter to the contractor.

(b) Upon receipt of the claimant's attestation and request to pay the contractor, the MBE 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. The contractor must enroll with DEEOIC as a provider to receive payment.

(c) In certain situations, the MBE may authorize payment of a pre-construction deposit, if required by the contractor whose bid has been accepted by the MBE. 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 MBE approval, the contractor may then submit Form OWCP-1500, to receive partial payment for the deposit amount of the estimated cost. Again, 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.

(d) 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 MBE Supervisor should contact the MBPU for assistance.

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

(1) Criteria for Modifications. Upon receipt of an LMN describing a medical need for vehicle modification, the MBE determines if the claimant's transportation needs for authorized medical services, appliances and supplies can be met by modifying or adding accessories/equipment to the claimant's presently owned vehicle. When considering modifications to an existing vehicle, the MBE 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.

(2) Proposals. If the MBE determines the medical needs of the claimant warrant vehicle modification, the MBE advises the claimant, in writing, to submit a detailed written proposal containing the following information:

(a) 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.

(b) 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.

(3) Acceptance by the MBE. The MBE has the latitude to approve an estimate that the claimant favors if the estimates are reasonably similar in scope and cost.

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

(b) 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 MBE issues a letter decision informing the claimant of the authorization denial.

k. Local Travel for Authorized Medical Services and Supplies. DEEOIC reimburses reasonable and necessary transportation expenses (taxis, rideshares, bus fare, medical transport, etc.) to obtain authorized medical services, appliances and supplies. However, courtesy services should be used when available. If no transportation service is readily available to the claimant, the MBE may conduct further development to explore additional transportation options that meet the medical transportation needs of the claimant.

l. Medical Expense Reimbursement for Extended Travel. This section describes procedures the MBE follows for authorizing reimbursement requests for extended medical travel (travel over 200 miles round-trip), and the process for approving reimbursement claims regardless of whether the claimant obtained prior approval for the trip.

(1) Upon acceptance of a medical condition, the claimant receives a benefits package from DEEOIC that includes instructions on how to submit a written request for pre-authorization of extended medical travel, when such travel is necessary to obtain treatment for that condition. Pre-authorization allows for reimbursement of costs for transportation, lodging, and a per diem allowance that covers meals and incidental expenses.

(2) Pre-authorization for reimbursement of medical travel expenses, when the round-trip is under 200 miles, is not required. The DEEOIC BPA processes these travel reimbursement claims without a pre- authorization letter from the MBE.

(3) Upon receipt of a travel authorization request from the claimant, for medical travel exceeding 200 miles round-trip, the MBE first determines whether the claimant has provided justification for extended travel to obtain medically necessary evaluation or treatment relating to an accepted medical condition. Medical justification will normally consist of evidence of a scheduled appointment with a medical provider and a description of the planned or scheduled treatment. The medical provider's enrollment in DEEOIC's program is not a prerequisite for approving extended medical travel if the claimant chooses to receive medical services from a non- enrolled provider. The claimant may choose the desired mode of transportation when making travel plans for medically necessary travel. In any instance where the purpose of extended travel is unclear, or a request does not properly document the medical necessity for

the travel, the MBE initiates development with the claimant or the claimant's physician.

In addition to reviewing the medical evidence supporting a travel request, the MBE reviews the request to determine if it meets the "prudent person" test, meaning the request is not deemed to be inappropriate, unreasonable, unnecessary, and/or unjustified with respect to the claimant's need to travel to obtain necessary medical treatment for an accepted medical condition. DEEOIC will not reimburse travelers for costs associated with an indirect or circuitous travel route; unnecessary delays or extended travel time; or luxury accommodations and services that are not essential to obtaining necessary medical treatment. Nor will travelers be reimbursed for fees, fines, and other costs incurred by travelers that are in non-compliance with DOL travel policies.

(4) Companion travel. If the travel request involves authorization for a companion to accompany the claimant, the claimant must provide a written medical rationale from a treating physician supporting the need for the companion, in conjunction with treatment for an accepted medical condition. If the physician confirms that a companion is medically necessary, and provides a satisfactory rationale, the MBE may approve companion travel.

(5) Approval for Extended Travel Reimbursement. Once the basic requirements for extended medical travel are met, the MBE prepares and sends the claimant a travel authorization letter. The MBE's authorization mode of travel the claimant has selected. The authorization letter includes a statement that travel costs are reimbursable only to the extent that the travel relates to obtaining medical treatment for an accepted medical condition. Additionally, the letter advises that the DEEOIC BPA processes travel reimbursement claims in accordance with Government Services Administration (GSA) travel guidelines. Per Diem rates for overnight stay and mileage reimbursement rates are published on the GSA website, and airfare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

Lastly, the MBE's letter advises that the claimant may contact the nearest DEEOIC Resource Center for assistance prior to making a trip, or for assistance in completing OWCP-957 Part A and Part B reimbursement forms upon completion of a trip. The MBE may approve an individual trip, or multiple trips within a specified date range, in one letter to the claimant. In addition to the authorization letter, the MBE also includes attachments for the claimant to use when submitting their reimbursement claim.

