

U.S. Department of Labor

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



RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE
INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL:
CHAPTER 3-0200 Medical Bill Process

EEOICPA TRANSMITTAL NO. 17-05

March 2017

EXPLANATION OF MATERIAL TRANSMITTED:

This chapter describes the roles of the Claims Examiner (CE), Medical Benefits Examiner, Fiscal Officer (FO), and District Medical Scheduler, in the medical bill process. It also outlines the procedures for evaluating and approving requests from employees who are in need of medical services, supplies, or reimbursement of expenses related to medical care. This material is issued as procedural guidance to update, revise, and replace the text of EEOICPA Procedure Manual (PM) Chapter 3-200, Medical Bill Process. This version removes Sections 7,8,9,10,11, and 12 which have been transferred to PM Chapter 3-300 Ancillary Medical Services and Related Expenses. Below is a brief summary of the changes and updates contained in this chapter.

- Removes pagination from the Chapter and the Page number column from the Table of Contents.
- Removes the footer on all pages subsequent to the Table of Contents.
- Updates abbreviation and title of Contract Medical Consultant (CMC) in Section 5.
- Removes Sections 7 - Psychiatric Treatment, 8 - Hearing Aids, Section 9 - Chiropractic Services, Section 10 - Acupuncture Treatments, Section 11 - Organ Transplants (including Stem Cell), and Section 12 - Experimental Treatment and Clinical Research from the previous publication of this chapter. These topics are now contained

in the newly released PM Chapter 03-300, Ancillary Medical Services and related Expenses.

- Adds new language in Section 1 and Section 2 pertaining to Medical Benefits Examiners' (MBE) roles and responsibilities.
- Updates language in Section 4 that corrects the acronyms for the Medical Bill Processing Unit, and also corrects the name change to the bill processing contractor's new image storage and retrieval system, Xerox Transaction Content Management (XTCM).
- Adds new coding reference to include ICD-10 in Section 4 (Mailbox for Medical Bill Inquiries), Section 8 (Eligibility Files), and adds language in Section 9 (ICD-CM Codes) regarding the effective date and process of using ICD-10 coding.



Rachel P. Leiton
Director, Division of
Energy Employees Occupational Illness Compensation

Filing Instructions:

