# Medical Benefit Authorizations

Presented by

Frankie Wallace, Acting Payment Systems Manager

LaTrice White, Management & Program Analyst

# Objectives

To provide an understanding of the various medical services that are paid for by the program that require review by a Medical Benefits Examiner, that should include a Letter of Medical Necessity with the request for pre-authorization.

# Overview

- DEEOIC Medical Benefits
- Accepted conditions
- General Letters of Medical Necessity (LMN) Guidelines
- Specific services requiring pre-authorization
- Best practices
- Contact information

# Coverage for Accepted Conditions

An employee who meets the statutory conditions of coverage is entitled to medical care consisting of services, equipment, and supplies prescribed or recommended by a qualified physician considered likely to cure, give relief, or reduce the degree or the period of that condition.

- DEEOIC only pays for medically necessary services and equipment for accepted conditions for the approved dates of eligibility.

# Treatment Suites

The DEEOIC uses a database of treatment suites as the core of the medical bill reimbursement process. Medical professionals within OWCP maintain and update the treatment suites as necessary. Treatment suites compare an accepted (ICD-9/10 code) diagnosis for which a provider has billed, with acceptable, allowable treatments for that condition. By using treatment suites, the DEEOIC can facilitate automatic payment of bills, for authorized services, when the service billed is reasonable and customary for an accepted condition.

Most medical services paid for by DEEOIC fall under a Treatment Suite and are paid without requiring pre-authorization.

# Treatment Suite Exception Processing

When a medically necessary treatment, service or medication is prescribed that does not typically require pre-authorization falls outside of the Treatment Suite (and is denied) the claimant can:

- Request Exception processing through the Medical Benefit Examiner (MBE) who:
  - Will require a well-supported LMN explaining:
    - What is the specific medical value and necessity of the prescribed treatment, service or medication in relation to the claimant's accepted condition(s) specifically
    - Why other common treatments included in the Treatment Suites are not available or sufficient; and
    - Why the prescribed treatment or equipment will cure, give relief, or reduce the degree or the period of the accepted condition.
  - Depending on the nature of the request, the MBE may request an advisory medical opinion from a Nurse Consultant, a Contract Medical Consultant, the OWCP Medical Director, or the OWCP Staff Pharmacist

# LMN General Guidelines

A Letter of Medical Necessity (LMN) is the written explanation from the treating physician describing the medical need for services, equipment, or supplies to assist the claimant in the treatment, care, or relief of their accepted work-related illness(es).

Medical Benefit Examiners (MBE) will weigh all evidence on file to determine if the medical evidence establishes medical necessity for the request.

# LMN General Guidelines (continued)

LMNs for any service or equipment should include:

- Services or equipment prescribed by the treating physician
- Medical explanation demonstrating the need for the service or equipment
- Medical rationale linking the requested service or equipment to an accepted condition
- Evidence of a physical exam performed within 60 days of the request for home health care and 6 months for ancillary medical

MBE will take development actions if the evidence documenting the medical need is insufficient:

- Letter to physician asking to clarify the medical need, and possibly asking for additional objective documentation
- Referral to a Nurse Consultant for an advisory opinion
- Referral to an independent contract physician or the OWCP Medical Director for an advisory opinion

# LMN content that may require development or clarification

LMNs that include opinions based on the following may require development to obtain additional information or clarification from the treating physician before the Medical Benefit Examiner can pre-authorize the service or equipment:

- Medical necessity based on non-accepted conditions
- Services or equipment prescribed for convenience, for possible future or non-accepted conditions or for potential side-effects
- Services or equipment based on speculation
- Lack of evidence of a face-to-face exam by a physician, or direct knowledge of the claimant, their medical condition(s) or medical history.

# Medical Benefits Requiring Pre-authorization and an LMN

- Prescription medications or medical supplies not ordinarily covered for the accepted condition
- Ancillary medical services:
  - Physical therapy, occupational therapy, medical massage therapy, etc.
- Durable medical equipment:
  - Wheelchairs, hospital beds, oxygen and supplies, etc.
- Requests for home or vehicle modifications
- In home health care:
  - Non-skilled care, skilled nursing care, and home hospice
- Residential care

# Rehabilitative Therapy Services

DEEOIC defines Rehabilitative Therapy Services as therapeutic services, for which a provider charges a fee to render care, that are outside the scope of routine and customary medical care generally provided by a qualified physician.

