U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
P.O. Box 8306
London, KY 40742-8306

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Subject: Update to Federal (EEOICPA) Procedure Manual (PM) Version 8.0 (v8.0): Chapter 30-Home and Residential Healthcare.

Background: PM Chapter 30 – Home and Residential Healthcare communicates procedures for Medical Benefit Examiners (MBEs) regarding Home and Residential Healthcare (HRHC) authorizations. Currently, authorization for levels of Home Health Care (HHC) may be authorized for up to a 6-month duration, or a shorter duration as established by the medical evidence. To facilitate the timely resolution of claims for HHC, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) is increasing the maximum allowable authorization for HHC from a duration of 6 months to 12 months in duration.

References: Federal (EEOICPA) Procedure Manual (Version 8.0)

Purpose: To provide revised guidelines within PM Chapter 30 – Home and Residential Health Care for MBEs authorizing levels of HHC.

Applicability: All staff.

Actions:

1. DEEOIC staff are to cease using PM v8.1 Chapter 30 – Home and Residential Healthcare and are to discard any remaining copies of that existing chapter. DEEOIC staff are to replace Chapter 30 in its entirety with the updated version found below as Attachment 1.

Disposition: Retain until incorporated in the Federal (EEOICPA) Procedure Manual.

RACHEL D. POND
Director, Division of Energy Employees
Occupational Illness Compensation

CHAPTER 30 – HOME AND RESIDENTIAL HEALTH CARE

1. Purpose and Scope. This section explains the process for the evaluation and authorization of claims for HRHC services available to DEEOIC claimants. DEEOIC staff evaluate all HRHC requests to ensure that claimants receive authorization for reimbursement of costs for medically appropriate care, either in the home or in an authorized HRHC facility, and that such care is necessary for the treatment of DEEOIC accepted, work-related illnesses. DEEOIC MBEs, or other designated staff reviewing claims for HHC, must rely on medical evidence produced by a qualified physician to determine the appropriate type, level, frequency, and duration of the requested care. This section provides an overview of terms and definitions applicable to the provision of HRHC; discusses the process claimants must follow for submitting a claim for HRHC services; describes the evidentiary requirement for documenting the medical need for HRHC; provides the developmental steps that DEEOIC may take to obtain clarifying evidence; explains how DEEOIC staff is to weigh medical evidence to substantiate the medical appropriateness of HRHC; and documents the claim adjudication and communication process for all HRHC requests. During the HRHC claims process, DEEOIC staff are responsible for properly scanning all documents created during the review process into OIS, and for recording necessary updates to ECS.

2. Definitions. This section provides definitions of the common terms, phrases and roles of the individuals involved with HRHC that a DEEOIC staff person may encounter during the HRHC claim adjudication process.

a. Accepted Condition. A diagnosed medical condition, accepted by DEEOIC, resulting from work-related toxic substance exposure.

b. Assisted Living Facilities (ALF). Although the types of services offered by ALFs vary, the term generally refers to a system of housing and limited care, designed for individuals who need some assistance with activities of daily living, but who do not require care in a residential nursing home.

c. Assistive Health Care Personnel. Non-skilled individuals (home health aides, personal care attendants, or certified nursing assistants) who are trained, and in many states licensed or certified, to provide personal care services to claimants, in their homes, as prescribed by a licensed physician. Personal care services include assisting claimants with activities of daily living, performance of which is required for personal self-care and independent living, including bathing, dressing, transferring, using the toilet, continence, and eating. Licensing and certification requirements vary from state to state.

d. Activities of Daily Living (ADL). ADLs refers to a set of common, everyday tasks, performance of which is required for personal self-care and independent living, including bathing, dressing, using the toilet, continence, and eating.

e. Conflict of Interest. DEEOIC expects a designated AR to act in a manner that promotes the best interests of his or her client. A conflict of interest arises when

an AR could benefit financially from the acceptance of a client's claim, either directly as a provider of services or supplies, or indirectly as an employee or contractor of such a provider, regardless of whether those services or supplies have already been provided or may be provided after the claim has been accepted. If this situation occurs, DEEOIC will not recognize that individual as an AR and will inform the claimant of the need to designate another person as his or her AR who does not have such a conflict, if the claimant still wishes to have a representative. (For additional conflict of interest information, refer to Chapter 12.7.)

f. Enrolled Provider. A licensed or credentialed provider of medical or HHC services (whether an individual or a business entity) that has completed the OWCP enrollment process and is approved to submit bills for reimbursement of authorized services performed. Providers enroll based upon the type of service for which they have the required licensure, including physician, hospital, diagnostic center, HRHC, DME, etc.

