## DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION Customer Journey Map — Ancillary Medical Benefits

**Customer Stages** 

Accepted Medical Condition

**File for Ancillary Medical Benefits** 

Written Decision

Receive or Request RD if Denied

**Final Decision** 

**Benefits** 

**Customer Steps** 

DEEOIC awards medical benefits for an accepted medical condition

Claimant seeks
reimbursement/
preauthorization for
services and/or
medical equipment
that is outside routine
treatment for an
accepted medical
condition

For Home and Residential Health Care (HRHC), Claimant submits Form EE 17A (Claim for Home Health Care, Nursing Home, or Assisted Living Benefits)

For HRHC, Medical
Benefits Examiner (MBE)
sends Form EE 17B
(Physician s Certification
of Medical Necessity) and
Physician Letter
explaining the HHC
process to the treating
physician

For HRHC, DEEOIC
receives back the Form EE
17B and supporting
evidence from the
treating physician which
the MBE will review along
with any other evidence
in the case file

For all other claim types,
the claimant or their
medical provider/
pharmacist submit Letter
of Medical Necessity
(LMN), necessary
supporting medical
evidence, and a request
for authorization form for
the requested ancillary
medical benefit

The majority of claims are adjudicated within 60 days of receipt

If the MBE is unable to approve the claim for HRHC, the claimant will receive a Recommended decision (RD) for denial

For all other claim type denials, the claimant will receive a decision letter explaining the reason for denial and the claimant's right to request a RD

If claimant receives
approval letter at this time,
they would skip straight to
receiving benefits

Claimant will receive an RD for denial or reduction of HRHC

Claimant may request recommended decision from MBE if denied of any other claim type

Claimant agrees with RD denial and signs waiver

Claimant disagrees with RD denial and requests review of the written record or requests hearing

Case transferred to Final Adjudication Branch (FAB). Claimant assigned FAB Hearing Representative

Claimant has the opportunity to submit new evidence (hearing or review of written record)

If hearing was requested, claimant participates in

FAB reviews case and issues Final Decision to accept or deny or remands case for further development

If denied, claimant may request reconsideration within 30 days

If reconsideration is denied, claimant may request reopening at any time with new evidence

If reconsideration is denied, may file with US District Court when all other administrative options are exhausted If accepted, MBE communicates to the claimant and the Medical Bill Processing Agency that the approved services are authorized for future payment

Medical Bill Processing
Agency sends payment to
supplier/vendor or
claimant (if paid out of
pocket by the claimant)
after receiving bills for
preauthorized services
and/or equipment

**Customer Touchpoints** 

Obtain literature from various community groups

Contacted by Authorized Representative or advocacy group

Phone interaction with Resource Center

In-person visit to Resource Center

Attend DEEOIC outreach event

Access tools and information on DEEOIC website

Receive correspondence from DEEOIC by mail

Phone interaction with CE/FAB Representative

**Access Energy Document Portal (EDP)** 

Access Employees' Compensation
Operations & Management Portal (ECOMP)

**Bright Spots**& Pain Points

"Great people who work hard to help people like me."

> "It would be nice if response was quicker."

"I would like to thank you all for doing a great job."

"Just be more caring to the customer. Don't make them feel like a statistic and nothing else." "Once I was approved everything went smoothly. I would have appreciated more communication during the wait time."

"Your 700+ page manual is not user friendly. The acronyms are too extensive and should be spelled out completely everywhere. But I realize this would make a couple hundred more pages." "I have never had any trouble with the DEEOIC in regards to my claim."

> "Everything I need as a necessity takes far too long to get approved."

"The program and care has been great. I don't know where I would be without it."

"Reimbursement claims could be filed in a more timely manner!"

United States Department of Labor—Office of Workers' Compensation Programs

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## **Frequently Asked Questions**

What are Ancillary Medical Benefits (AMB)?	Ancillary Medical Benefits (AMB) include services and medical equipment or accessories that DEEOIC does not consider as routine or usually necessary for the treatment of an accepted medical condition, and requires the submission of additional evidence before DEEOIC can pre-authorize or authorize reimbursement.
What services and/or medical equipment require AMB authorization?	Home and Residential Health Care, Durable Medical Equipment, Rehab, Home/Vehicle Modifications, Medical travel over 200 miles.
How are AMB bills paid?	If your medical service provider has enrolled in the program, we will pay them directly based upon our fee schedule. If your medical service provider has not enrolled in the program, you can obtain reimbursement for your out-of-pocket expenses for covered medical care by completing Form OWCP-915, Claim for Medical Reimbursement.
How long does the AMB authorization process take?	The majority of claims are adjudicated within 60 days of receipt.  If the MBE is unable to approve the claim for HRHC, the claimant will receive a RD for denial. For all other claim type denials, the claimant will receive a decision letter explaining the reason for

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