- DEEOIC considers rehabilitative therapy services medically appropriate only if a qualified physician provides an appropriate medical rationale explaining how the prescribed rehabilitative therapy will lead to an expected, measurable improvement in one or more activities of daily living, within a reasonable period.
    - Physical Therapy (PT)
    - Occupational Therapy (OT)
    - Speech Therapy (ST)
    - Pulmonary Therapy
    - Medical Massage Therapy
    - Acupuncture Treatment

# Rehabilitative Therapy Services

- Report of a face-to-face exam from the treating physician supporting the request for the specific therapy services.
- An initial evaluation completed by the therapy provider listing the current level of function
- LMN with a detailed explanation of how the requested services are related to the accepted condition(s) based on the results of an initial evaluation by the therapy provider.
- LMN must discuss the specific quantity, frequency, and duration of the therapeutic service and the face-to-face exam. This should include a discussion on how the therapy will lead to measurable improvement within a reasonable period.

Therapy for any one discipline is not allowed more than 60 visits per calendar year and each type of therapy may have other limitations.

# Home and Vehicle Modification

Require the same general information for other requests:

- A physical exam by the treating physician
- A LMN from the same treating physician that includes:
- A detailed description of the requested home or vehicle modification
  - A description of why the home or vehicle modification is medically needed to give relief for the claimant's accepted medical condition(s).

Once the medical justification is determined, the MBE will develop for bids and estimates.

- If the medical evidence supports the need for a home or vehicle modification the MBE will send a letter outlining specific requirements and specific documents needed to approve the cost of the modification.

# Durable Medical Equipment (DME)

Medically necessary equipment and appliances, prescribed by a qualified physician, for a claimant's extended use in treating or mitigating the effect of an accepted medical condition.

LMN for Durable Medical Equipment:

- Required for each specific type of DME ordered
- Must give an explanation of the claimant's medical need for equipment, or accessories necessary to provide relief for the DEEOIC-accepted medical condition(s).
- Provide the length of time the item is needed.
- Include a report of a face-to-face exam by the ordering physician conducted within six months prior to the date of the LMN.

# Request for DME

The DME supplier will need to submit a pre-authorization request to the bill pay contractor (Acentra) which includes:

- Claimant information,
- Provider information
- Appropriate CPT codes
- Number of units for each piece of equipment
- Beginning and end date for the request
- The total cost for each piece of equipment

The request should include the supporting documentation substantiating the medical need for the prescribed DME:

- LMN and medical reports
- Prescriptions/Order for each time period
- Therapy reports or diagnostic reports, etc.

# DME Fee Schedule

If a DME item is not specified/itemized under the fee schedule and is over $500.00 the DEEOIC requires a second estimate by another DME provider. The request should include the following:

- Two estimates from two different DME suppliers, that clearly identify the provider's name and contact information.
- The two estimates must quote a price for the exact same type, model, and/or description of the prescribed DME and/or appliances.
- An estimate should include a signed statement describing the unadorned DME item that meets the treating physician's specifications.
- The statement must contain a breakdown of all costs, including delivery and installation, and the current Healthcare Common Procedure Code System (HCPCS) code for each of the DME items.

# DME Add-on or Upgrade

A MBE may consider approval for DME add-ons or upgrades where the LMN and supporting medical evidence substantiates medical need for the enhancement (e.g. a bariatric mattress or wheelchair when the evidence supports this).

# Claimant reimbursement of DME for the accepted condition(s)

Claimants need to submit the same information as a pre-authorization request:

- A LMN from the physician ordering the DME for an accepted condition(s)
- A recent physical exam by the same physician
- Details of the DME purchased, receipt, and proof of payment

Claimants will use the OCWP-915 form to submit the request and reimbursements are subject to the OWCP fee schedule.

