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Comment On: WCPO-2015-0003-0177
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Comment from Greg Austin, NA

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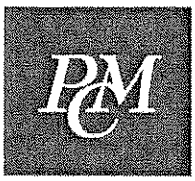
General Comment

See attached file(s)

Attachments

16.02.18 PCM Comments to RIN 1240-AA08 - With Exhibits



Professional Case Management

Helping People Live at Home

February 18, 2016

VIA FEDERAL E-RULEMAKING PORTAL

Rachel P. Leiton, Director
Division of Energy Employees Occupational Illness Compensation
Office of Workers' Compensation Programs
U.S. Department of Labor
Room C-3321
200 Constitution Avenue NW
Washington, DC 20210

Re: RIN 1240-AA08, Comments on Department of Labor's Proposed Regulations for Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, 80 Fed. Reg. 72296 (November 18, 2015)

Dear Ms. Leiton:

Professional Case Management, Inc. ("PCM") respectfully submits these comments in response to the proposed rule[1] for claims under the Energy Employees Occupational Illness Compensation Program Act of 2000 ("EEOICPA" or the "Act").[2] PCM is the most experienced and specialized EEOICPA health care provider in the country, serving the needs of former uranium miners, millers and haulers, and former nuclear weapons workers since 2002. In addition, PCM has been a home health care provider under various state and federal programs since 1997. As a specialty home care provider, PCM is distinguished by our dedication and knowledge in meeting the unique needs of clients requiring extensive treatment and long term care in the home.

With nearly 20 years as a specialty home health care provider, PCM appreciates the Department's on-going efforts in implementing the Program for the benefit of claimants as intended by the Act. Consistent with the mission of the Division of Energy Employees Occupational Illness Compensation ("DEEOIC") charged with administering EEOICPA, PCM supports regulations that "protect the interests of workers who were injured or became ill on the job, or their families, by making timely, appropriate, and accurate decisions on claims and providing prompt payment of benefits to eligible claims."

Many of the proposed rule changes, however, are inconsistent with EEOICPA's remedial nature and purpose. As a remedial statute, EEOICPA—and any regulations implementing the

[1] Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, 80 Fed. Reg. 72,296 (Nov. 18, 2015) (to be codified at 20 C.F.R. pt. 30) (hereinafter "NOPR").
[2] Pub.L. No. 106-398, Title XXXVI, §§ 3601 to 3661, 114 Stat. 1654 (2000) (codified at 42 U.S.C. § 7384 *et. seq.*).

Act—must be liberally construed to achieve EEOICPA's purpose of providing a remedy to those workers who contracted life-threatening illnesses after being unwittingly exposed to toxins while serving our government.[3] As the Act explains: "[s]ince the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay."[4] Rather than further EEOICPA's remedial purpose, the proposed changes contradict the Act's mandate and increase the administrative burden on claimants by creating additional and unnecessary hurdles and delays for them to obtain the benefits they so desperately need.[5]

Recently, the Director of the Office of Workers Compensation stated:

> This is not an adversarial program . . . . Our goal is to accept as many claims as we can under the law. Any implication to the contrary dishonors the men and women who spent their lives and sacrificed their health in service to this nation, and degrades the dedication shown by our staff every single day to provide compensation and medical benefits for those affected.[6]

The proposed rules are not consistent with this promise or the Act. PCM thus urges the Department to clarify, alter, or abandon parts of the proposed rule as discussed below. PCM also respectfully requests DOL to consider PCM's comments in promulgating its Final Rule, and requests DOL to include these comments in the administrative record for the Department's rulemaking.

I. Proposed Section 30.400. What are the basic rules for obtaining medical treatment?

The Department proposes a number of changes to § 30.400(c) regarding providers of medical services. In particular, the Department adds to the existing regulations that providers of medical services or supplies may provide relevant services and supplies "so long as such provider possesses all applicable licenses required under State law and has not been excluded from participation in the program under subpart H of this part." Additionally, the Department proposes the additional authority that "OWCP may contract with a specific provider or providers to supply

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[3] 82 C.J.S. *Statutes* § 523 (2015). *See also* 3 SUTHERLAND STATUTORY CONSTRUCTION § 60:1 (7th ed. 2015) ("Remedial statutes are liberally construed to suppress the evil and advance the remedy.").

[4] 42 U.S.C. § 7384(a)(2). Executive Order 13179 also makes clear EEOICPA is remedial in nature, stating, "Thousands of these courageous Americans, however, paid a high price for their service, developing disabling or fatal illnesses . . . Too often, these workers were neither adequately protected from, nor informed of, the occupational hazards to which they were exposed. . . . While the Nation can never fully repay these workers or their families, they deserve recognition and compensation for their sacrifices." Exec. Order No. 13179, 65 Fed. Reg. 77487 (Dec. 7, 2000).

