U.S. Department of Labor

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

MEMORANDUM

DATE: July 16, 2019

TO: JOHN VANCE
Branch Chief, Branch of Policy, Regulations and Procedures

FROM: CURTIS JOHNSON
Unit Supervisor, Branch of Policy, Regulations and Procedures

RE: CMC AUDIT REPORT – 4th Quarter 2018

Below is the analysis of twelve (12) cases determined to have a deficient Contract Medical Consultant (CMC) report based on a review by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) Medical Director.

1. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition: Accepted: ICD 9 code 491.0, Simple chronic bronchitis
Accepted: ICD 9 code 492.8, Other emphysema
Accepted: ICD 10 code G47.33, Obstructive sleep apnea (adult)
Accepted: ICD 10 code J45.40, Moderate persistent asthma, uncomplicated

The Medical Director's findings are as follows: The second medical opinion (SECOP) report lacks a signed Potential Conflict of Interest Statement. This would not have changed the final determination in this case.

I accept the Medical Director's opinion regarding the error found in this SECOP.

The program referred the case for a SECOP regarding the medical necessity of continued home health care (HHC). Following review of the [redacted] *SECOP report, the medical benefits adjudication unit authorized continued HHC for* [redacted] *through* [redacted]. *Given that the period of approved HHC in connection with the SECOP examination expired in* [redacted]*, no further action is required for this case.*

RECOMMENDATION: The contractor must obtain the signed Potential Conflict of Interest Statement.

2. [redacted]
Seattle District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 502, Pneumoconiosis due to other silica or silicates

The Medical Director's findings are as follows: The CMC elected not to base his WPI rating on Table 5-12 on Page 107 of "AMA Guides to the Evaluation of Permanent Impairment" as required by DEEOIC policy. Instead, he based his WPI rating "on the extent and severity of [the claimant's] pulmonary dysfunction and inability to perform activities of daily living." Even if DEEOIC policy allowed the use of that approach, the CMC did not include a "detailed description with supporting, objective documentation of the type of pulmonary impairment and its impact on the ability to perform activities of daily living " as required by Section 5.10 on Page 107. In any case, the evidence in the claimant's file pertaining to his accepted condition does not support a WPI of 9%. The pulmonary function studies performed on [redacted] were neither valid nor reliable. The most recent valid and reliable pulmonary function studies in this file appear to be those performed on [redacted]. The [redacted] studies reveal the claimant's FVC to be 80% of predicted, his FEV1 to be 84% of predicted, and his Dco to be 99% of predicted, which places him in Class 1 on Table 5-12 on Page 107 with a WPI of 0%.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The employee has previously received compensation benefits for 9% whole person impairment [redacted]. *The CMC's* [redacted] *report provided a whole person impairment rating of 9%. The Final Adjudication Branch (FAB) issued a final decision on* [redacted] *to deny the employee's Part E claim for increased whole person impairment. Given that the evidence of record does not support a level of impairment greater than the previous award of 9%, no further action is needed*

RECOMMENDATION: Discuss the error in this report with QTC so the CMC can improve future submissions.

3. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition: Accepted: ICD 9 code 503, Pneumoconiosis due to other inorganic dust

Accepted: ICD 9 code V81.4, Screening for other and unspecified respiratory conditions

The Medical Director's findings are as follows: The SECOP report lacks a review of systems, a report of physical examination, and a signed Potential Conflict of Interest Statement. This would not have changed the final determination in this case.

I agree with the Medical Director's assessment that a Potential Conflict of Interest Statement is missing from the SECOP report. However, I find that while the SECOP physician could have improved the report with additional details, the overall presentation of the patient's medical history and physical findings is satisfactory.