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Ch. 3-0200

Insert

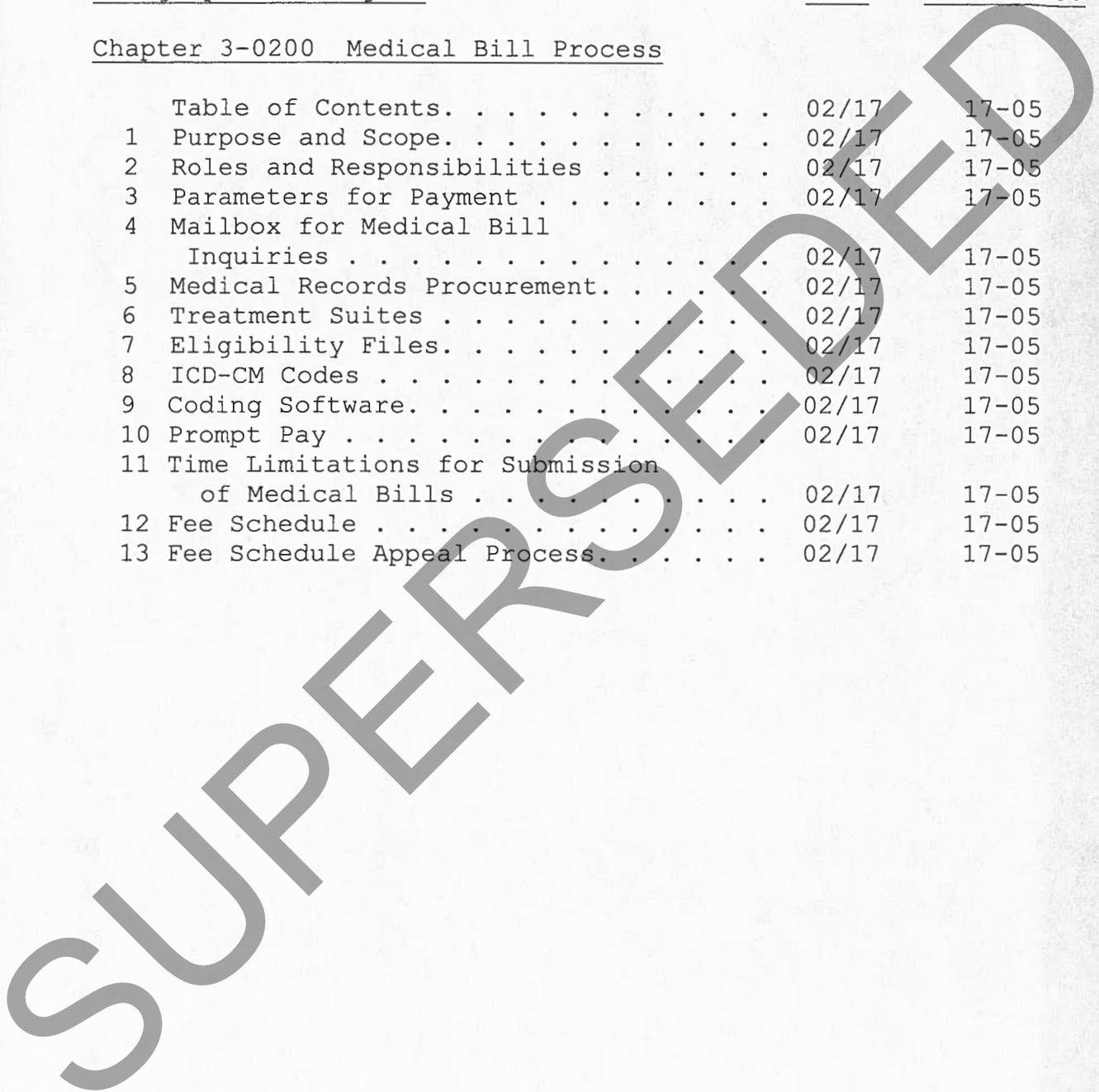
Ch. 3-0200

File this transmittal behind Part 3 in the front of the Unified Federal (EEOICPA) Procedure Manual.

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

TABLE OF CONTENTS

| <u>Paragraph and Subject</u> | <u>Date</u> | <u>Trans. No.</u> |
|--|-------------|-------------------|
| <u>Chapter 3-0200 Medical Bill Process</u> | | |
| Table of Contents | 02/17 | 17-05 |
| 1 Purpose and Scope | 02/17 | 17-05 |
| 2 Roles and Responsibilities | 02/17 | 17-05 |
| 3 Parameters for Payment | 02/17 | 17-05 |
| 4 Mailbox for Medical Bill Inquiries | 02/17 | 17-05 |
| 5 Medical Records Procurement | 02/17 | 17-05 |
| 6 Treatment Suites | 02/17 | 17-05 |
| 7 Eligibility Files | 02/17 | 17-05 |
| 8 ICD-CM Codes | 02/17 | 17-05 |
| 9 Coding Software | 02/17 | 17-05 |
| 10 Prompt Pay | 02/17 | 17-05 |
| 11 Time Limitations for Submission of Medical Bills | 02/17 | 17-05 |
| 12 Fee Schedule | 02/17 | 17-05 |
| 13 Fee Schedule Appeal Process | 02/17 | 17-05 |



1. Purpose and Scope. This chapter describes the roles of the Claims Examiner (CE), Medical Benefit Examiner (MBE), Fiscal Officer (FO), and District Medical Scheduler (MS), in the medical bill process. It also outlines the procedures for evaluating and approving requests for employees who are in need of medical services, supplies, or reimbursement of expenses related to medical care.

2. Roles and Responsibilities. Upon issuance of a final decision approving a specific medical condition, the CE, MBE, the Bill Processing Agent (BPA), the FO, and the MS must ensure that the medical needs of the claimant, as they relate to his or her accepted medical condition, are reasonably provided for.

a. Medical Bill Processing Agent. The use of a contractor for processing medical bills allows the DEEOIC to provide a high level of service to eligible claimants and their providers. Once a claimant has been accepted for a covered condition under the EEOICPA, an eligibility file is automatically generated in the Energy Compensation System (ECS) and sent to the BPA electronically.

(1) When the BPA receives the eligibility file, the BPA sends a medical bill identification card (MBIC) and general information about the medical bill process to the claimant.