[5] While the justifications offered for the proposed changes—such as controlling costs and increasing efficiency—are laudable, such considerations cannot trump the need to provide appropriate care to claimants. *See* Notice of Proposed Rulemaking Letter from Rachel Leiton, January 7, 2015; CONGRESSIONAL BUDGET JUSTIFICATION, EEOICPA, FY 2016, http://www.dol.gov/sites/default/files/documents/general/budget/2016/CBJ-2016-V2-06.pdf.

[6] "*Nuclear Workers Fear New Policy Will Make It Harder to Win Compensation*," TRI-CITY HERALD (Jan. 22, 2016, 1:54 PM), http://www.tri-cityherald.com/news/local/article56125775.html.

non-physician medical services or supplies." The proposed changes raise a number of concerns, which should be addressed to ensure clarity and consistency with EEOICPA.

First, the portion of the proposal mandating that providers "possess all applicable licenses under State law" requires clarification. As proposed, the Department ignores the complexities of state licensure processes. For example, within a state's licensing schema are local licensing requirements, with different triggers for licensing applications. As PCM operates in this dynamic licensing environment across many states, PCM may take a variety of actions including limiting its operations to certain services, patients, or geographies to remain compliant with state laws. In addition, PCM may expand or suspend its operations in one county or state while obtaining a requisite license, operate under an exemption or on a limited basis, or appeal an adverse license decision. Where PCM appeals an adverse decision, operates under an exemption, or on a limited basis, relief is granted by a state or local tribunal, not by a federal agency or tribunal.

Recognizing the complexity of state licensing, the multiple state jurisdictions and the relatively limited DEEOIC resources, PCM requests that the Department amend the proposed language to acknowledge that the applicable state regulatory body must determine whether a state license is required. Specifically, PCM requests that this section be revised as follows:

> (c) [A] hospital or provider of medical services or supplies may furnish appropriate services, drugs, supplies and appliances, so long as such provider possesses all applicable licenses required under State law **as determined by the applicable State regulatory body** and has not been excluded from participation under subpart H of this part.

Second, the proposed additional authority for OWCP to "contract with a specific provider or providers to supply non-physician medical services or supplies" appears inconsistent with the Act and should be removed. Section 7484t provides that medical benefits shall be at the individual's option, or by an order of U.S. medical officers or hospitals, or by order of government-designated physicians or hospitals.[7] The Act mandates that a claimant be able to choose her care provider absent a medical order. The plain language of the Act—"shall"—removes the Department's discretion in making available to claimants the ability to choose care providers. Thus, PCM requests that the proposed language "OWCP may contract with a specific provider or providers to supply non-physician medical services or supplies" be removed in its entirety.

II. Section 30.403. Will OWCP pay for home health care, nursing home, and assisted living services?

The Department proposes amending section 30.403 to include a new subsection (c), which requires for filing an initial claim for home health care, nursing home, or assisted living services that:

- the beneficiary submit form EE-17A to OWCP and identify his treating physician;
- the OWCP then send form EE-17B to the treating physician;

[7] *See* 42 U.S.C. § 7384t(b).

- the treating physician then submit to OWCP a letter of medical necessity and verify that timely face-to-face physical examination of the beneficiary took place.

The Department mandates that this pre-authorization process be followed for the initial claim, as well as any subsequent request for preauthorization. Upon successful preauthorization, OWCP will authorize and pay for home health care claimed under 7384t of the Act that is medically necessary. A claimant may appeal OWCP's denial of preauthorization through a prescribed adjudicatory process.

PCM requests that the Department remove proposed subsection 30.403(c) in its entirety and remove the "subject to" clauses of subsections 30.403(a) and 30.403(b) in their entirety. This proposed process will result in claimants suffering over a month without care that has been deemed medically necessary by their physician, but lacks authorization by OWCP. The proposed preauthorization process creates the very regulatory obstacles that the Act was intended to cure; it is impermissible under the plain language of the Act; it will result in home health care delays or denials to qualified and seriously-ill claimants; and it will force home health care providers to either violate state laws or deny care to these elderly, sick workers.

A. Congress's Intent in Enacting EEOICPA Precludes the Proposed Preauthorization Process.

The Department's proposed changes presume that it must filter away illegitimate claims through a preauthorization process. In passing EEOICPA, Congress intended to "abandon this position . . . which has been a presumption against the worker in the past."[8] The Department's proposed changes defy congressional intent.

