



RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL  
VERSION 4.2:

EEOICPA TRANSMITTAL NO. 20-03

April 29, 2020

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 4.2 (v4.2) which replaces v4.1, effective the date of publication of this transmittal.

Following are the content edits that make up PM v4.2:

**Chapter 1 - Definitions**

- Exhibit 1-1 has been updated to remove abbreviation Workers' Compensation Assistant (WCA) and replaces it with the abbreviation Claims Assistant (CA).

**Chapter 2 – The EEOICPA**

- Ch. 2.3 has been updated to reflect changes in the DEEOIC organizational structure to eliminate reference to regional jurisdiction and replace it with reference to National Administrator of Field Operations. Ch. 2.3 previously read:

3. *Organization. This paragraph describes the structure and authority of the National, Regional, and District Offices (DOs). OWCP has seven divisions, of which DEEOIC is one. The others are the Division of Federal Employees' Compensation (DFEC); the Division of Longshore and Harbor Workers' Compensation (DLHWC); the Division of Coal Mine Workers' Compensation (DCMWC); the Regional Directors (6 Regions), the Division of Administration and Operations, and the Division of Financial Administration.*

- Regional Director. OWCP Programs, in each of its six regions, are administered by a Regional Director, who reports to the Director for OWCP.*
- District Director (DD). DEEOIC has four DOs, which are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington. Each DO is managed by a DD, who reports to the Regional Director. ([Exhibit 2-1](#) contains a jurisdictional map. [Exhibit 2-2](#) contains a list of addresses, telephone numbers, and fax numbers for the DOs.)*

Ch. 2.3 has been updated to:

3. *Organization.* This paragraph describes the structure and authority of the National and District Offices (DOs). OWCP has six divisions, of which DEEOIC is one. The others are the Division of Federal Employees' Compensation (DFEC); the Division of Longshore and Harbor Workers' Compensation (DLHWC); the Division of Coal Mine Workers' Compensation (DCMWC); the Division of Administration and Operations, and the Division of Financial Administration.

a. *District Offices (DO).* DEEOIC has four DOs, which are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington. Each DO is managed by a DD, who reports to the National Administrator of Field Operations. Exhibit 2-1 contains a list of addresses, telephone numbers, and fax numbers for the DOs.)

- What was Exhibit 2-1, Jurisdictional Map, has been removed from v4.2. Accordingly, what was previously Exhibit 2-2, has been renumbered in v4.2 to Exhibit 2-1, and has been updated to remove jurisdictional information.

- Ch. 2.4a(3) has been updated to remove references to the term Medical Scheduler (MS). DEEOIC is realigning the duties of the MS to the roles/responsibilities of the Claims Assistant (CA) or Fiscal Officer (FO). Ch. 2.4a(3) previously read:

(3) *Medical Referrals.* DEEOIC uses the services of a contractor to assist in obtaining medical opinions on a range of issues including causation, impairment, wage-loss, etc. The contractor is also responsible for the scheduling of second opinion medical examinations. Within each DO, a designated District Medical Scheduler (MS) is responsible for coordinating case referrals with the contractor.

Ch. 2.4a(3) has been updated to:

(3) *Medical Referrals.* DEEOIC uses the services of a contractor to assist in obtaining medical opinions on a range of issues including causation, impairment, wage-loss, etc. The contractor is also responsible for the scheduling of second opinion medical examinations. Within each DO, a designated District Claims Assistant (CA) is responsible for coordinating case referrals with the contractor.

- Ch. 2.4b(5) has been updated to reflect changes in the DEEOIC organizational structure to correctly reference the Branch of Medical Benefits. Ch. 2.4b(5) previously read:

(5) *Branch of Medical Benefits Adjudication and Bill Processing (BMBABP).* Personnel in this branch are responsible for medical bill processing, adjudication of certain medical benefits that require pre-approval (like home health care related activities) for claimants who have accepted conditions, and program integrity.

Ch. 2.4b(5) has been updated to:

- (5) *Branch of Medical Benefits (BMB). Personnel in this branch are responsible for medical bill processing, adjudication of certain medical benefits that require pre-approval (like home health care related activities) for claimants who have accepted conditions, and program integrity.*

## **Chapter 16 – Developing and Weighing Medical Evidence**

- Ch. 16.11 has been updated to remove references to the term Medical Scheduler and replaces it with Claims Assistant (CA). Ch. 16.11 previously read:

11. *Referral to CMC. It is ultimately the responsibility of the jurisdictional DO to ensure that all the necessary components of a CMC referral are prepared accurately, the content of the referral is appropriate and specific to the issue under determination, and sufficient factual documentation is prepared to allow the CMC a clear understanding of the medical question(s) to be addressed. When guidance requires that email communication be prepared, a copy of the email is to scanned/bronzed into the case file in OIS.*

*Interactions between DEEOIC staff and the CMC contractor occur through a secure internet portal, referred to as the Client Portal. All DEEOIC staff are to reference the “Client Portal User Guide” for additional information about using the Client Portal and referring cases to CMCs. Coordination of information between DEEOIC staff and the CMC contractor, including transmission of referral packages, is the responsibility of designated staff (i.e., Medical Scheduler). The CE, however, initiates the CMC referral process.*