(2) Providers, Claimants and District Office Staff send all medical bills, bill attachments, treatment notes, and requests for claimant reimbursement to the contractor for scanning and keying into their system.

(3) The BPA maintains a customer call center, medical staff, and bill resolution units.

b. Medical Benefits Examiner. The MBE is a specialized CE responsible for reviewing, developing, and approving or denying claims for in-home health care.

c. Claims Examiner. The CE considers for approval services, appliances, supplies, modifications, or travel expenses that are recommended or prescribed by a

licensed physician, and necessary to cure, give relief, or reduce the degree or the period of an illness. (Refer to EEOICPA PM 3-0300 for detailed information on approval of durable medical equipment, oxygen therapy/oxygen medical supplies, massage therapy, sun-protective clothing, gym memberships, extended medical travel, and other ancillary medical services.)

(1) The CE considers the level of care prescribed by the treating physician as it relates to the accepted medical condition and the facts of the case. The CE must then make an informed judgment based on the level of care prescribed by the doctor.

(2) This decision must take into account the overall desires and needs of the patient, as well as those of the family. The Division of Energy Employees occupational Illness Compensation (DEEOIC) will not dictate what option an employee must accept, nor will decisions be made based solely upon cost. The CE must also consider what level of care or services satisfy the patient's needs.

(3) The CE is responsible for communicating all decisions (approval/denial) to the requestor.

(a) If a request for services or payment originates from the BPA, the FO notifies the CE via email. These requests may come to the CE as a prior authorization request, or may come after submission of a charge to the BPA.

The CE emails his or her determination to the FO, inputs it into ECS under the correspondence tab and communicates the decision via thread to the BPA.

(b) If the request originates from a claimant or provider, the CE immediately sends a copy via facsimile to the FO, and concurrently begins development for approval or denial of the request. The CE communicates all approvals or denials to the requestor as

outlined above.

d. Fiscal Officer. The FO acts as liaison between the CE and the BPA, serves as coordinator for medical bill issues between the District Offices (DO) and the National Office (NO), and maintains a DO record of persons authorized to access the BPA website. The FO does not determine eligibility or authorize payments.

e. District Medical Scheduler. The MS coordinates all requests for both Contract Medical Consultant (CMC) and Non-Contracted Impairment reviews.

f. Contract Medical Consultant. The CMC reviews and evaluates the medical evidence of record and provides medical opinions about various aspects of cases; including interpretation of medical evidence, causation between an illness and occupational toxic substance exposure, and percentage of impairment.

3. Parameters for Payment. The Office of Workers' Compensation Programs (OWCP) procedures employ four levels of review in the medical bill process, only two of which DEEOIC currently uses. The BPA processes charges for Level 1 services without CE approval. Any higher level of service (i.e. two, three or four) is treated as a Level 4 service in our program and requires that the CE review the proposed procedures or service(s), the proposed charges if applicable, and the supporting medical documentation, prior to approving or denying the request.

4. Mailbox for Medical Bill Inquiries. The Policy, Regulations and Procedures Unit (PRPU) of the DEEOIC Policy Branch, located in the NO, has created an electronic mailbox (email) for use in resolving medical bill questions. Staff must use this mailbox when submitting inquiries concerning medical bills, travel reimbursement, treatment suites, provider outreach, or policy questions regarding medical bill processing.

The FO in each respective DO serves as liaison for CEs with questions that require review by the Medical Bill Processing Unit (MBPU) located in the NO.

Use of this mailbox provides for expedited resolution of medical bill issues as they arise, and provides a more

uniform process for responding to these questions and issues, program wide.

a. When a CE receives an inquiry regarding reimbursement of a medical bill, for an accepted condition, the CE first reviews the bill in the Achieve medical bill inquiry system, and/or the XTCM Image Retrieval system, available at: <http://owcp.dol.acs-inc.com/portal/main.do>) to verify that the supporting medical documentation is on file. If, after reviewing the supporting documentation in the BPA web portal and in the case file, the CE still has questions related to medical bill processing, travel reimbursement, treatment suites, provider outreach, or a policy question regarding medical bill processing, additional assistance may be requested through the medical bill inquiries mailbox.

b. The CE prepares an email to the FO. In order to maintain consistency and to provide clarity in the communication process, it is imperative that the CEs provide sufficient information in the email, clearly defining the nature of the question, so that it can be routed properly for response. Inquiries to the mailbox must be categorized using the subject headings below, and the subject line of the email must contain one of the following four subject headings:

(1) Policy Questions. Questions regarding policy interpretation or implementation are answered by the MBPU.