The HHC provider requested HHC for an initial period for [redacted] *through* [redacted]. *The program referred the case file for a SECOP on* [redacted] *regarding the medical necessity for HHC. The* [redacted] *SECOP report provided a medical history, objective and subjective findings, findings from medical records and show that the SECOP physician performed a physical examination of the claimant (his lungs are clear, has mild to moderate congestion of the nasal mucosa worse on the left than the right, small airways obstructive defect which improves by 18%). The SECOP physician determined that while the claimant does have "berylliosis that is probably causing his asthma…he does not have pulmonary functions that would allow me to recommend that he have home health care." Given the weight of medical evidence, the medical benefits adjudication unit did not authorize HHC for the requested period.*

RECOMMENDATION: The contactor must obtain a signed Potential Conflict of Interest Statement.

4. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 10 code C56.1, Malignant neoplasm of right ovary
Accepted: ICD 10 code C79.11, Secondary malignant neoplasm of bladder
Accepted: ICD 10 code K56.52, Intestinal adhesions [bands] with complete obstruction
Accepted: ICD 10 code V81.4, Screening for other and unspecified respiratory conditions

The Medical Director's findings are as follows: The CMC was asked to review the claimant's medical records and independently determine a WPI rating, which takes into consideration each of the claimant's accepted conditions (ovarian cancer, bladder cancer, and bowel obstruction). Instead, the CMC combined his rating for the claimant's bowel obstruction with the WPI rating for the claimant's ovarian cancer and bladder cancer determined by another physician three months previously. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in the CMC's evaluation; however, there are extenuating circumstances in this case.

[redacted] *provided an initial impairment rating report dated* [redacted]. *However, on* [redacted], *the district office accepted intestinal blockage (small bowel obstruction) as a consequential condition under Part E. Since this condition required inclusion in the impairment rating, the district office referred the file for CMC review on* [redacted], *and requested that the file be sent to back to* [redacted] *Instead, the contractor sent the file to* [redacted]. *The CMC's* [redacted] *report provided a 24% whole person impairment rating. FAB issued a final decision on* [redacted] *to accept the employee's Part E claim for 24% whole person impairment* [redacted].

RECOMMENDATION: Recommend that QTC redo the impairment correctly, by assigning the case to [redacted], to determine if a higher rating exists. If a correct rating results in a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment. The contractor must reiterate how to properly combine multiple system impairment ratings with the CMC who conducted the audited impairment rating.

5. [redacted]
Cleveland District Office
Supplemental Evaluation (re: Impairment)
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.2, Other and unspecified malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.4, Other and unspecified malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.62, Squamous cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 232.4, Carcinoma in situ of scalp and skin of neck
Accepted: ICD 9 code 496, Chronic airway obstruction, not elsewhere classified
Accepted: ICD 9 code 503, Pneumoconiosis due to other inorganic dust
Accepted: ICD 9 code V81.4, Screening for other and unspecified respiratory conditions

The Medical Director's findings are as follows: The CMC did not provide a clinical history or summary of facts. This would not have changed the final determination in this case.

I accept the Medical Director's opinion regarding the error found in this supplemental evaluation.

The employee has previously received compensation benefits for 30% whole person impairment [redacted]. *In response to the employee's Part E claim for increased impairment, the CMC's*

initial impairment rating report of [redacted] *provided a 19% whole person impairment rating. Following the submission of additional medical evidence, the district office requested a supplemental impairment rating report. The CMC's* [redacted] *supplemental report provided a 30% whole person impairment rating. FAB issued a final decision on* [redacted] *to deny the employee's claim for increased impairment. There is no further action required for this case.*

RECOMMENDATION: Discuss the error in this report with QTC so the CMC can improve future submissions.