Ch. 16.11 has been updated to:

11. *Referral to CMC. It is ultimately the responsibility of the jurisdictional DO to ensure that all the necessary components of a CMC referral are prepared accurately, the content of the referral is appropriate and specific to the issue under determination, and sufficient factual documentation is prepared to allow the CMC a clear understanding of the medical question(s) to be addressed. When guidance requires that email communication be prepared, a copy of the email is scanned/bronzed into the case file in OIS.*

*Interactions between DEEOIC staff and the CMC contractor occur through a secure internet portal, referred to as the Client Portal. All DEEOIC staff are to reference the “Client Portal User Guide” for additional information about using the Client Portal and referring cases to CMCs. Coordination of information between DEEOIC staff and the CMC contractor, including transmission of referral packages, is the responsibility of designated staff (i.e., CA). The CE, however, initiates the CMC referral process.*

- Ch. 16.12 has been updated to remove references to the term Medical Scheduler and replaces it with Fiscal Officer (FO) or Claims Assistant (CA). Ch. 16.12 previously read:

12. Role of Medical Scheduler in CMC Referrals. Each DD designates a Medical Scheduler who processes and tracks CMC referrals. The Medical Scheduler is also responsible for coordinating communication between DO staff and the CMC contractor. When guidance requires that email communication be prepared, a copy of the email is to be printed and placed in the case file. Upon receipt of a CMC referral submission from a CE, the Medical Scheduler is to take the following actions:

- a. *Review of Referral.* Conducts a thorough review of the referral package to ensure all required documentation is present, questions to the CMC are clear, and imaged records are legible. The SOAF should also be inspected to ensure that relevant factual findings have been reached that will allow for a comprehensive and reliable CMC analysis. Upon inspection, any referral package that is deemed to be incomplete or defective is returned to the CE for corrective action. The Medical Scheduler is to return the referral package to the originating CE with a memo describing the problem to be addressed before a referral can be initiated.
- b. *Submission of Referral.* Once the Medical Scheduler has determined that a referral is complete and ready for submission to the CMC contractor, he or she is to log onto the CMC contractor's internet portal, and follow the steps in the "Client Portal User Guide" for creating a claimant referral. Using the referral tab on the Client Portal, the Medical Scheduler inputs the claimant's information as needed, and uploads all relevant electronic documents to complete the transaction. "Client Portal User Guide" for creating a claimant referral. Using the referral tab on the Client Portal, the Medical Scheduler inputs the claimant's information as needed, and uploads all relevant electronic documents to complete the transaction.
- c. *Confirmation.* Upon receipt of submission confirmation from the CMC contractor, the Medical Scheduler is to notify the originating CE via email that the referral is complete.
- d. *Processing for Payment.* When the Medical Scheduler receives confirmation from the CE that the report is complete and accurate (see Section 13 of this chapter), the Medical Scheduler compares the referral sheet to the billing form submitted by the contractor to validate that the charged amount corresponds to the service request. The Medical Scheduler must ensure that the billing codes/units identified on the OWCP-1500 correspond appropriately to what the CE requested be performed by the contractor. The Medical Scheduler must be aware of the following when reviewing billing for CMC reports completed through the contractor process:
  - (1) For cases with multiple questions regarding the same or related conditions requiring the services of one specialist, (e.g., occupational medicine) one billable charge is permitted.

- (2) *For cases with one or more unrelated conditions, requiring the services of a single specialist, (e.g., pulmonary or occupational medicine) one billable charge is permitted.*
- (3) *For cases with unrelated conditions requiring the services of multiple specialists, (e.g., oncology, pulmonary, dermatology) separate charges are appropriate for each referral to a different specialist.*
- e. *If the OWCP-1500 is correct, the Medical Scheduler prints the OWCP-1500 and stamps the document "Prompt Pay" in black ink, with a signature and date in black ink, in the top right hand corner of the OWCP-1500. The "Prompt Pay" date (date received in the DO plus 7 days) must be entered in block 11 of the OWCP-1500. The Medical Scheduler scans the stamped document, titles the bill using the last four digits of the employee's SSN and the employee's last name (e.g., 1234Smith).*

*The Medical Scheduler does not attach the CMC report or other documents to the bill. The Medical Scheduler then submits the approved OWCP-1500 to the Contracting Officer Representative (COR) or alternate COR designee via email at the email group "DEEOIC-CMC-INVOICES." The COR coordinates, communicates, and ensures cooperation among the contractor and associated Government personnel, for the purpose of anticipating and resolving difficulties, and ensuring satisfactory completion of contracts. For efficiency and management purposes, payable bills should be collected throughout each business day and electronically transmitted by batch in one email at the end of each work day. The Medical Scheduler should include in the body of the email a list of the bills that should be included as attachments to ensure that the COR or alternate COR designee receives an accurate listing of bills. The case file should contain a copy of the OWCP-1500 and the original medical.*