Congress enacted EEOICPA because existing workers' compensation programs had failed to provide for the needs of these workers and their families. Those programs had imposed long latency periods, denied claims premised upon inadequate exposure data, and failed to account for the uniqueness of the hazards to which workers had been exposed.[9] Exacerbating this failure was the Department of Energy policy of fighting against workers' benefit claims.[10] In assessing the obstacles that the government had already imposed upon claimants—"Cold War veterans . . . that kept this Nation safe"[11]—members of Congress were clear in their intent: "We must not establish a program that makes it impossible for workers to receive compensation."[12] Congress then amended the Act to remove further obstacles and delay imposed by regulatory bureaucracy that resulted in the "vast majority of men and women who have filed claims through this program—many of whom will die before they ever see a compensation check—[]being denied justice."[13] And even now, Congress expresses clear and consistent intent: "Too often, workers die waiting for

[8] 146 CONG. REC. H3346-02 (daily ed. May 18, 2000) (statement of Rep. Hunter).
[9] Exec. Order No. 13179, 65 Fed. Reg. 77487 (Dec. 7, 2000).
[10] *Id.*
[11] 146 CONG. REC. H3346-02 (daily ed. May 18, 2000) (statement of Rep. Whitfield).
[12] 146 CONG. REC. H3346-02 (daily ed. May 18, 2000) (statement of Rep. Strickland).
[13] 150 CONG. REC. H3415-02 (daily ed. May 20, 2004) (statement of Rep. Udall).

compensation that they never receive. Congress didn't intend for the . . . process to be so burdensome."[14]

PCM urges the Department to recognize that the proposed preauthorization process will precipitate low potential savings for the federal government, in exchange for the further high costs that will befall these workers and their families. Chairman Hostettler of the House Subcommittee on Immigration, Border Security, and Claims explained that "[u]nlike assistance programs where millions of dollars are paid out on fraudulent claims of harm, the claimants under this program can't fake cancer."[15] As the Department itself knows, many claimant have stressed that they have "no desire to seek, or be viewed as seeking, money or benefits from the government for which they are not entitled" and that they "find it embarrassing to file a claim" that is subsequently rejected.[16] The likelihood is low that the government's perceived savings in avoiding improper claims merit effecting the opposite of Congress's repeated, explicit intent. To the contrary, because the proposed preauthorization process does not improve the adjudication of home health care claims, the only possible savings will result from delaying access to much needed home care services for seriously-ill beneficiaries.

PCM understands that the Department seeks to ensure that only eligible claims are in fact covered. But the proposed preauthorization process discourages not only the rare instance of a potentially illegitimate claim, but also introduces literally at least 36 new steps, complicated paperwork requiring expert input, and months of waiting and anxiety to many elderly patients suffering from what Congress described as "among the cruelest ways to die."[17] Congress explicitly stated that if there is any doubt as to the validity of a claim under EEOICPA, "the benefit of the doubt must go to the workers who were put in harm's way."[18]

B. The Proposed Preauthorization Process is Impermissible under the Act.

The proposed preauthorization process provides a date of eligibility that depends on the date of the Department's issuance of preauthorization. But, the Act unambiguously states the date of eligibility is the date a claim is filed:

> An individual receiving benefits under this section shall be furnished those benefits as of the date on which that individual submitted the claim for those benefits in accordance with this subchapter.[19]

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[14] *See* Jim Morris & Jamie Smith Hopkins, *Ailing, angry nuclear-weapons workers fight for compensation*, Ctr. for Pub. Integrity (Dec. 11, 2015, 5:00 AM), http://www.publicintegrity.org/2015/12/11/18936/ailing-angry-nuclear-weapons-workers-fight-compensation.

[15] *Energy Employees Occupational Illness Compensation Program: Are We Fulfilling the Promises We Made to These Cold War Veterans When We Created This Program? (Part III): Hearing Before the Subcomm. on Immigration, Border Sec., & Claims of the H. Comm. on the Judiciary*, 109th Cong. 11 (2006) (statement of Rep. Hostettler) (hereafter "2006 Congressional Hearing").

[16] *See* 2013 EEOICP, OFF. OF THE OMBUDSMAN ANN. REP. 20.

[17] 146 CONG. REC. H3346-02 (daily ed. May 18, 2000) (statement of Rep. Kaptur).

[18] 146 CONG. REC. H3346-02 (daily ed. May 18, 2000) (statement of Rep. Strickland).

[19] 42 U.S.C. § 7384t(d).