6. [redacted]
Jacksonville District Office
Impairment Evaluation
Report date: [redacted]
Condition: Accepted: ICD 9 code 173.2, Other and unspecified malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.3, Other and unspecified malignant neoplasm of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.4, Other and unspecified malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.41, Basal cell carcinoma of scalp and skin of neck
Accepted: ICD 9 code 173.5, Other and unspecified malignant neoplasm of skin of trunk, except scrotum
Accepted: ICD 9 code 173.51, Basal cell carcinoma of skin of trunk, except scrotum
Accepted: ICD 9 code 173.6, Other and unspecified malignant neoplasm of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.61, Basal cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.62, Squamous cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.7, Other and unspecified malignant neoplasm of skin of lower limb, including hip
Accepted: ICD 9 code 173.71, Basal cell carcinoma of skin of lower limb, including hip
Accepted: ICD 9 code 185, Malignant neoplasm of prostate
Accepted: ICD 9 code 591, Hydronephrosis
Accepted: ICD 9 code 733.90, Disorder of bone and cartilage, unspecified
Accepted: ICD 10 code C44.212, Basal cell carcinoma of skin of right ear and external auricular canal
Accepted: ICD 10 code C44.219, Basal cell carcinoma of skin of left ear and external auricular canal
Accepted: ICD 10 code C44.311, Basal cell carcinoma of skin of nose
Accepted: ICD 10 code C44.319, Basal cell carcinoma of skin of other parts of face

Accepted: ICD 10 code C44.622, Squamous cell carcinoma of skin of right upper limb, including shoulder
Accepted: ICD 10 code C44.629, Squamous cell carcinoma of skin of left upper limb, including shoulder
Accepted: ICD 10 code D04.61, Carcinoma in situ of skin of right upper limb, including shoulder

The Medical Director's findings are as follows: The CMC rated the employee's level of impairment due to skin cancer at Class 2, based on findings which included, but were not limited to, limitations to sun exposure, some limitations to activities of daily living and no reported requirement for further treatment. However, each of the employee's skin cancers has been cured--leaving him with scars from the treatment and the need for regular screening for new lesions, but his history of skin cancer has little impact on his activities of daily living (Outdoor activities in direct sunlight are not considered an activity of daily living. See Table 1-2 on Page 4 of AMA Guides.). Therefore, the employee's level of impairment due to skin cancer falls into Class 1 (0%-9% Impairment of the Whole Person) because his skin disorder signs and symptoms are only intermittently present and he has no or few limitations in his performance of activities of daily living and he requires only intermittent treatment. When rating the employee's prostate cancer, the CMC appropriately placed him in Class 3 on Table 7-8 on Page 161 of "AMA Guides to the Evaluation of Permanent Impairment"--but the CMC did not "combine [his] impairment estimate for prostate and seminal vesicle loss with impairment for sexual dysfunction or urinary incontinence" as instructed in the table. The employee's impotence and urinary incontinence are both clearly documented on his activities of daily living questionnaire dated [redacted]. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The employee has previously received compensation benefits for 49% whole person impairment [redacted]. The CMC's [redacted] report provided a 24% whole person impairment rating. The district office requested a supplemental impairment rating due to the acceptance of the consequential illness of hydronephrosis of the right kidney resulting from the treatment of prostate cancer. The CMC's supplemental report of [redacted] provided a 55% whole person impairment. FAB issued a final decision on [redacted] to accept the employee's Part E claim for 55% whole person impairment (6% increase for [redacted]).

RECOMMENDATION: Recommend that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

7. [redacted]
Denver District Office
Impairment Evaluation
Report date: [redacted]
Condition**:** Accepted: ICD 9 code 225.1, Benign neoplasm of cranial nerves
Accepted: ICD 9 code 351, Facial nerve disorders
Accepted: ICD 9 code 388.3, Tinnitus
Accepted: ICD 9 code 389.12, Neural hearing loss, bilateral

The Medical Director's findings are as follows: The employee's accepted conditions are the result of an acoustic neuroma on the right side of his head (physician's letter dated [redacted]. He has accepted conditions related to impaired hearing (Cranial Nerve VIII) and weakness of the facial muscles of expression and accessory muscles for chewing and swallowing (Cranial Nerve VII). The employee also has difficulty with balance (Cranial Nerve VIII), although this is not one of his accepted conditions. The CMC appropriately rated the employee's impaired hearing in accordance with Chapter 11 of "AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition", but he inappropriately evaluated the employee's difficulty with balance using Table 13-15 on Page 336, which is used to rate station and gait disorders; the CMC should have used Table 13-13 on Page 334, which is used to rate impairment of Cranial Nerve VIII. The employee has also developed difficulty swallowing (dysphagia), which can be attributed to weakness of the accessory muscles for chewing and swallowing (Cranial Nerve VII) and rated using Table 13-12 on Page 332 or to a newly diagnosed tumor on the employee's hypoglossal nerve (Cranial Nerve XII)--which is not one of his accepted conditions. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this impairment evaluation.