- f. *The Medical Scheduler will enter the following dates in ECS to ensure prompt payment of all physician referral bills: 1) Status Effective Date (enter the date listed in block 24A of the OWCP-1500); and 2) Eligibility End Date (enter the date of the physician's response, i.e., the date of the report).*
- g. *Once the COR or alternate COR designee receives the batch, the bills are to be certified by the designated COR by placing a signature stamp on each invoice. The office Administrative Assistant will then mail the bills to the Bill Processing Agent (BPA) for processing and payment.*
- h. *If a problem with the billing is identified, the Medical Scheduler communicates the issue with the contractor and copies the COR and alternate COR designee via e-mail.*
- i. *Problems with Reports. The Medical Scheduler notifies the DD of any problems dealing with the CMC contractor.*

Ch. 16.12 has been updated to:

12. Role of CA in CMC Referrals. Each DD designates a CA who processes and tracks CMC referrals. The CA is also responsible for coordinating communication between DO staff and the CMC contractor. When guidance requires that email communication be prepared, a copy of the email is to be scanned/bronzed into the case file. Upon receipt of a CMC referral submission from a CE, the CA is to take the following actions:

- a. *Review of Referral.* Conducts a thorough review of the referral package to ensure all required documentation is present, questions to the CMC are clear, and imaged records are legible. The SOAF should also be inspected to ensure that relevant factual findings have been reached that will allow for a comprehensive and reliable CMC analysis. Upon inspection, any referral package that is deemed to be incomplete or defective is returned to the CE for corrective action. The CA is to return the referral package to the originating CE with a memo describing the problem to be addressed before a referral can be initiated.
- b. *Submission of Referral.* Once the CA has determined that a referral is complete and ready for submission to the CMC contractor, he or she is to log onto the CMC contractor's internet portal, and follow the steps in the "Client Portal User Guide" for creating a claimant referral. Using the referral tab on the Client Portal, the CA inputs the claimant's information as needed, and uploads all relevant electronic documents to complete the transaction.
- c. *Confirmation.* Upon receipt of submission confirmation from the CMC contractor, the CA is to notify the originating CE via email that the referral is complete.
- d. *Processing for Payment.* When the FO receives confirmation from the CE that the report is complete and accurate (see Section 13 of this chapter), the FO compares the referral sheet to the billing information submitted by the contractor to validate that the charged amount corresponds to the service request. The FO must ensure that the billing information identified within the OWCP's Workers' Compensation Medical Bill Processing (WCMBP) system corresponds appropriately to what the CE requested be performed by the contractor. The FO must be aware of the following when reviewing billing for CMC reports completed through the contractor process:
  - (1) For cases with multiple questions regarding the same or related conditions requiring the services of one specialist (e.g., occupational medicine) one billable charge is permitted.
  - (2) For cases with one or more unrelated conditions, requiring the services of a single specialist (e.g., pulmonary or occupational medicine) one billable charge is permitted.

(3) *For cases with unrelated conditions requiring the services of multiple specialists (e.g., oncology, pulmonary, dermatology) separate charges are appropriate for each referral to a different specialist.*

e. *If the billing information captured within WCMBP is correct, the FO processes the invoice for approval. The FO then forwards the approved invoice for review by COR or designated COR via WCMBP.*

f. *If a problem with the billing is identified, the FO communicates the issue with the contractor and copies the COR or designated COR via e-mail.*

g. *Problems with Reports. The CA notifies the COR of any problems dealing with the CMC contractor.*

- Ch. 16.13 has been updated to remove references to the term Medical Scheduler and replaces it with Fiscal Officer (FO) or Claims Assistant (CA). Ch. 16.13 previously read:

13. *Post Referral to CMC. Upon submission of a referral to the CMC contractor, the contractor will then assign a particular CMC to respond. The CMC selection is the function of the CMC contractor, and DEEOIC has no input in the selection of the physician chosen to review the case, other than the preferred specialty of the physician. Once assigned, the CMC is to assess all submitted documentation, and prepare a comprehensive and responsive medical narrative to the questions posed by the referring CE. The CMC then submits his or her report back to the contractor. The contractor then undertakes a quality control review to ensure that the report is complete, rationalized, and fully responsive to the questions posed by the CE. Upon clearance for release, the CMC contractor will then post the completed report along with a completed Form OWCP-1500 on the Client Portal.*

*To access the reports, the Medical Scheduler or designated staff logs into the Client Portal using the steps listed in the “Client Portal User Guide” and accesses the status for the relevant claim. The Medical Scheduler or designated staff downloads the CMC report and completed Form OWCP-1500 from the Client Portal.*

a. *Completed Reports. Once the medical report is downloaded, the CE reviews it for accuracy and completeness. The review should include the CMC’s interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the CMC’s rationale showing how his or her opinion is supported by the evidence in the file.*

(1) *If the medical report is accurate, appropriate, and complete, the CE sends approval to the Medical Scheduler, via email, to authorize payment of the medical bill no later than the next business day. The CE indicates in the text of the email that the review completed by the CMC is acceptable. The email is scanned/bronzed to the case file in OIS.*

- (2) *If the medical report is incomplete or incorrect, or not properly responsive to the questions posed, the CE notifies the Medical Scheduler, via email, of the issues with the medical report. The email is scanned/bronzed to the case file in OIS. The DD or designated staff will return the medical report to the contractor and request the contractor provide an additional report to correct the situation. The CMC shall provide the additional report within 14 days of receipt of the request without additional charge. The DD will notify the contractor in writing of the request for the additional report. A copy of the notification should be scanned/bronzed to the case file in OIS. To ensure prompt payment of all physician referral bills to the BPA, (i.e., CMC, Second Opinion, Referee Specialist bills) the Medical Scheduler or designated staff records the referral and receipt of the medical report/billing in ECS.*