# Portal update for Claimant reimbursement forms

Effective from 2/17/2024, the Energy Document Portal has been updated to include the following new features:

OWCP-957 Part A (Medical Travel Refund Request – Mileage)*: Claimants can now conveniently submit mileage reimbursement for up to 30 trips on a single form within the Energy Document Portal. This enhancement, driven by customer feedback, aims to streamline the reimbursement process. Paper copies of this form will still be accepted and the PDF version of the form can be found on the Forms section of our website.

OWCP-957 Part B (Medical Travel Refund Request – Expenses)*: This form is used for non-mileage reimbursement including expenses such as meals, lodging, tolls, and taxi (or other transportation) fees. It can be completed online through EDP or submitted as a hard copy. The PDF version of the form can be found on the Forms section of our website.

# Home & Residential HealthCare (HRHC)

Professional medical services provided in a claimant's home or in an assisted living facility.

- A Letter of Medical Necessity (LMN) or exam reports for HRHC do not need to include the type of work the employee/patient did, or the number of years and exposures. This has already been established when DEEOIC accepted the claimed condition.

# Home Health Care

- Request for approval of payment for Home Health Care require a LMN and a face to face exam performed withing 60 days of the LMN
- Home Health Care requests are approved for up to 180 days and require renewal every 180 days.
- Emergency requests are handled separately – they are initiated by calling the Bill Processing Agent (CNSI) and speaking to the Triage Nurse

# HRHC physical exam

Physical face-to-face exam must have been performed within 60 days of the request for service by a physician (M.D. or D.O.).

- The physical exam findings will need to support those duties to be provided as ordered in the physician's LMN and the relationship of the medical needs to the accepted conditions. This should include physical findings such as measurements, observations, and test results, which support the need for HHC.

If the LMN identifies that skilled care is medically necessary for medication management, the medications for the accepted condition should be reported in the exam findings. The specific duties to be performed should also be supported in the exam findings. For example:

- If the LMN orders non-skilled care to assist the patient with mobility and transferring, the specific physical limitations should be identified in the exam findings.

During the review process, the MBE will be looking at all evidence in the claimant's case record including the physical exam to determine if the HRHC order is based on objective medical evidence.

# Home Health Care LMN

The LMN requesting HHC must include:

- The accepted condition(s).
- The current treatment the patient is undergoing or is recovering from, and the specific physical limitations based on objective medical evidence.
- A description of any effects that non-covered illnesses have on the need for services.
- The specific level of care, number of hours per day, days per week for each level of care- skilled nursing (RN, LPN) or non-skilled care (HHA, PCA).
- The duties the skilled nurse or non-skilled aide will perform for the next 180 days.
- As in-home health care is covered in the claimant/patient's home, the LMN should include any medical rationale explaining why the prescribed services that would ordinarily be provided at an out-patient facility or medical office should be provided in the home.

# Residential Care

- Requests for approval of Residential Care facilities require the same evidence as Home Health Care requests, including a LMN and face to face exam performed within 60 days of the LMN.
- Residential care is requested for a one-year period, with renewal each year. It requires a LMN and evidence of a face-to-face exam by a physician at each renewal request.

# Prior Authorization Requests

- Ensure that all the required documents are submitted with the request
- Ensure that the LMN is based on accepted conditions
- List the requestor's name and phone number (and extension) so that the MBE can contact the right individual with questions
- If the MBE sent a development letter, provide information or documents by fax or through the Energy Document Portal (EDP) so DEEOIC receives them quickly without mail delays.
- Let the assigned MBE know if there will be a delay in obtaining the documents or information requested.