g. Face to Face Examination. An in-person physical examination of the claimant by his or her treating physician.

h. Homebound. Generally, homebound refers to the inability of a claimant to leave their place of residence, due to illness or injury. Claimants do not need to be totally immobilized or bedridden to be homebound but should only be able to leave their residence infrequently and for short durations. Any departure of the claimant from his/her residence must incur considerable and taxing effort.

i. HRHC Services. The umbrella title of this chapter which encompasses hospice care, HRHC, care in a skilled nursing facility, and assisted living facilities.

j. Home Health Aid. (See Assistive Health Care Personnel)

k. Home Health Care (HHC). HHC includes the services of skilled nurses (RN/LPN) or the services of assistive health care personnel, provided in the home, for the medically necessary care required of DEEOIC accepted condition(s).

l. Home Therapeutic Services. Physical therapy, occupational therapy, speech therapy, respiratory therapy, or any other professional therapeutic service that a provider charges a fee to perform.

m. Hospice. Hospice refers to a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals whose medical prognosis indicates a life expectancy of 6 months or less. Hospice care emphasizes palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the claimant's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the claimant.

n. Letter of Authorization. A written notice, issued by DEEOIC, describing the type, level, frequency, and duration of care for which DEEOIC authorizes a designated provider to provide approved services.

o. Letter of Medical Necessity (LMN). The LMN is a narrative statement, prepared by a qualified physician who has been actively treating the claimant for one or more DEEOIC accepted conditions. The LMN is the physician's independent opinion regarding the claimant's HRHC needs.

p. Licensed Practical Nurse (LPN). The licensed practical nurse is any person licensed to practice practical nursing. State statutes define practical nursing as the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist.

q. Nurse Consultant. DEEOIC Nurse Consultants are registered nurses who function as subject matter experts in assessing medical evidence to ensure it reasonably correlates to the prescribed type, level, frequency, or duration of HHC, as prescribed by a qualified physician. Nurse consultants apply their individual experience, education, and working knowledge of the practice of nursing to provide consultative advice to MBEs regarding the medical appropriateness of HRHC requests.

r. Nursing Home, Skilled Nursing Facility, and Rehabilitation Hospital. These three types of facilities provide the services of skilled nurses and therapy staff, such as registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists, who treat, manage, observe, and evaluate medical care.

s. Personal Care Attendant. (See Assistive Health Care Personnel)

t. Plan of Care. HHC agencies prepare a Plan of Care, which is a description of the services it recommends for an individual, following an in-home assessment of the claimant's needs. A Plan of Care serves as a resource, in addition to other factors, that the treating physician may consider when preparing a LMN prescribing HHC.

u. Registered Nurse. A Registered Nurse (RN) is a nurse who has graduated from a nursing program and met the requirements, outlined by a county, state, province or similar licensing body, to obtain a nursing license. An RN's scope of practice is determined by legislation and is regulated by a professional body or council, depending upon the jurisdiction in which the RN is licensed.

v. Targeted Case Management (TCM). TCM is a process for coordinating multi-disciplinary home health services that assist eligible DEEOIC claimants in

gaining access to medically necessary medical, social, educational, and other services directly related to their accepted conditions. Individuals performing TCM must possess appropriate licensure or certification from the recognized state authority for oversight of such services (e.g., a state department of labor and/or a licensing and regulation board).

w. Treating Physician. The physician, selected by the claimant to manage his or her HRHC needs, is considered the treating physician.

x. Weight of Medical Evidence. The evaluation of the relative value, or merit of medical evidence in support of a claim for compensation, including claims for HRHC. When presented with a conflict of opinion between different qualified physicians on the need for HRHC, DEEOIC applies a weighing methodology to assign a higher weight to the medical opinion of greater probative value.

3. Claimant's Role in the HRHC Authorization Process. The claimant, or a properly designated AR, has the final decision-making authority regarding filing a claim for HRHC and can choose to decline or reduce the prescribed level and/or frequency of HRHC by submitting a written request to DEEOIC. Any HRHC claim, submitted to DEEOIC, represents a request from a claimant for authorization of reimbursement for those medically necessary costs to provide HRHC services, in a home or other residential setting, for the treatment or care of an accepted condition. The claimant is responsible for working with his or her treating physician to identify and collect medical evidence supporting the need for HRHC services (e.g., HHC, assisted living, nursing home, or in-home hospice care) directly related to DEEOIC accepted medical conditions.

a. Claim Form EE-17A. Upon issuance of a FD awarding medical benefits for an accepted condition(s) DEEOIC mails a medical benefits letter, which explains details regarding HRHC and includes Claim Form EE-17A. The claimant, or a properly designated AR, must complete, sign, and return this form to initiate the first claim for HRHC services.