Chapter 16.13 has been updated to:

13. *Post Referral to CMC. Upon submission of a referral to the CMC contractor, the contractor will then assign a particular CMC to respond. The CMC selection is the function of the CMC contractor, and DEEOIC has no input in the selection of the physician chosen to review the case, other than the preferred specialty of the physician. Once assigned, the CMC is to assess all submitted documentation, and prepare a comprehensive and responsive medical narrative to the questions posed by the referring CE. The CMC then submits his or her report back to the contractor. The contractor then undertakes a quality control review to ensure that the report is complete, rationalized, and fully responsive to the questions posed by the CE. Upon clearance for release, the CMC contractor will then post the completed report and invoice electronically to the WCMBP.*

*To access the CMC report, the FO logs into WCMBP at <https://owcpmed.dol.gov> to access the pending invoice. WCMBP will identify imaged correspondence submitted with the invoice, including the CMC report, via hyperlink. The FO may also opt to obtain a copy of the CMC report via the Correspondence Retrieval Page within WCMBP.*

- a. *Completed Reports. Once the medical report is downloaded, the CE reviews it for accuracy and completeness. The review should include the CMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the CMC's rationale showing how his or her opinion is supported by the evidence in the file.*
  - (1) *If the medical report is accurate, appropriate, and complete, the CE sends approval to the FO, via email, to authorize payment of the medical bill no later than the next business day. The CE indicates in the text of the email that the review completed by the CMC is acceptable. The email is scanned/bronzed to the case file in OIS.*
  - (2) *If the medical report is incomplete or incorrect, or not properly responsive to the questions posed, the CE notifies the FO, via email, of the issues with*

*the medical report. The email is scanned/bronzed to the case file in OIS. The CE will request clarification to address any inadequacies within the original CMC report. A copy of the clarification request should be scanned/bronzed to the case file in OIS. The CMC shall provide the additional report within 14 days of receipt of the request without additional charge. To ensure prompt payment of all physician referral bills, (i.e., CMC, Second Opinion, Referee Specialist bills), the CA will initiate proper coding of the Authorize Payment for Medical Review screen within ECS.*

- Ch. 16.14b has been updated to remove references to the term Medical Scheduler and replaces it with Claims Assistant (CA). Ch. 16.14b previously read:

- b. *Referral for Second Opinion Examination. As discussed in Section 11 of this chapter, interactions between the DEEOIC staff, the CMC, and physicians selected for Second Opinion examinations occur through the Client Portal. The Medical Scheduler or designated staff is responsible for the coordination of information between DEEOIC staff and the contractor, including transmission of referral packages. The CE initiates the process for obtaining a Second Opinion examination and ensures all necessary referral and medical documentation is sent to the Medical Scheduler or designated staff.*

*Arranging for a Second Opinion examination follows the same basic referral steps listed as when making a CMC referral.*

- (1) *Preparation of referral email. The CE sends an email to the Medical Scheduler indicating that a Second Opinion examination is needed, and requesting referral to the CMC contractor. The body of the email should contain:*
  - (a) *Claimant name.*
  - (b) *Claim number.*
  - (c) *Second Opinion review request.*
  - (d) *Medical Specialty requested. Refer to Section 11.a(4) of this chapter for further discussion of medical specialty.*
  - (e) *Previous physicians involved in the case.*
  - (f) *SOAF*
  - (g) *List of Questions for the Second Opinion physician to address (Exhibit 16-2).*
  - (h) *Medical Records.*

- (i) *Cover Letter to the claimant. (Exhibit 16-3)*

*A copy of the referral email is scanned/bronzed to the case file in OIS.*

- (2) *Role of the Medical Scheduler. The Medical Scheduler follows the steps listed in Sections 11 and 12 of this chapter to transmit the Second Opinion examination request to the CMC contractor and perform follow-up actions. As is the case with the CMC referral process, the identification of any systematic deficiencies or other problematic situations involving the Second Opinion examination referral process, should be brought to the attention of the DD.*

Ch. 16.14b has been updated to:

- b. *Referral for Second Opinion Examination. As discussed in Section 11 of this chapter, interactions between the DEEOIC staff, the CMC, and physicians selected for Second Opinion examinations occur through the Client Portal. The CA or designated staff is responsible for the coordination of information between DEEOIC staff and the contractor, including transmission of referral packages. The CE initiates the process for obtaining a Second Opinion examination and ensures all necessary referral and medical documentation is sent to the CA or designated staff.*

*Arranging for a Second Opinion examination follows the same basic referral steps listed as when making a CMC referral.*

- (1) *Preparation of referral email. The CE sends an email to the CA indicating that a Second Opinion examination is needed, and requesting referral to the CMC contractor. The body of the email should contain:*
  - (a) *Claimant name.*
  - (b) *Claim number.*
  - (c) *Second Opinion review request.*
  - (d) *Medical Specialty requested. Refer to Section 11.a(4) of this chapter for further discussion of medical specialty.*
  - (e) *Previous physicians involved in the case.*
  - (f) *SOAF*
  - (g) *List of Questions for the Second Opinion physician to address. (Exhibit 16-2)*
  - (h) *Medical Records.*