The employee has previously received compensation benefits for 25% whole person impairment [redacted]. The CMC's [redacted] report provided a 26% whole person impairment rating. FAB issued a final decision on [redacted] to accept the employee's Part E claim for 26% whole person impairment (1% increase for [redacted]).

RECOMMENDATION: Recommend that QTC redo the impairment correctly to determine if a higher rating exists. If a correct rating results in a higher award, DEEOIC must take action to reopen the case to issue a corrected final decision for impairment.

8. [redacted]
Cleveland District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition**:** Accepted: ICD 9 code 503, Pneumoconiosis due to other inorganic dust

Accepted: ICD 9 code V81.4, Screening for other and unspecified respiratory conditions

The Medical Director's findings are as follows: The SECOP examination was thorough and the SECOP physician's recommendations were valid. Unfortunately, his answers to the CE's questions lacked specificity with regard to the number of hours to be approved for the weekly RN visits, the number of hours of case management required each month, and the specific physical limitations caused by the accepted conditions that necessitate assistance with ADLs. Also, the SECOP physician's rationale for recommending personal care attendant services for the employee relates to mostly to the employee's left shoulder injury and gait instability--neither of which are accepted conditions. Finally, the SECOP physician did not include a signed Potential Conflict of Interest Statement. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this SECOP.

The program referred the case for a SECOP regarding the medical necessity for continued HHC. Following review of the [redacted] *SECOP report, the medical benefits adjudication unit authorized HHC for* [redacted] *through* [redacted]. *Given that the period of approved HHC in connection with the SECOP examination expired in* [redacted]*, no further action is required for this case.*

RECOMMENDATION: Discuss the errors in this report with QTC so the SECOP physician can improve future submissions including specificity regarding the necessary rate of home health care to be provided. The contractor also needs to obtain the signed Potential Conflict of Interest Statement.

9. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition**:** Accepted: ICD 9 code 173.2, Other and unspecified malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.3, Other and unspecified malignant neoplasm of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.6, Other and unspecified malignant neoplasm of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.61, Basal cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 185, Malignant neoplasm of prostate
Accepted: ICD 9 code 198.5, Secondary malignant neoplasm of bone and bone marrow
Accepted: ICD 9 code 337.0, Idiopathic peripheral autonomic neuropathy
Accepted: ICD 9 code 607.84, Impotence of organic origin
Accepted: ICD 9 code 707.15, Ulcer of other part of foot

Accepted: ICD 9 code 781.2, Abnormality of gait
Accepted: ICD 9 code 782.0, Disturbance of skin sensation
Accepted: ICD 10 code M86.172, Other acute osteomyelitis, left ankle and foot

The Medical Director's findings are as follows: The SECOP report lacks a comprehensive medical history and review of systems. The SECOP physician's physical examination was cursory and [redacted] opinion was based on physical limitations that are not attributable to one of the employee's accepted conditions. The SECOP physician confuses peripheral neuropathy, which is not one of the employee's accepted conditions, with peripheral autonomic neuropathy, which is one of the employee's accepted conditions. The SECOP physician focuses [redacted] attention on the employee's inability to button his clothes and cut his food, and his decreased grip strength and his thumb-index finger pinch strength, which could be measures of peripheral neuropathy, but are definitely not measures of peripheral autonomic neuropathy. In addition, the SECOP physician did not answer Question 3 posed by the CE; i.e., [redacted] did not specifically identify the physical limitations caused by the employee's accepted conditions that necessitate assistance with accomplishing ADLs. Instead, [redacted] referred to the Home Health Plan of Care signed by the employee's treating physician. Finally, the statement directly above the SECOP physician's signature is not the required Potential Conflict of Interest Statement found on Page 13 of the "Physician's Reference Manual." This may change the final determination in this case.