(2) Treatment Suites. The treatment suites and ICD-9/10 codes utilized by the DEEOIC are contained within a database, administered by medical professionals within the OWCP. This database compares an ICD-9/10 coded diagnosis, and associated services being billed by a provider, with a group (or suite) of acceptable, allowable treatments or services for that accepted condition. The use of treatment suites allows bills to be paid automatically when the treatment being billed is reasonable and customary for the accepted

condition. Often, issues arise when a claimant is trying to obtain payment for a consequential illness and the medical bills are being denied because the consequential illness is not being recognized within the treatment suite(s) for the accepted condition. Inquiries of this nature will be directed to the MBPU, for a response.

(3) Provider Outreach. Questions from medical providers regarding assistance with enrollment, submission of bill(s), or understanding DEEOIC's medical billing process, must be forwarded to the MBPU, who will then coordinate with the Resource Center (RC) Manager on these issues. Provider outreach issues must be coordinated through the MBPU.

(4) Bill Payment Processing. Questions regarding reimbursement of medical bills must be routed to the MBPU for a response.

The body of the email itself must contain the following information (as applicable):

- DO Location;
- CE Name;
- Employee's Name;
- DOL File Number(not to be used in the subject line);
- Accepted Condition(s) with ICD-9/10 code(s);
- Billed Amount(s);
- Date(s) of Service(s) or Travel day(s);
- Medical Provider Name(s);
- Type of Service(s) (i.e., Pharmacy, In-Home Health);
- Question(s) or issue(s) to be resolved.

c. Upon receipt of an email question, the FO reviews the email and determines whether the issue warrants referral. If the question does warrant such review, the FO forwards the inquiry to the medical bill inquiries mailbox.

d. The MBPU reviews all submissions submitted to the medical bill inquiries mailbox and it determines the proper course of action. As noted above, the MBPU reviews and answers all policy, treatment suite, and medical provider outreach questions. It also responds to issues related to medical bill payments. Some referrals to the mailbox may have elements related to several topics in the inquiry. In these situations, the Payment Systems Manager (PSM) will coordinate the development of the referral between different subject matter experts to respond.

e. In the case of a policy or treatment suite issue, the MBPU researches the inquiry and provides an answer to the requesting DO within five (5) business days. If a policy question requires additional research, the PSM will grant an extension. Complex policy issues might require the involvement of the Policy Branch Chief.

f. The MBPU may refer provider enrollment issues to the RC Manager for development. The RCs serve as the primary point of contact for DEEOIC's provider enrollment inquiries. The RC Manager has three (3) business days of receipt to attempt to resolve the situation with the provider and report the outcome back to the MBPU. The MBPU will relay the response(s) by email to the requester.

g. Upon receipt of the MBPRU responses, the FO forwards the response to the appropriate CE via email. The CE is responsible for notifying the employee, claimant, authorized representative and or provider (if applicable), via telephone or in writing, of the appropriate response to the issue at hand. All telephone activity is documented in ECS and a copy of the email response from the MBPU or PSM is added to the case file.

5. Medical Records Procurement. DEEOIC pays costs associated with obtaining medical records regardless of whether a claim has been approved for benefits. 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 employee.

Part 3 - Fiscal

Medical Bill Process

a. Form of Request. The provider provides the CE with the written fee request on official letterhead or billing statement. The request includes the tax identification number of the facility, total amount charged for the record request, and the provider enrollment number. If the provider is not enrolled, the CE forwards an enrollment package to the provider with a letter requesting that the provider enroll, and after completion of the enrollment process, the provider informs the CE of their new provider number.

b. Approval of Payment. Upon receipt of the required information, the CE approves the payment of the bill by completing a Form OWCP-1500, sending an approval letter to the requestor, and completing ECS coding as required in DEEOIC procedures. The CE then forwards the completed Form OWCP-1500, approval letter, and invoice to the Fiscal Officer for payment processing.