(i) *Cover Letter to the claimant. (Exhibit 16-3)*

*A copy of the referral email is scanned/bronzed to the case file in OIS.*

(2) *Role of the CA. The CA follows the steps listed in Sections 11 and 12 of this chapter to transmit the Second Opinion examination request to the CMC contractor and perform follow-up actions. As is the case with the CMC referral process, the identification of any systematic deficiencies or other problematic situations involving the Second Opinion examination referral process should be brought to the attention of the CMC contractor.*

- Ch. 16.15c has been updated to remove references to the term Medical Scheduler and replaces it with Claims Assistant (CA). Ch. 16.15c previously read:

c. *Assignment of the Referee. The CE will utilize the same basic referral process for referral to a Referee examiner as is used for a Second Opinion, except for some notable differences.*

(1) *In the referring email to the Medical Scheduler, the CE is to denote the type of review as a Referee Specialist examination. A copy of the email is to be scanned/bronzed to the case file in OIS.*

Ch. 16.15c has been updated to:

c. *Assignment of the Referee. The CE will utilize the same basic referral process for referral to a Referee examiner as is used for a Second Opinion, except for some notable differences.*

(1) *In the referring email to the CA, the CE is to denote the type of review as a Referee Specialist examination. A copy of the email is to be scanned/bronzed to the case file in OIS.*

- Ch. 16.16 has been updated to remove references to the term Medical Scheduler and replaces it with Claims Assistant (CA). Ch. 16.16 previously read:

16. *Failure to Undergo Second Opinion or Referee Specialist Examination.* *The employee assigned to undergo either a Second Opinion or Referee Specialist examination is obligated to attend the examination. Moreover, the CE is responsible for evaluating any request to change the date or time of an appointment to determine if sufficient reasons exist to allow for such a change. The employee and/or claimant will not be authorized to change a scheduled Second Opinion or Referee Specialist examination without providing a substantive and documented cause. The determination of whether an appointment should be changed is at the discretion of the CE who is responsible for initiating the referral. Generally, appointment changes should only be permitted in emergency situations, or when the employee has given a sufficiently convincing rationale for a need to change the appointment. Appointment changes that are*

*necessary merely for the general convenience of the employee are usually not permitted. Once authorization for an appointment change is granted, the CE, through the Medical Scheduler, must notify the designated contractor.*

Chapter 16.16 has been updated to:

16. *Failure to Undergo Second Opinion or Referee Specialist Examination. The employee assigned to undergo either a Second Opinion or Referee Specialist examination is obligated to attend the examination. Moreover, the CE is responsible for evaluating any request to change the date or time of an appointment to determine if sufficient reasons exist to allow for such a change. The employee and/or claimant will not be authorized to change a scheduled Second Opinion or Referee Specialist examination without providing a substantive and documented cause. The determination of whether an appointment should be changed is at the discretion of the CE who is responsible for initiating the referral. Generally, appointment changes should only be permitted in emergency situations, or when the employee has given a sufficiently convincing rationale for a need to change the appointment. Appointment changes that are necessary merely for the general convenience of the employee are usually not permitted. Once authorization for an appointment change is granted, the CE, through the CA, must notify the designated contractor.*

## **Chapter 28 – Medical Bill Process**

- Ch. 28.4 has been edited to add revised procedures for DEEOIC to use when submitting medical bill inquiries to the Branch of Medical Benefits. References to outdated bill processing systems are deleted. Ch. 28.4 previously read:

4. *Mailbox for Medical Bill Inquiries. The 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 MBE's with questions that require review by the 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 MBE receives an inquiry regarding reimbursement of a medical bill, for an accepted condition, the MBE 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 MBE 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 MBE prepares an email to the FO. In order to maintain consistency and to provide clarity in the communication process, it is imperative that the MBE's 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 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 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 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 MBE via email. The MBE is responsible for notifying the employee, claimant, AR, 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.*

Ch. 28.4 has been updated to:

4. *Mailbox for Medical Bill Inquiries.* *An electronic mailbox (email) is available to resolve medical billing questions. DEEOIC staff may submit billing inquiries, through designated supervisory staff, to the mailbox about medical bills, travel reimbursement, treatment suites, provider outreach, or policy questions regarding medical bill processing. Use of this mailbox provides for expedited resolution of medical bill issues as they arise, and provides a uniform process for responding to questions and issues, program wide. DEEOIC CEs are to submit inquiries to the assigned FO. DEEOIC MBEs are to submit inquiries to their assigned Team Lead/Supervisor. Once reviewed, the FO or MBE Team Lead/Supervisor will work to address the inquiry locally or decide to forward the inquiry to the mailbox for review and response.*