(1) The claimant must designate a physician responsible for medical management of HRHC services, as instructed on the claim form. Once DEEOIC receives the Form EE-17A containing the physician information, a claimant wishing to change that physician must notify DEEOIC, in writing, of the name, address and telephone number of the new physician selected to medically manage their HRHC needs.

(2) Form EE-17A designates three types of HRHC for which a claimant may request authorization: HHC, care in a nursing home, or residence in an assisted living facility.

(a) The claimant must schedule a face-to-face examination with their designated physician, and that physician is responsible for the preparation of a LMN addressing the claimant's HRHC needs.

(b) To initiate an authorization request for in-home hospice care, a DEEOIC enrolled provider of hospice services must submit a request (via fax, mail, or electronically) to DEEOIC's BPA. Form EE-17A is not required to initiate a request for in-home hospice care. The authorization request must include a Hospice Certification specifying the individual's prognosis for life expectancy as 6 months or less. Clinical information supporting the medical prognosis must accompany the certification.

4. Receipt of Form EE-17A. Upon receipt of a properly executed (signed by claimant or recognized AR) Form EE-17A, CMR staff route the form to the MBE Unit for assignment to an MBE.

a. MBE Review. Upon assignment, the MBE calls the claimant if any information on the form is incomplete. The MBE may provide the claimant with information about searching for enrolled medical providers, using the DEEOIC online provider search; however, the MBE may not advocate for any particular provider. The MBE may also refer the claimant to the closest DEEOIC ~~Resource Center~~ RC for assistance. Additionally, the MBE advises the claimant to submit their choice of a HRHC provider in writing, providing DEEOIC with the provider's name and contact information. At the conclusion of any telephone call, the MBE completes an ECS phone call note documenting the information discussed during the call.

b. Responding to Telephone Requests. Upon receipt of any telephone request for HRHC services, the receiving DEEOIC staff person (including any DO, FAB or RC staff) advises the caller that claim requests must be submitted in writing, using Form EE-17A, to initiate the first authorization process. DEEOIC staff is responsible for recording telephone requests in ECS, after explaining the forms process to the caller.

c. MBE Mails Form EE-17B to the Physician. The MBE mails Form EE-17B to the claimant's designated physician (as identified on Form EE-17A) along with the DEEOIC Physician Letter (Exhibit 30-1) that explains how the DEEOIC HHC process works. The Physician Letter offers the physician two courses of action:

(1) Complete and sign the Form EE-17B and return it with an LMN.

(2) Sign and return Form EE-17B after checking the box to indicate the physician wishes to have claimant's designated HHC provider perform an in-home assessment of needs.

d. Handling Requests for In-Home Assessments. If the physician requests an assessment, the MBE sends an authorization letter to the claimant's designated HRHC provider. Upon receipt of the provider assessment, the physician completes a LMN and forwards it to DEEOIC.

5. Evaluating an LMN. The underlying function of the MBE is to ensure that covered employees receive medical care necessary for their accepted condition(s) and that any such request for care reasonably corresponds with the medical evidence in the case file. Evaluation of the medical evidence, contained in the case record, begins upon receipt of a request for HRHC services and a physician's LMN. The LMN is the physician's opinion regarding the claimant's HRHC needs. After reviewing the medical evidence, the MBE must carefully examine the LMN to ascertain whether the care requested by the physician is consistent with and supported by the medical evidence.

a. Elements of a Physician's LMN.

(1) Evidence of a face-to-face medical examination, conducted within 60 days of the date of the LMN, and performed by the claimant's designated (as identified on the EE-17A) treating physician.

(2) A list of the accepted medical condition(s) and the care prescribed with respect to each condition.

(3) Physician notes during the face-to-face examination describing the claimant's general health, prognosis, and changes since the last exam.