6. Treatment Suites. At the core of the medical bill reimbursement process is the use of treatment suites. The treatment suites used by the DEEOIC are contained in a database maintained by medical professionals within the OWCP. They compare an accepted (ICD-9/10 coded) diagnosis for which a provider has billed, with acceptable, allowable treatments for that condition. The use of treatment suites allows automatic payment of bills, for authorized services, when the amount billed is reasonable and customary for an accepted condition.

7. Eligibility Files. In order for a claimant's bills to be paid, an eligibility file is generated automatically in ECS and sent to the bill processing agent once a condition has been accepted. This eligibility file contains the accepted condition for which a claimant is entitled to medical treatment. When the accepted condition(s) are coded and billed with the correct ICD-9/10 Code, the volume of suspended and denied bills is significantly reduced. Consequently, accurate code selection expedites provider reimbursement for all approved medical services rendered to the claimant.

8. ICD-CM Codes. The International Classification of Diseases, 9th and 10th Revision, and Clinical Modification, (referred to simply as ICD-9/10 codes), is a statistical classification and coding system used to assign appropriate

codes for signs, symptoms, injuries, diseases, and other medical conditions.

These codes are assigned, based on the claimants' medical documentation (records), including, but not limited to physician notes, diagnostic tests, and surgical reports. ICD-9/10 codes are divided into an alphabetic index, which is an alphabetic list of terms and their corresponding codes. ICD-9/10 codes are composed of numbers with 3, 4, 5, 6 or 7 digits. Three-digit category codes are generally subdivided by adding a fourth, fifth and/or sixth digit to further specify and clarify the nature of the disease or medical condition. The CE entering an ICD-9/10 code must identify and enter the code that references the disease, illness or medical condition that was reported, and should identify the organ(s) or portion of the body affected by the condition.

In general, three-digit codes identify a category of illness, while codes with fourth digits are called subcategory codes, and those with fifth digits are referred to as sub-classifications.

When a specific condition, illness, etc., contains a 5th or 6th digit, the CE uses all available digits to identify the condition. In addition to providing further specificity of the anatomical site, the 4th and 5th digits also provide additional pertinent clinical information related to the injury or medical condition. Therefore, when selecting ICD codes, the CE should always use the code that most specifically describes the medical condition reported.

a. Examples of valid 3-character ICD-10-CM codes:

- (1) I10 Primary Hypertension
- (2) N19 Renal Failure.

b. Examples of 4, 5, and 6 character ICD-10-CM codes:

- (1) J44.9 chronic obstructive pulmonary disease unspecified (requires a 4th digit).
- (2) C34.11 Malignant neoplasm of upper lobe, right bronchus or lung (requires 5th digit).

(3) C50.012 Malignant neoplasm of lower-outer quadrant of left female breast (requires a 6th digit).

For all medical conditions with a medical eligibility begin date on or after October 1, 2015, the CE will use ICD-10-CM coding in ECS, development, and decisions. If the condition is input into ECS after October 1, 2015, ECS will default to entry of an ICD-10 code. However, the system will allow entry of an ICD-9 if appropriate. If the condition is determined to be a consequential condition and the underlying condition has a filing/eligibility begin date prior to October 1, 2015, the ECS system will force the user to enter an ICD-9 code, even though the condition itself was filed after October 1, 2015. Ultimately, the medical eligibility begin date is the driving factor on whether an ICD-9 or ICD-10 code must be used on a medical condition. If the medical eligibility begin date is on or after October 1, 2015, the ICD-10 code is what will be reflected throughout the system wherever ICDs are reflected. CEs will also reference ICD-10 in decisions and development letters if the filing/eligibility begin date is on or after October 1, 2015. For example, if the medical records list a primary diagnosis of renal failure and the status effective date is October 1, 2015, the CE enters (N19) as the ICD-10-CM code in the medical condition field and uses this code in the rest of the correspondence throughout the case.

9. Coding Software. CEs are to utilize Optum, an online tool that helps to identify the appropriate ICD-9/10-CM code. These guidelines are to be used as a supplement to the ICD-9/10-CM Coding books.

10. Prompt Pay. The Prompt Payment Act requires federal agencies to pay vendors in a timely manner. The Act requires assessment of late interest penalties against agencies that pay vendors after a payment due date. The DEEOIC has identified three classes of bills that fall under the Prompt Pay Act: Reviews by a CMC, Second Opinion/Referee Medical Examinations, and Impairment Rating Examinations. These bills must be processed within seven calendar days from date of receipt in the District Office. (Refer to PM 2-800 for the specific actions to be taken by the CE and the MS in the processing of CMC bills.)