- a. *To maintain consistency and to provide clarity in the communication process, email submissions by the FO or MBE Team Lead/Supervisor to the medical bill mailbox must provide sufficient information, 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) *Medical Bill Processing Policy Questions. This subject involves policy interpretation of existing program guidance related to medical authorizations, bill processing, travel reimbursement and other ancillary services.*
  - (2) *Treatment Suites. This subject involves automatic payment of treatment or services based on accepted conditions.*
  - (3) *Provider Outreach. This subject involves inquiries from medical providers regarding assistance with enrollment, submission of bill(s), or understanding DEEOIC's medical billing process.*
  - (4) *Bill Payment Processing. This subject involves inquiries regarding reimbursement of medical bills that do not require policy interpretation of existing program guidance. The body of the email itself must contain the following information (as applicable):*
    - *Location;*
    - *CE/MBE 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.*
- b. *Upon receipt of a mailbox inquiry, designated staff within BMB will evaluate the submission and determine the proper course of action to generate a response. If follow-up is necessary, the staff person will contact the CE or MBE for clarifying information about the nature of the inquiry. BMB staff will work with appropriate subject matter experts within DEEOIC to draft a response. Managerial staff within BMB will then review drafted responses to clear for publication to the submitting FO or MBE Team Lead/Supervisor. The FO and MBE Team Lead/Supervisor will then refer the response to the originating CE or MBE.*

## **Chapter 29 – Ancillary Medical Services and Related Expenses**

- Ch. 29.4h(4) has been edited to remove reference to outdated bill processing systems. Ch. 29.4h(4) previously read:

(4) *DEEOIC allows up to two hours of service within a 120-day period. If a 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 CE/MBE is to list details of the documented thread, including the document control number retrieved from the Xerox Transaction Content Management (XTCM) stored image retrieval system and/or attached supporting documentation.*

Ch. 29.4h(4) has been updated to:

(4) *DEEOIC allows up to two hours of service within a 120-day period. If a 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.*

- Chapter 29.21 has been edited to remove references to the term Workers' Compensation Assistant (WCA) and replaces it with Claims Assistant (CA). Chapter 29.21 previously read:

21. Rehabilitative Therapy Services. The DEEOIC requires prior authorization for the therapy services outlined below.

a. *Types of Therapy Requiring Prior Authorization.*

- (1) *Physical Therapy 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 his or her maximum functional motor potential.*
- (2) *Occupational Therapy involves treatment that helps develop adaptive or physical skills that will help the claimant to return to the ordinary tasks of daily living. Occupational therapy focuses on the use of hands and fingers, coordination of movement, fine motor skills and self-help skills such as preparing meals and dressing.*
- (3) *Speech Therapy is the treatment of defects and disorders of speech and swallowing.*
- (4) *Other rehabilitative therapy services is defined as a therapeutic service for which a provider charges a fee to render care outside of the scope of*

*routine and customary medical care generally provided by a qualified physician.*

- b. The recommended other therapeutic service must be considered safe and effective by the medical community and intended to improve the health of the patient. An appropriately licensed (in accordance with relevant state requirements) or credentialed specialist must perform the prescribed rehabilitative therapy.*
- c. Requests for the authorization of rehabilitative therapy, including physical therapy, occupational therapy, speech therapy or other rehabilitative therapy, may originate from an employee, a designated AR or a medical provider. The DEEOIC Bill Processing Agent (BPA) must register all authorization requests for rehabilitative therapy services in its electronic case tracking system. The BPA will record authorization requests it receives and then forward the request, as a thread, to the Workers' Compensation Assistant (WCA)/FO for processing. Authorization requests received at the DO via mail or facsimile must be routed through the WCA/FO to the BPA for record creation and thread initiation.*
- d. Once the assigned MBE receives a thread for authorization of a rehabilitative therapy, he or she must undertake a review of the evidence in the case to make a determination as to whether or not the request is medically necessary in the care of the covered employee's accepted work-related medical condition(s).*
- e. The MBE must approve requests for a rehabilitative therapy initial assessment as long as the employee's treating physician prescribes it. The MBE approves the request and sends an email to the WCA who then notifies the BPA to authorize an initial therapy assessment. The MBE sends a letter authorizing the initial assessment to the requestor with a copy to the employee. If the MBE receives a request for an initial rehabilitative therapy assessment without a physician's prescription, he or she sends a letter to the employee (with a copy to the therapy provider) requesting a signed prescription for the initial assessment. In the letter, the MBE advises that the employee has 15 days within which to submit a signed physician's prescription for an initial therapeutic evaluation.*

*If medical documentation or a signed physician's prescription is not received within 15 days, the MBE must deny the request. The MBE sends an email to the WCA who then notifies the BPA to deny the request. The MBE sends a letter to the requestor with a copy to the employee denying the request and providing instruction to resubmit the request once the treating physician submits a signed prescription.*

- f. Requests for rehabilitative therapy must be substantiated by the results of the initial evaluation by the applicable therapy specialist and a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for the requested rehabilitative therapy based on the*

*results of the initial evaluation and the physician's face-to-face examination of the employee occurring within sixty days of the date of the LMN.*

*The physician must provide a description of the type of rehabilitative therapy he or she is prescribing, 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 describes, with appropriate medical rationale, how the prescribed rehabilitative therapy will lead to an expected measurable improvement in one or more activities of daily living within a reasonable period. The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.*