(4) Physical findings such as measurements, observations, and test results, which support the need for HHC. Examples include:

(a) Significant measured reductions in oxygen saturations after activity;

(b) PFT that indicates obstructive/restrictive lung function;

(c) Demonstrated cognitive deficits that indicate inability to manage self-care routines such as medication administration, managing medical appointments, etc.;

(d) Invasive medical procedures or conditions that require the skill of medically trained personnel, such as intravenous medications, management of inserted urinary catheters, management of feeding/gastrostomy tubes, bed-bound patients, etc.;

(e) Significant gait disturbances secondary to neurological conditions;

(f) Management of wound infections, that require routine dressing changes;

(5) The physician's review of nursing notes (for reauthorization requests) supporting the need for continuation of the care previously authorized.

(6) Conditions Requiring Care. A LMN for a DEEOIC HRHC authorization must provide a clear explanation of the medical evidence supporting the justification for HRHC services related to the claimant's accepted conditions. The physician should also describe any effect that non-covered illnesses have on the claimant's need for particular HRHC services; and the treating physician must make an effort to differentiate those services from services required because of the accepted conditions.

(7) Type of Care Required. The physician is to provide an explanation as to why any specific service for the claimant is required, either in the home, or at a facility, which provides a higher level of care, such as a nursing home or ALF. With respect to in-home services, the LMN must explain why any needed services cannot be performed outside the home, such as the claimant's inability to travel from home to a clinic or physician's office, or the need for medical services required on an hourly, daily, or unpredictable basis.

(8) Level of care required. The doctor's LMN must specify the appropriate level of care required for the claimant regardless of whether the claimant is residing in the home or in some other living arrangement (such as an ALF) where the prescribed care is not available.

(a) Skilled Nursing (RN/LPN). The physician's LMN must identify the specific medical needs of the claimant, for an accepted condition(s), and explain what services are required of a skilled nurse to meet those medical needs (e.g., administration of prescription medication, wound dressing changes, administration of intravenous medications, and assessment of claimant's medical condition.)

(b) Assistive Health Care Personnel (Home Health Aide/Personal Care Attendant). Separate from any prescribed skilled nursing services, the physician must describe the physical condition of the claimant and identify specific limitations related to the claimant's accepted condition(s) that necessitate ADL assistance. The LMN should clearly identify those activities for which the claimant requires assistance and explain how those activities are linked to the DEEOIC accepted medical conditions. Such services often include activities such as mobility within the household, dressing and undressing, toileting, bathing, and meal preparation.

(9) Frequency of service. The number of times each level of HRHC service is to be performed, (e.g., daily, weekly, monthly, or intermittently as needed, etc.).

(10) Duration of Care. The number of minutes or hours required to perform the HRHC service at the frequency prescribed. For example, a home health aide is required 8 hours each day, during the claimant's waking hours, to assist with activities of daily living or, a nurse is required 2 hours a day to clean, dress and evaluate the claimant's wounds.

(11) Period of Required Care. The length of time for which the HRCH care is expected to be required to address the effect of an accepted condition(s) up to a period not to exceed one year. For example, an assistive health care individual is prescribed to provide care continuing for a one-year period, as the patient is unlikely to gain functional ability to perform ADLs on their own. For assisted living or nursing home requests, the physician must describe the relative permanency of the claimant's medical need for such care.

b. MBE's Review of LMN for HRHC Reimbursement. In judging the appropriateness of a LMN for authorization of service reimbursement, the MBE compares the information presented by the physician against other case information to determine whether the LMN reasonably aligns with information known about the status of the employee. This includes the MBE's analysis of the level and frequency of prescribed services and whether the physician properly explained how those prescribed services align with a claimant's need for specific skilled nursing services and/or the services of assistive health care personnel. Upon review, the MBE may make the determination that a LMN reasonably supports a request for HRHC and may do so when the evidence sufficiently supports the request for HRHC. The MBE may consider several factors when making this judgement.

(1) The physician has provided relevant information regarding the claimant's medical history, findings during the face-to-face examination, a clear explanation of the specific level and frequency of HHC services required of the claimant, and an explanation (medical rationale) as to why the claimant requires that specific care for their accepted condition(s). Further, a properly written LMN will provide detail as to the specific functions a nurse or assistive health care aide is to perform in the home, for any or all accepted conditions, and the frequency with which these services are to be performed.

(2) Medical evidence contained in the case file reasonably aligns with the description of the claimant's status with regard to the effect of an accepted condition(s) and the claimant's ability to perform of ADLs. For assisted living or nursing home referrals, the physician must provide a descriptive assessment of the claimant's current living circumstances and medical rationale explaining the reason(s) why the claimant's current environment no longer safely supports the claimant's medical needs.