I accept the opinion of Medical Director that the report contains deficiencies with regard to the analysis performed. In addition, I agree that the physician did not provide a signed Potential Conflict of Interest Statement.

The program referred the case for a SECOP regarding the medical necessity for continued HHC. The claimant was receiving HHC (TCM-12 hours per month, RN-14 hours per week, HHA-12 hours per day X 7 days per week). The [redacted] SECOP report stated that the claimant required continued HHC at the prescribed levels. In response to question #3, the SECOP report states that the detailed Home Health Care Plan from the claimant's treating physician meets the claimant's medical needs. The claimant has neuromotor dysfunction as evidenced in the SECOP examination which shows that his condition has deteriorated. Given these findings, the medical benefits adjudication unit authorized HHC for [redacted] through [redacted]. While there are defects with regard to how the SECOP physician supported her analysis of the need for home health care, the outcome represented the SECOP physician's interpretation of the patient's need for home health care. Given that the period of approved HHC in connection with the SECOP examination expired in [redacted], no further action is required for this case.

RECOMMENDATION: Discuss the SECOP report with the contractor to identify how the SECOP physician can improve the quality of future reports including accurate identification and assessment of accepted medical conditions. The contractor must obtain the signed Potential Conflict of Interest Statement.

10. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition**:** Accepted: ICD 9 code 503, Pneumoconiosis due to other inorganic dust
Accepted: ICD 9 code V81.4, Screening for other and unspecified respiratory conditions

The Medical Director's findings are as follows: The SECOP report does not include a comprehensive review of systems--despite the fact that the employee's medical history is long and complex and the vast majority of his medical problems (morbid obesity, epilepsy, heart disease, diabetes, gout, sleep apnea, and chronic kidney disease) are not related to his accepted conditions. The SECOP physician did not document the presence or absence of important indicators of pulmonary impairment, including if the employee has a barrel chest or spooning of his nails, or if he was using accessory muscles of respiration. The SECOP physician's answers to the CE's Questions 2 and 3 lack specificity regarding the specific medical services the employee requires during each 24-hour period, and the specific physical limitations caused by the accepted conditions. His primary rationale for recommending the types and numbers of hours of healthcare he recommends is not that the employee needs a certain level of care for specific reasons, but rather that "there is no reason to end the previously approved home health aide/RN targeted medical care that the employee has received in the past." Finally, the SECOP report does not include the required Potential Conflict of Interest Statement. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this SECOP.

The program referred the case for a SECOP regarding the medical necessity for continued HHC home health care. The Medical Director reviewed the [redacted] *SECOP report and he found several deficiencies. However, based on a review of the case file, the district office subsequently submitted a request to the SECOP physician asking for clarification of his report, including more complete responses to question 2 and 3. On* [redacted]*, the SECOP physician responded with an updated narrative. Based on this response, the medical benefits adjudication unit authorized HHC for* [redacted] *through* [redacted]*. Given that the period of approved HHC in connection with the SECOP examination expired in* [redacted]*, no further action is required for this case.*

RECOMMENDATION: While the MBE unit obtained an updated assessment to the report found deficient by the Medical Director, the contactor should review the problems identified in the initial report so that future submissions are improved. Neither the [redacted] nor the [redacted] report contain the required

Potential Conflict of Interest Statement. The contactor must obtain the signed Potential Conflict of Interest statement from the physician.

11. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]
Condition**:** Accepted: ICD 9 code 189.0, Malignant neoplasm of kidney, except pelvis

The Medical Director's findings are as follows: The SECOP report is not on letterhead stationery, and it is very difficult to read and understand. It includes almost no punctuation and it does not adhere to any of the structural rules governing the composition of clauses, sentences, and paragraphs in English. The SECOP physician's opinion was based on physical limitations that are not attributable to the employee's accepted condition. The employee's history of renal cancer is remote; his right kidney was removed in [redacted]. There has been no recurrence of the employee's renal cancer and he is not undergoing any treatment. The employee's history of renal cancer has no impact on his ability to perform activities of daily living. The SECOP physician's rationale for recommending home healthcare for the employee is based on the employee's ataxia (ICD 10-CM R27.0) and major depressive disorder (ICD 10-CM F32.9)--neither of which are accepted conditions. In addition, the SECOP physician's answers to the CE's Questions 2 and 3 lack specificity regarding the type of care the employee requires, how the care is related to the employee's accepted condition, the specific medical services he requires, and the frequency with which these services are to be performed. Finally, the report does not include the required Potential Conflict of Interest Statement. This may change the final determination in this case.