- g. When the MBE receives a request for authorization of rehabilitative therapy accompanied by an appropriate LMN, the MBE prepares a decision letter to the employee authorizing the requested therapy. The initial authorization period may be fewer than, but must not exceed 3 months (90 days). The assigned MBE may approve up to 3 visits per week by 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 more than 60 visits per calendar year. The approval letter must contain the following information:*

- (1) Covered medical condition(s) for the rehabilitative therapy.*
- (2) Number and frequency of visits approved (e.g., 3 visits per week for 12 weeks).*
- (3) Authorized billing code(s) relevant to the approval.*
- (4) Dates for the authorized period.*
- (5) Statement to indicate that corresponding medical notes must be provided for each service date.*
- (6) Statement advising that fees are subject to the OWCP fee schedule.*

- h. Upon receipt of requests for rehabilitative therapy unaccompanied by a sufficient LMN, the MBE undertakes development by contacting the prescribing physician and the employee to request evidence necessary to allow for authorization.*

- (1) After 15 days has passed with no satisfactory response from the treating physician, or no response from the employee, the MBE prepares a second letter to the employee (accompanied by a copy of the initial letter), advising that following the previous letter, no additional information has been received from the treating physician. The MBE advises that an additional period of 15 days will be granted for the submission of*

*necessary evidence, and if the information is not received in that time, the request for rehabilitative therapy may be denied by the DEEOIC.*

- (2) *If the employee or the physician does not provide a response to the second request for information within the 30-day period allowed, the MBE issues a letter decision to the employee denying the claim for rehabilitative therapy. The MBE further sends an email to the FO, who sends a thread to the BPA for system update.*

*A MBE can refer requests with unclear medical documentation to a DEEOIC nurse consultant or CMC for review to obtain expert advice on the recommended course of action. Once the MBE has undertaken development, including allowance for the treating physician to provide further support for an unsubstantiated request for rehabilitative therapy, he or she can issue a letter decision denying the authorization if sufficient medical justification has not been forthcoming.*

*The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The MBE is to send a letter to the employee along with a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:*

*If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.*

- i. *Once the MBE decides to approve or deny the request, he/she sends an electronic mail message to the WCA/FO, who prepares and sends a thread to the BPA, authorizing or denying the rehabilitative therapy request. The MBE creates a correspondence entry on the correspondence screen of ECS, documenting the decision and bronzes the letter along with the supporting documentation into OIS.*
- j. *An employee, AR, treating physician, or rehabilitative therapy provider must request a renewal of an expiring authorization or modification of an existing authorization for rehabilitative therapy and should do so prior to the expiration date of the existing authorization, to allow care to continue uninterrupted. In either of these situations, the requestor must submit a LMN documenting the continuing medical necessity of the request. Requests for rehabilitative therapy outside of this guidance must be evaluated on a case-by-case basis, including possible consultation with the DEEOIC Medical Director. The employee, or his or her AR, has final responsibility regarding the amount or type of rehabilitative therapy sought.*

- k. *Rehabilitative therapy providers must conduct services in an appropriate setting; (i.e., in a clinic, professional office, or other similar location). If the MBE receives a request for in-home professional therapy, the employee must be homebound to receive such authorization. Medical evidence from the treating physician must demonstrate that the employee is medically unable to travel to obtain the therapy outside the home. Once the MBE receives convincing medical evidence that the employee is not able to travel for therapy, and sufficient documentation exists regarding the medical necessity for care, the MBE may authorize in-home rehabilitative therapy. Provider travel to and from an employee's residence is not a billable service.*
- l. *Rehabilitative therapy providers 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 the rehabilitative therapy specific to unique features of the employee, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. 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 with the prescribing physicians LMN.*

Chapter 29.21 has been updated to:

21. Rehabilitative Therapy Services. *The DEEOIC requires prior authorization for the therapy services outlined below.*

- a. *Types of Therapy Requiring Prior Authorization.*
  - (1) *Physical Therapy 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 his or her maximum functional motor potential.*
  - (2) *Occupational Therapy involves treatment that helps develop adaptive or physical skills that will help the claimant to return to the ordinary tasks of daily living. Occupational therapy focuses on the use of hands and fingers, coordination of movement, fine motor skills and self-help skills such as preparing meals and dressing.*
  - (3) *Speech Therapy is the treatment of defects and disorders of speech and swallowing.*
  - (4) *Other rehabilitative therapy services is defined as a therapeutic service for which a provider charges a fee to render care outside of the scope of*

*routine and customary medical care generally provided by a qualified physician.*

- b. The recommended other therapeutic service must be considered safe and effective by the medical community and intended to improve the health of the patient. An appropriately licensed (in accordance with relevant state requirements) or credentialed specialist must perform the prescribed rehabilitative therapy.*
- c. Requests for the authorization of rehabilitative therapy, including physical therapy, occupational therapy, speech therapy or other rehabilitative therapy, may originate from an employee, a designated AR or a medical provider. The DEEOIC Bill Processing Agent (BPA) must register all authorization requests for rehabilitative therapy services in its electronic case tracking system. The BPA will record authorization requests it receives and then forward the request, as a thread, to the CA/FO for processing. Authorization requests received at the DO via mail or facsimile must be routed through the CA/FO to the BPA for record creation and thread initiation.*
- d. Once the assigned MBE receives a thread for authorization of a rehabilitative therapy, he or she must undertake a review of the evidence in the case to make a determination as to whether or not the request is medically necessary in the care of the covered employee's accepted work-related medical condition(s).*
- e. The MBE must approve requests for a rehabilitative therapy initial assessment as long as the employee's treating physician prescribes it. The MBE approves the request and sends an email to the CA who then notifies the BPA to authorize an initial therapy assessment. The MBE sends a letter authorizing the initial assessment to the requestor with a copy to the employee. If the MBE receives a request for an initial rehabilitative therapy assessment without a physician's prescription, he or she sends a letter to the employee (with a copy to the therapy provider) requesting a signed prescription for the initial assessment. In the letter, the MBE advises that the employee has 15 days within which to submit a signed physician's prescription for an initial therapeutic evaluation.*