(3) The physician has provided sufficient justification to support the amount of time needed to fulfill the specific HHC needs of the claimant, as they relate to an accepted condition(s). Where assisted living or nursing home care is prescribed, the physician should provide an explanation of the duration or relative permanency of the need for such care.

Whenever the MBE has sufficient medical documentation to authorize reimbursement for a prescribed level of HRHC, at the frequency and duration recommended by the physician, the MBE should proceed with an authorization for reimbursement. In situations where more than one level of service is prescribed (i.e., the services of both a skilled nurse and an assistive health care aide) and the evidence is sufficient for the MBE to approve one level (at the prescribed frequency and duration), but not the other, the MBE may do so. However, under this circumstance, the MBE must proceed with development for the service level the MBE cannot authorize. Additional guidance regarding authorization for assisted living or nursing home referrals is referenced later in this chapter.

6. Development Resources. If, after a review of the medical evidence and the physician's LMN, the MBE determines the treating physician's LMN does not provide sufficient information to permit authorization, the MBE must undertake additional development. The MBE must decide, from the available development options, which will be the most likely to produce a response that addresses the identified deficiency in evidence supporting the request. Development must concurrently address any remaining deficiencies so the MBE can ultimately issue a uniform decision for the balance of all claimed components of the HRHC.

a. Communication with the Treating Physician. The MBE should consider the claimant's treating physician (identified on Form EE-17A) as the primary source of medical information supporting the need for HRHC. As such, the MBE should permit the treating physician the opportunity to address any questions or other deficiencies the MBE identifies during an examination of the medical evidence. The simplest course of action might be for the MBE to contact the physician's office by telephone. If a telephone call results in a clarifying response, and appropriate information is forthcoming, no further action may be necessary. However, if a telephone call is not productive, a letter to the physician is necessary. Any such letter, to the physician who signed the LMN, should be clear and concise. The MBE should identify the specific issue requiring clarification and should describe the evidence or information the MBE needs to proceed with adjudication of the claimant's HRHC claim.

b. Nurse Consultant Referrals. DEEOIC Nurse Consultants assess medical evidence to ensure it reasonably support the type, level, and frequency of the care prescribed by the treating physician. Upon receipt of a referral from a MBE, a Nurse Consultant does not offer their own recommendations regarding the appropriate HRHC a claimant should receive but serve to assist in providing advice allowing the MBE to make an informed decision whether to authorize the care prescribed, or to undertake further development. With regard to the

assessment of HRHC prescriptions (or LMNs,) the Nurse Consultant can perform one or more of the following functions.

(1) Assessing objective evidence. The Nurse Consultant can evaluate an LMN, or a hospital discharge order for HRHC, to ascertain whether the prescribed care correlates reasonably with the objective evidence present in the case file.

(2) Assessing the appropriate skill-level of service. Nurse consultants can apply their knowledge and understanding of the field of nursing to assess whether the prescribed level of HHC relates properly to the skill level required to perform such service.

(a) For assisted living or nursing home assessments, nurse consultants can assess the medical evidence to determine if a move to assisted living or a nursing home has sufficient medical support and that such care will properly align with the ADL assistance needed by the claimant.

(3) Frequency and Duration of Care. The Nurse Consultant can advise if the time allotted represents a reasonable period within which to accomplish specific tasks. Example: a nurse is required, 2 hours each day, to clean, dress, and evaluate the claimant's wounds.

(4) Period of Required Care. The LMN must state the length of time (days, weeks, or months) for which care is being prescribed. Emergency authorizations may be limited to a number of days, or weeks, but cannot exceed 60 days. Nurse consultants can advise as to whether the period of care, recommended by the physician, represents a reasonable period of time.

(5) Compliance with Plan of Care. Nurse Consultants can evaluate ongoing home health services to ascertain whether the authorized provider is complying with the physician's plan of care.

c. CMC File Review, SECOP, and Referee Medical Examinations. If, after completion of appropriate development with the prescribing physician, the MBE determines that the HRHC prescribed by the treating physician is not supported by a well-rationalized medical opinion, and if attempts by the MBE are unsuccessful in resolving the matter, the MBE refers the case to a CMC for a file review of the case records. If, after a CMC file review, further clarification is required, the MBE may refer the claimant to a SECOP examination which requires a physical examination of the claimant and the SECOP physician's review of the available medical evidence. When the MBE determines that there are two equally weighted, but competing, opinions regarding the medical necessity for HRHC, a referee file review is required.