# DEEOIC Address

| Medical Billing Address | General Correspondence and Claims Forms | Energy Document Portal (EDP) |
|---|---|---|
| Division of Energy Employees Occupational Illness Compensation (DEEOIC)<br>General Bills<br>P.O. Box 8304<br>London, KY 40742-8304 | U.S. Department of Labor<br>OWCP/DEEOIC<br>P.O. Box 8306<br>London, KY 40742-8306 | https://eclaimant.dol.gov |
| Documents to send to P.O. Box 8304<br>• OWCP 1500<br>• OWCP 915<br>• OWCP 957A<br>• OWCP 957B | Documents to send to P.O. Box 8306<br>• General correspondence<br>• Documents supporting claim (medical records, employment records, birth certificates, etc.)<br>• Claim forms (e.g. EE-1, EE-2, EE-3)<br>• Form EN-20<br>• Form EE-17A<br>• Requests for Ancillary Medical Services. | Documents to upload to EDP<br>• Documents supporting claim (medical records, employment records, birth certificates, etc.)<br>• Form EE-17A<br>• Form 957 A<br>• Form 957 B<br>• Request for Ancillary Medical Services<br>*After Proper Identity Verification*:<br>• Forms EE-1, EE-2, EE-3, EN-20, EN-10, EN-11A, EN-11B, OWCP-915, OWCP-957A, OWCP-957B |

# DEEOIC Online Resources

- DEEOIC Website
  - Procedure Manual
  - Information for Medical Providers
- DEEOIC Resource Centers
- Acentra Portal: Tutorials, claimant eligibility inquiry, how-to-guides
- DEEOIC Public Bill Support Mailbox: DEEOICbillinquiries@dol.gov

# DEEOIC – Nurse Consulting Services

John Vance, Branch Chief for Policy, Regulations and Procedures
Jimmy Ryals, Lead Nurse Consultant

# Lesson Objectives

- Provide insights into the work of the DEEOIC Nurse Consultants
- Role and Function
- Nurse Analysis and Reports
- Establishing Medical Need

# Nurse Consulting Team

Component of the Medical Health Science Unit within the DEEOIC Policy Branch
- Four Registered Nurses

Assist Medical Benefit Examiners in informing decisions about medical necessity of prescribed care

<u>DO NOT</u> make decisions about medical benefits –limited to consulting and advisory role

# Function of Nurse Consultants

Evaluation of cases referred by Medical Benefits Examiners (MBE) to the DEEOIC Nurse Team

Assist the MBE with weighing evidence to support medical necessity of prescribed care including:

- Objective support and alignment to nursing standards of care
- Development recommendations
- Clarify information about medical terminology, or treatment modalities

Obtain information from providers to inform MBE decision making

Nurse Consultants DO NOT decide outcome of claims

# Referral Subjects

The nurse consultant team provides analysis and consulting advice to MBEs about a variety of medical services including:

- Diagnostic test findings
- Medical terminology
- Plan of care/letter of medical necessity
- In-home health care, assisted living, and hospice
- Auto/home modification
- Ancillary medical services
- Durable medical equipment (DME)
- Medical billing and treatment modalities

# Nurse Consultant Referral Reasons

Unclear or poorly explained requests from a qualified physician after initial development

Disconnect between need for care for an accepted and non-occupational illnesses

Novel requests for services or equipment with unproven medical efficacy

Home and Residential Health Care

- Scope of necessary services due to effect of accepted illness
- Types of needed professional support – skilled or unskilled
- Expected duration or frequency of service visits

# Nurse Consultant Reports

Summarize Incoming Referral Topic

Describe Claim Background
- Accepted Conditions
- Comorbid Illnesses
- Available clinical and diagnostic data

Comparative analysis of objective evidence and rationale for requested medical benefits
- Aligns with available clinical and diagnostic evidence
- Conforms to usual and customary industry standards

# Nurse Consultant Reports (continued)

Conclusion about whether available evidence supports the need for care/service/equipment – or additional development is recommended

# Recommendations from the Nurse Team

Engage collaboratively with prescribing physician to obtain clarification of services or requested benefits.

Connect need for services to the **accepted work-related** conditions

# Recommendations from the Nurse Team (continued)

## Evaluate Home and Residential Health Care Request

Physician must explain the service justification for a skilled nurse vs. unskilled home health aide (or similar). Must adhere to usual and customary industry nursing standards for providing medically necessary services

Requests for an increased level of home care must be documented objectively by a change in the claimant's accepted medical condition or living circumstance

# Questions

Questions can also be submitted to DEEOIC-Outreach@dol.gov

Thank you very much for attending the DEEOIC Webinar