11. Time Limits for Submission of Medical Bills. DEEOIC pays providers and reimburses employees promptly for all

bills that are properly submitted on an approved form and which are submitted in a timely manner. No such bill is paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was provided; or, more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later.

12. Fee Schedule. For professional medical services, OWCP maintains a schedule of maximum allowable fees for procedures performed in a given locality.

The schedule consists of:

- a. An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class.
- b. An index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs.
- c. A monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

Generally, bills submitted using HCPCS/CPT codes cannot exceed the fee schedule. If the time, effort and skill required to perform a particular procedure varies widely from one occasion to the next, DEEOIC may choose not to assign a fee schedule limitation. In these cases, the allowable charge is set individually based on consideration of a detailed medical report and other evidence. At its discretion, DEEOIC may set fees without regard to schedule limits for specially authorized consultant examinations, and for other specially authorized services.

13. Fee Schedule Appeal Process. As part of the medical bill review process, program regulations provide for the appeal of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service.) In order to maintain consistency, record responses, and track fee schedule appeals, the following procedures have been developed to further delineate

this process.

a. When the BPA receives a fee appeal request letter, the BPA stores an electronic copy of the appeal letter in the XTCM Image Retrieval system, linked to the remittance voucher if submitted by the provider, and sends an email to the MBPU for review.

b. For each fee schedule appeal letter received, the MBPU creates a record, and maintains it in a tracking system (spreadsheet or database) created for this purpose.

c. The MBPU POC reviews the fee appeal request to determine if the provider has met any of the conditions below which justify a reevaluation of the amount paid. These three conditions, as found in 20 C.F.R. 30.712, are:

(1) The service or procedure was incorrectly identified by the original code; or

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

d. Within 30 days of receiving the request for reconsideration, the MBPU prepares a response to the medical provider outlining DEEOIC's decision to either:

(1) Approve an additional payment amount: In this instance, the MBPU generates a draft letter for the District Director's (DD) signature, informing the provider of the approval for additional payment. Where an additional amount is found to be payable based on unusual provider qualifications, the DD determines whether future bills for the same or similar service from that provider should be exempt from the fee schedule. The MBPU also prepares a

memorandum for the case file stating the findings and the basis for the approval of the additional amount, or;

(2) Deny any additional payment: In this instance the MBPU prepares a draft letter-decision for the DD's signature, advising that additional payment is denied, based upon the provider's inability to establish one of the conditions listed above in Item c(1)(2)(3). Where additional payment is denied, the letter decision must contain a notice of the provider's right to further review, similar to the following:

If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and should be addressed to the Regional Director, District _____, Office of Workers' Compensation Programs, U.S. Department of Labor, [Insert appropriate Regional Office address and Zip Code.]

e. The draft approval or denial letters are prepared by the MBPU, for the signature of the DD whose office has control of the claim file(s) being addressed in the decision(s). The MBPU sends the draft letter (via email) to the DD for review, signature, and mailing. The DD places a copy of the signed letter in the case file and also returns (via email) a scanned copy of the signed letter, to be retained by the PSM.

f. The MBPU continues to track the status of any fee schedule appeal case, and maintains an electronic copy of all correspondence. This includes a copy of the draft letter and a scanned copy of the signed letter mailed by the DD.

g. If a denial is subsequently appealed to the Regional Director (RD), the RD must consult with the PSM to obtain copies of relevant bills and documents, and to discuss the appeal. The PSM also provides the Regional Director (RD) with a copy of the denial letter signed by the DD. This can be handled via email.

Part 3 - Fiscal

Medical Bill Process

h. After consultation with the PSM, the RD prepares a written response to the provider within 60 days of receipt of the request for review. Where additional payment is denied at the regional level, the letter decision from the RD advises the provider that the decision is final and is not subject to further administrative review. The RD forwards a scanned copy of the signed letter decision to the PSM. The PSM also retains that response as part of the appeal record.

i. The final outcome of each appeal letter is recorded in the MBPU tracking system to indicate:

- (1) Additional payment made.
- (2) DD Denial letter.
- (3) RD Appeal letter.
- (4) Time limit (30 days) has expired for appeal to RD.
- (5) The final disposition date for each appeal letter.