7. Developing Evidence to Support HRHC Requests. The goal of MBE development is to obtain medical evidence substantiating that the need for HRHC is medically appropriate to address the effects of an accepted illness. To attain this goal, the MBE should focus development specifically on the topic or issue that is preventing an authorization at the type/level/frequency/duration/period of care prescribed in the physician's LMN.

a. Initial Review. Upon receipt of a request for HRHC, the MBE reviews the case to determine if the basic requirements necessary to substantiate an HRHC request are present.

(1) Evidence that the physician conducted a face-to-face examination of the claimant within 60 days of the date of the LMN.

(2) Evidence supports that the requested HRHC is related to one or more accepted conditions.

(3) The type/level/frequency/duration/period of prescribed care is described clearly, including any need to move to an ALF or nursing home.

b. Incomplete or defective evidence. If, upon review of the case evidence, the MBE finds that any of the basic criteria, above, are missing, or there is a documented defect in the medical evidence that conflicts with the care prescribed in the LMN the MBE is to initiate development. The duration allocated by the MBE for the submission of necessary evidence to support a HRHC claim is 30 days. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period provided, the MBE sends a second development letter, providing an additional 15 days to submit the requested documentation.

(1) For issues requiring development, the MBE is to prepare a letter to the treating physician briefly summarizing any deficiencies in the LMN and requesting a response from the physician addressing those deficiencies. The MBE is to request a response, along with an amended LMN, if appropriate. The MBE is to send a copy of the development letter to the claimant and any designated AR.

(a) Upon receipt of a response, the MBE is to evaluate information supplied by the treating physician to determine if the information adequately addresses the concern(s) identified for evaluation. Should the MBE determine that the physician's response is adequate, the MBE authorizes reimbursement of care as prescribed.

(b) Upon receipt of a response from the treating physician, that is not fully responsive, or in those situations where the MBE has not

received a response to an inquiry after the allotted 15 days, the MBE is to make a determination based on the available medical evidence. Options available to the MBE at this point include a partial authorization, a denial of the request, or a decision to undertake additional development.

c. Scheduling a directed medical examination to obtain a SECOP and obtaining a referee medical opinion. Upon completion of development (including providing the claimant's physician opportunities to clarify supporting medical rationale), if the MBE determines the file does not contain a sufficiently well-rationalized medical opinion necessary to authorize the requested care, the MBE will proceed with additional development adhering to the following medical development process:

(1) CMC File Review. The MBE prepares a referral to a CMC for a file review of the case evidence. If, upon completion of the CMC file review, the MBE determines that any component of the requested HRHC is medically necessary, the MBE authorizes reimbursement up to the level established by the weight of medical evidence. Should the CMC file review determine that there is no recognized medical need for the claimed HRHC or DME, or suggests a reduction in the services previously authorized, the MBE must proceed with a SECOP directed medical examination.

(2) SECOP Examination. In those instances where development with the prescribing physician and a CMC file review have not produced the evidence necessary to establish the medical appropriateness of the prescribed HRHC, the MBE is to refer the claimant to an in-person SECOP examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for HRHC. The MBE must make every effort to expedite a SECOP examination referral to resolve an outstanding HRHC request.

(a) Once the SECOP examination is complete and the report received, the MBE then needs to conduct a full examination of the case evidence, including any medical evidence submitted by the treating physician.

(b) If the SECOP examination results in a validation of the care prescribed by the claimant's physician, the MBE is to authorize reimbursement of the prescribed care.

(c) If the SECOP examination results in an opinion that recommends a reduction or termination of the requested HRHC, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of SECOP physician is of greater weight than that of

the treating physician, the MBE authorizes care at the level, if any, prescribed by the SECOP physician. In any instance where the MBE is authorizing HRHC at a level that is less than what was previously authorized, or it is determined that no HRHC care is medically necessary, the MBE is to proceed with the issuance of a RD explaining the basis for the authorization of reduced care or a decision denying any prescribed care.

(3) Referee Examination (File Review). If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the SECOP physician, and there is a conflict regarding the claimant's needed HRHC, the MBE is to proceed with a referral for a referee examination of the competing medical reports. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving a conflict of medical opinions.

d. Where the claimant is seeking an adjustment to a previously authorized level of HRHC to a higher level, the MBE is to undertake development to determine if the need for an adjustment to the level/frequency/duration of HRHC is medically appropriate.

e. Development involving renewal of a prior HRHC authorization may require the MBE to issue periodic extensions of an existing authorization (increments not to exceed 30 days), until the MBE reaches a resolution of the medical appropriateness of renewal.

f. 60 days prior to the expiration of an existing HRHC authorization, the MBE is to notify the claimant of the need for a renewal request and updated LMN, based upon a current (within 60 days) face-to-face examination with his or her selected physician.