I accept the Medical Director's opinion regarding the errors found in this SECOP.

The program referred the case for a SECOP regarding the medical necessity for continued HHC. Following review of the [redacted] SECOP report, the medical benefits adjudication unit authorized HHC for [redacted] through [redacted]. Given that the period of approved HHC in connection with the second opinion examination expired in [redacted], no further action is required for this case.

RECOMMENDATION: Discuss the errors in this report with QTC so the SECOP physician can improve future submissions. The contractor also needs to obtain the signed Potential Conflict of Interest Statement.

12. [redacted]
Jacksonville District Office
Second Medical Opinion (re: Home Health Care)
Report date: [redacted]

Condition**:** Accepted: ICD 9 code 053.8, Herpes zoster with unspecified complication
Accepted: ICD 9 code 173.2, Other and unspecified malignant neoplasm of skin of ear and external auditory canal
Accepted: ICD 9 code 173.21, Basal cell carcinoma of skin of ear and external auditory canal
Accepted: ICD 9 code 173.22, Squamous cell carcinoma of skin of ear and external auditory canal
Accepted: ICD 9 code 173.31, Basal cell carcinoma of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.32, Squamous cell carcinoma of skin of other and unspecified parts of face
Accepted: ICD 9 code 173.4, Other and unspecified malignant neoplasm of scalp and skin of neck
Accepted: ICD 9 code 173.42, Squamous cell carcinoma of scalp and skin of neck
Accepted: ICD 9 code 173.52, Squamous cell carcinoma of skin of trunk, except scrotum
Accepted: ICD 9 code 173.6, Other and unspecified malignant neoplasm of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.61, Basal cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 173.62, Squamous cell carcinoma of skin of upper limb, including shoulder
Accepted: ICD 9 code 232.4, Carcinoma in situ of scalp and skin of neck
Accepted: ICD 9 code 232.5, Carcinoma in situ of skin of trunk, except scrotum
Accepted: ICD 9 code 232.6, Carcinoma in situ of skin of upper limb, including shoulder
Accepted: ICD 9 code 377.34, Toxic optic neuropathy
Accepted: ICD 9 code 389.16, Sensorineural hearing loss, asymmetrical
Accepted: ICD 9 code 586, Renal failure, unspecified
Accepted: ICD 9 code 698.9, Unspecified pruritic disorder
Accepted: ICD 9 code 716.9, Unspecified arthropathy
Accepted: ICD 10 code C44.229, Squamous cell carcinoma of skin of left ear and external auricular canal
Accepted: ICD 10 code C44.329, Squamous cell carcinoma of skin of other parts of face
Accepted: ICD 10 code C44.41, Basal cell carcinoma of skin of scalp and neck
Accepted: ICD 10 code D04.5, Carcinoma in situ of skin of trunk
Accepted: ICD 10 code L03.115, Cellulitis of right lower limb

The Medical Director's findings are as follows: The SECOP report does not include the required Potential Conflict of Interest Statement. This would not have changed the final determination in this case.

I accept the Medical Director's opinion regarding the error found in this SECOP.

The program referred the case for a SECOP regarding the medical necessity of continued HHC. Following review of the [redacted] report, the medical benefits adjudication unit authorized continued HHC for [redacted] through [redacted]. Given that the period of approved HHC in connection with the SECOP expired in [redacted], no further action is required for this case.

RECOMMENDATION: Have the contractor obtain the signed Potential Conflict of Interest Statement.