*If medical documentation or a signed physician's prescription is not received within 15 days, the MBE must deny the request. The MBE sends an email to the CA who then notifies the BPA to deny the request. The MBE sends a letter to the requestor with a copy to the employee denying the request and providing instruction to resubmit the request once the treating physician submits a signed prescription.*

- f. Requests for rehabilitative therapy must be substantiated by the results of the initial evaluation by the applicable therapy specialist and a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for the requested rehabilitative therapy based on the*

*results of the initial evaluation and the physician's face-to-face examination of the employee occurring within sixty days of the date of the LMN.*

*The physician must provide a description of the type of rehabilitative therapy he or she is prescribing, 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 describes, with appropriate medical rationale, how the prescribed rehabilitative therapy will lead to an expected measurable improvement in one or more activities of daily living within a reasonable period. The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.*

- g. When the MBE receives a request for authorization of rehabilitative therapy accompanied by an appropriate LMN, the MBE prepares a decision letter to the employee authorizing the requested therapy. The initial authorization period may be fewer than, but must not exceed 3 months (90 days). The assigned MBE may approve up to 3 visits per week by 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 more than 60 visits per calendar year. The approval letter must contain the following information:*

- (1) Covered medical condition(s) for the rehabilitative therapy.*
- (2) Number and frequency of visits approved (e.g., 3 visits per week for 12 weeks).*
- (3) Authorized billing code(s) relevant to the approval.*
- (4) Dates for the authorized period.*
- (5) Statement to indicate that corresponding medical notes must be provided for each service date.*
- (6) Statement advising that fees are subject to the OWCP fee schedule.*

- h. Upon receipt of requests for rehabilitative therapy unaccompanied by a sufficient LMN, the MBE undertakes development by contacting the prescribing physician and the employee to request evidence necessary to allow for authorization.*

- (1) After 15 days has passed with no satisfactory response from the treating physician, or no response from the employee, the MBE prepares a second letter to the employee (accompanied by a copy of the initial letter), advising that following the previous letter, no additional information has been received from the treating physician. The MBE advises that an additional period of 15 days will be granted for the submission of*

*necessary evidence, and if the information is not received in that time, the request for rehabilitative therapy may be denied by the DEEOIC.*

- (2) *If the employee or the physician does not provide a response to the second request for information within the 30-day period allowed, the MBE issues a letter decision to the employee denying the claim for rehabilitative therapy. The MBE further sends an email to the FO, who sends a thread to the BPA for system update.*

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*The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The MBE is to send a letter to the employee along with a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:*

*If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.*

- i. *Once the MBE decides to approve or deny the request, he/she sends an electronic mail message to the CA/FO, who prepares and sends a thread to the BPA, authorizing or denying the rehabilitative therapy request. The MBE creates a correspondence entry on the correspondence screen of ECS, documenting the decision and bronzes the letter along with the supporting documentation into OIS.*
- j. *An employee, AR, treating physician, or rehabilitative therapy provider must request a renewal of an expiring authorization or modification of an existing authorization for rehabilitative therapy and should do so prior to the expiration date of the existing authorization, to allow care to continue uninterrupted. In either of these situations, the requestor must submit a LMN documenting the continuing medical necessity of the request. Requests for rehabilitative therapy outside of this guidance must be evaluated on a case-by-case basis, including possible consultation with the DEEOIC Medical Director. The employee, or his or her AR, has final responsibility regarding the amount or type of rehabilitative therapy sought.*

- k. *Rehabilitative therapy providers must conduct services in an appropriate setting; (i.e., in a clinic, professional office, or other similar location). If the MBE receives a request for in-home professional therapy, the employee must be homebound to receive such authorization. Medical evidence from the treating physician must demonstrate that the employee is medically unable to travel to obtain the therapy outside the home. Once the MBE receives convincing medical evidence that the employee is not able to travel for therapy, and sufficient documentation exists regarding the medical necessity for care, the MBE may authorize in-home rehabilitative therapy. Provider travel to and from an employee's residence is not a billable service.*
- l. *Rehabilitative therapy providers 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 the rehabilitative therapy specific to unique features of the employee, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. 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 with the prescribing physicians LMN.*

- Exhibit 29-1 has been edited to remove outdated references to prior Bill Processing Agent
- Exhibit 29-2 has been edited to remove outdated references to prior Bill Processing Agent

RACHEL D. POND

Director

Division of Energy Employees Occupational Illness Compensation