8. Authorizing Reimbursement for Medically Appropriate Care. Upon completion of development and after a thorough review of the case evidence, a decision is necessary regarding authorization for reimbursement of medically appropriate HRHC. The MBE must issue authorization upon receipt of sufficient medical evidence that substantiates the medical appropriateness of a prescribed level of HRHC.

a. Letter of Authorization. In those instances where sufficient medical evidence supports the authorization of reimbursement for HRHC, the MBE prepares an authorization that describes the type, level, frequency, and duration of care approved for billing by an enrolled provider of HRHC services. The MBE addresses the authorization letter to the claimant (and AR if appropriate), with a copy to the HRHC provider identified by the claimant, and a copy to the prescribing physician.

(1) Authorization for levels of HHC, residence in an assisted living facility, or for nursing home care, may be authorized for up to12 months duration, or a shorter duration as established by the medical evidence.

(2) For the purposes of authorizing the reimbursement of TCM, the MBE is to authorize a maximum of 15 minutes (1 unit) of TCM services per week. TCM services may not exceed 52 units for 12-month period. The MBE authorizes TCM for reimbursement when an employee, with an accepted condition(s), is receiving HHC for multiple disciplines of care supplied by a single provider, or multiple service providers. Multiple disciplines of care are categorizations, by service level, including skilled nursing, assistive health care personnel, rehabilitative therapists, or other licensed/certified health care service providers. Authorization for TCM should align with the period of authorization for concurrent multiple disciplines of HHC (e.g., all HRHC authorizations must run concurrently).

(3) For claims involving a requested change to an existing authorization, the MBE may authorize a change once any necessary development is complete and sufficient medical evidence exists to support the request. In this situation, the MBE must terminate the existing authorization and create a new one. The MBE sends a letter to all involved parties, terminating the existing authorization, and informing the parties of the new authorization terms.

(4) The MBE may authorize retroactive periods of HRHC, as long as the necessary medical evidence exists to support the level, frequency, and duration of the previously provided services.

(5) Upon receipt of a claim for multiple levels of HRHC, the MBE conducts development, concurrently, to address each component of the claim. Upon receipt of sufficient evidence to authorize any component of a multiple level claim for HRHC, the MBE is to issue a written authorization. The MBE communicates in the authorization that the MBE must defer any pending component of the HRHC claim until development completes.

(a) Once development completes for any deferred component, if the MBE cannot authorize any claimed HRHC at the level, frequency or duration requested, the MBE is to issue a letter decision. The MBE is to describe the components of the claim authorized for reimbursement. For any balance of care, that the MBE cannot authorize, the MBE explains the basis for the partial authorization. Included with any such partial authorization, the MBE must 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.

9. Issuing RD to Deny or Reduce Authorized HRHC. A recommended denial of authorization occurs when the MBE identifies a deficiency in the medical evidence and after the MBE has taken appropriate development steps, as described in this chapter. A RD to deny is only appropriate under certain circumstances:

a. Denial of a claim for initial HRHC in its entirety. Where the medical evidence for an initial claim does not support an authorization for any of the claimed HRHC, the MBE issues a RD to deny authorization.

b. A reduction of previously authorized HRHC. For either an ongoing, or renewing authorization for HRHC, should the evidence support an authorization at a level, frequency, or duration of care that is less than previously authorized by the MBE, a RD is necessary. Under this circumstance, the MBE issues a recommendation explaining the evidence that warrants a reduction in the level, frequency, or duration of HRHC previously authorized. Within the recommendation, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the FAB determines whether to finalize the RD.

When issuing a RD in these circumstances, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (except for the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The MBE is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. The MBE is to provide notice of the RD to any impacted HRHC service provider associated with the request and the HRHC prescribing physician.

The FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD. In considering whether to finalize a recommendation, the FAB must weigh any new evidence received to determine if it is sufficient to overcome the finding of the MBAU. Either the FAB decides that the weight of the new evidence is not sufficient to change the outcome and it finalizes the recommendation, or it issues a remand to require additional examination of the claim. FAB is to provide notice of its decision to the same recipients identified in the recommendation, including any impacted HRHC provider and the prescribing physician. Even though the servicing providers are receiving a copy of the RD, they do not possess the authority to file objection or request an oral hearing before FAB. An objection requiring FAB consideration must originate from the claimant, or a properly designated authorized representative or attorney-in-fact.