(a) Two copies of the detailed authorization letter.

(b) Two copies of a blank Form OWCP-957.

Once the MBE issues an initial authorization letter, future visits to the same doctor or facility may be approved by telephone and confirmed in a follow-up letter.

(6) The MBE may authorize retroactive reimbursement for extended medical travel when the claimant did not request prior approval; however, the claimant must submit evidence conforming to the same requirements as a pre-authorization request. Additionally, the claimant is entitled to receive reimbursement, up to the per-diem amount permitted for authorized travel, regardless of any actual travel costs incurred. Under a retroactive authorization, the MBE only provides the claimant with an authorization letter, not the complete authorization package.

(7) Upon completion of the adjudication of an extended medical travel claim, the MBE updates the authorization request in the WCMBP system to include the decision outcome, including the information needed by the BPA for processing of the reimbursement request.

(a) Approved dates for a single trip, or a date range and number of trips authorized within that timeframe.

(b) Approved mode of transportation.

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

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

(e) Companion travel if approved.

m. Medical Alert Systems. A medical alert system is an electronic device that, when activated, sends an emergency signal via a telephone landline or cellular signal. Given these devices do not cure, give relief, or reduce the frequency of an accepted illness, and that there are other commonly available communication devices that facilitate requests for urgent or emergency care, medical alert systems are typically considered a convenience item. However, circumstances may exist where an alert system is allowable. For consideration of reimbursement, a physician's LMN is required that specifically outlines the need for a medical alert system, and justification as to why other commonly available communication devices are not suitable or available to the employee. The MBE reviews the physician's LMN to determine if it contains an appropriate medical rationale explaining the need for a medical alert system and may authorize reimbursement for up to twelve months at a time. The claimant is responsible for requesting renewal authorizations each year if the service is still necessary.

n. Sun Protective Clothing. Sun protective clothing is outerwear, designed for sun protection, produced from a fabric specifically rated for its level of ultraviolet protection. Any request for a reimbursement of sun protective clothing must be accompanied by an LMN from a qualified physician that provides a well-rationalized and convincing argument as to the medical need for a specific type of sun protective clothing to address the effect of an accepted dermatological condition. Upon the establishment of medical necessity, the MBE may approve a reimbursement request for the purchase of sun protective clothing that aligns with the physician's LMN, with a maximum allowance of $400 per calendar year. For MBE approval or reimbursement, the claimant will need to provide proof of purchase of sun protective clothing specifically rated for sun protection that meets the requirements described by the prescribed physician.

o. Gym or Health Club Membership. The MBE may authorize reimbursement of fees for membership in a private gym or health club when a claimant presents evidence that such a membership serves to fulfill a medical need arising from an accepted medical condition; specifically, to cure, reduce or alleviate the symptoms or period of an accepted illness. In addition to providing a well-rationalized and compelling justification for gym or health club membership, the physician's LMN should provide a discussion of the specific expectations of any membership, including frequency/duration of visits, exercise regimen, or other factors.

If the MBE obtains sufficient justification for a gym or health club membership, the MBE may authorize a membership for a period of up to 12 months. For any renewal, the MBE must obtain evidence that the claimant has been utilizing his or her membership in a manner that conforms to the requirements of the LMN. Moreover, the MBE must obtain an updated LMN that provides justification for the continued efficacy of a gym or health claim membership in addressing the effect of an accepted condition.

The MBE may only authorize the rental or purchase of home gym equipment when it has been established that no other reasonable alternative exists (i.e. the employee is homebound, no suitable gym or health club exists within a reasonable distance, etc.) and that the medically prescribed exercise(s) cannot be performed without the prescribed equipment.

p. Medical Records Procurement. DEEOIC pays costs associated with obtaining medical records regardless of whether it has approved a claim for benefits. MBE staff are responsible for providing reimbursement authorization upon request from a medical provider or claimant. However, this reimbursement is payable only to a hospital, physician's office, or other medical facility that charges a fee to produce records. The maximum allowable reimbursement is $100 per request. Upon receipt of the required information, including a completed Form OWCP-1500, the MBE sends an approval letter to the requestor and completes all

necessary ECS coding. The MBE then forwards the completed Form OWCP-1500, approval letter, and invoice to the NO FO for payment processing.

RACHEL POND

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Director, Division of
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