10. Notification of Discontinuance of Authorization. If a period of HRHC expires, without the claimant taking action to request renewal or submit a qualifying LMN for consideration, the

MBE sends a letter notifying the claimant, the AR where appropriate, and the HRHC provider, of the expiration of authorized benefits, and that the HRHC claim is administratively closed.

11. Processing Requests for Emergency Authorizations. In certain circumstances, claimants may require HRHC on an emergency basis, for a limited time period, while a claimant's condition stabilizes. Emergency requests can arise from a number of situations, including hospital discharge, where the claimant needs immediate care in the home; or a sudden change in the claimant's condition necessitating an urgent change in the level and/or frequency of currently authorized services. To obtain approval for an emergency authorization, the requesting party (hospital discharge staff, the claimant's AR, or a treating physician), must contact a DEEOIC enrolled provider of HRHC services. Alternatively, a currently authorized provider of HRHC services can initiate a request for an emergency increase in an existing authorization. In either circumstance, the designated or current HRHC provider contacts DEEOIC's BPA and provides (by fax or letter) an emergency care order from either the claimant's treating physician, or a hospital discharge order signed by a physician.

a. BPA Review and Reporting To DEEOIC. The hospital discharge order or LMN must describe a medical need for emergency HRHC. The BPA does not make a decision regarding the request but receives the pertinent documentation and forwards it to the MBE unit.

(1) The MBE must evaluate an emergency request to ensure the medical evidence links the claimant's need for HRHC services to a DEEOIC accepted medical condition and that a reasonable medical basis exists for emergency care. If these two conditions are met, the MBE proceeds with an authorization for 30 days of the prescribed emergency HRHC. If any reason exists to obtain additional information to substantiate an emergency authorization, the MBE must take expedited action to call an appropriate POC for clarification or initiate a prioritized Nurse Consultant referral seeking assistance.

(2) Upon approval of the emergency authorization, the MBE initiates development with the claimant's treating physician. The purpose of the MBE's development is to seek evidence regarding the duration of HRHC at the emergency level and the transition to the appropriate level of non-emergency HRHC. The MBE may grant additional, written authorizations for the emergency HRHC, in increments of 30 days during development. The MBE's authorized extensions should not exceed a total of 90 days.

12. Billing and Documentation of Services. DEEOIC requires that all provider billing, for services rendered, include evidence supporting those services. The supporting documentation must be dated and signed by the medical professional performing the billed services, and the dates of service on the supporting documentation must match the dates of service and charges listed on the billing form. Also, the name of the individual performing the service must be legible, and there must be a signature of that individual with their appropriate credential (i.e., MD, RN, PCA, HHA, PT, OT, etc.). For authorized billing codes relevant to the level and

duration of care, reference Exhibit 30-2. The following supporting documentation must be included with the bills:

a. HHC documentation includes, but is not limited to, RN/LPN progress notes, HHA/PCA/CNA notes, Targeted Case Management notes, and initial assessments.

b. Home Hospice documentation includes, but is not limited to, admission summaries, progress notes, and initial assessments.

c. Assisted Living Facility documentation includes, but is not limited to, admission and/or discharge summaries, monthly/daily itemizations of bills.

d. Nursing Home documentation includes, but is not limited to, admission and/or discharge summaries, monthly/daily itemization of bills.

13. Medical Travel Occurring During Authorized Periods of HRHC. DEEOIC permits HRHC providers to travel with a claimant to and from medical appointments when medically necessary for the treatment or care of an accepted work-related illness. DEEOIC considers this type of travel assistance as included within the scope of authorized HRHC service hours and not a separate or additional transportation service. DEEOIC will reimburse travel mileage to either the HRHC provider or the claimant, depending on whose vehicle is used for the travel. Aside from mileage and HRHC service hours spent assisting with travel, no other ancillary costs associated with conducting travel covered under this section are reimbursable. As with any other billable medical service, HRHC providers are to document properly any service time spent assisting with medically necessary travel. Travel under this guidance will not require pre-approval by an MBE for travel under 200 miles round-trip or less than three qualifying trips per week. DEEOIC provides guidance relating to extended travel authorization in Chapter 29 – Ancillary Medical Services and Related Expenses. For HRHC travel with the claimant for more than three trips in a week period, a pre-authorization request must be submitted to DEEOIC along with medical justification for such travel.