The Department itself has defined a "claim" to mean "any written communication that requests benefits under the Act."[20] It has followed this definition in its adjudications. DOL Hearing Officers have ordered medical benefits for three conditions to begin on the date of the claim submission for only one condition. A 2003 Final Decision cited the Act in stating, "The date you filed your claim is the date you became eligible for medical benefits for cancer."[21] Similarly, a 2005 Decision held that "entitlement to medical benefits is retroactive to the earliest date of filing."[22]

DEEOIC Director Rachel P. Leiton explicitly stated, "authorization for in-home health care services already provided may be granted retroactively, potentially back to the date that the claim was filed with DEEOIC."[23] Director Leiton affirmatively rejected preauthorization in a July 5, 2011 letter concerning a past attempt to mandate it, characterizing the concern as a "miscommunication."[24] Further evincing the Department's position, the Department has provided brochures to claimants that instruct, "Reimbursement of expenses is allowed retroactive to the filing of the claim."[25]

The Department's existing regulations are consistent with the Act and the Department's own practice. Under them, medical benefits under EEOICPA include home health care. When a claimant becomes eligible to receive medical benefits under EEOICPA, the eligibility begins at the date of the claim.[26] Thus, the eligibility for home health care begins at the date of the claim.

But the Department now proposes to reduce the coverage it will provide by inserting a period of ineligibility via the new preauthorization process. As proposed, initial eligibility would commence only after a 36-step process, summarized below:

1. Home care provider receives referral;
2. Home care provider instructs claimant to request EE-17A form;
3. Claimant contacts OWCP to request Form EE-17A;
4. OWCP partially completes Form EE-17A;

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[20] DOL Generic Decisions, Docket No. 62339-2005, http://www.dol.gov/owcp/energy/regs/compliance/Decisions/GenericDecisions/DecisionsRef/62339-2005--20051118.htm (emphasis added); *see also* 20 C.F.R. § 30.5(k) (Claim (defined) means "a written assertion to OWCP of an individual's entitlement to benefits under EEOICPA.").

[21] DOL Generic Decisions, Docket No. 10522-2004, http://www.dol.gov/owcp/energy/regs/compliance/Decisions/GenericDecisions/DecisionsRef/10522-2004--20031114.htm (emphasis added).

[22] DOL Generic Decisions, Docket No. 10001749-2005, http://www.dol.gov/owcp/energy/regs/compliance/Decisions/GenericDecisions/DecisionsRef/10001749-2005--20051214.htm (emphasis added).

[23] July 5, 2011 Letter from Rachel Leiton, Director, DEEOIC, to Greg Piche, attached as Exhibit 1.

[24] *Id.*

[25] DEEOIC Brochure, *How Will My EEOICP Medical Benefits Be Paid?*, http://www.dol.gov/owcp/energy/regs/compliance/brochure/medicalqaform.pdf.

[26] *See, e.g.*, 20 C.F.R. § 30.400(a) (eligibility begins "retroactive to the date of the claim for benefits for that occupational illness or covered illness under Part B or Part E of EEOICPA was filed").

5. OWCP mails partially completed Form EE-17A to claimant;

6. Claimant completes Form EE-17A;

7. Claimant mails EE-17A to DOL Central Mailroom;

8. DOL Central Mailroom receives and scans EE-17A;

9. OWCP reviews completed Form EE-17A;

10. OWCP completes Form EE-17B;

11. OWCP mails partially completed Form EE-17B;

12. Physician completes EE-17B and requests in-home assessment;

13. Physician conducts face-to-face examination;

14. Physician mails partially completed EE-17B to DOL Central Mailroom;

15. DOL Central Mailroom receives and scans EE-17B;

16. OWCP reviews partially completed Form EE-17B;

17. OWCP contacts home care provider to conduct in-home assessment;

18. Home care provider contacts claimant to schedule in-home assessment;

19. Home care provider contacts treating physician to request order for assessment;

20. Physician writes order for in-home assessment;

21. Home care provider conducts in-home assessment of claimant;

22. Home care provider mails completed assessment to DOL Central Mailroom;

23. DOL Central Mailroom receives and scans completed in-home assessment;

24. OWCP reviews in-home assessment;

25. OWCP prepares report for physician per Additional Instructions to Physician on Form EE-17B;

26. OWCP mails assessment and/or report with another partially completed Form EE-17B;

27. Physician reviews in-home assessment and completes EE-17B for second time;

28. Physician prepares letter of medical necessity ("LOMN");

29. Physician mails completed EE-17B, LOMN and evidence to OWCP;

30. DOL Central Mailroom receives and scans EE-17B, LOMN and evidence;

31. OWCP reviews EE-17B, LOMN and evidence;

32. OWCP conducts adjudication process;

33. OWCP notifies claimant, physician and home care provider via U.S. Mail;

34. Home care provider completes Home Plan of Care for physician;

35. Physician reviews, edits and signs Home Plan of Care;

36. Care begins.[27]

The protracted process will likely take months, thus truncating claimants' benefits by months, and creates unnecessary obstacles that contradict the intent and purpose of EEOICPA, as further discussed below.[28] Therefore, the proposed preauthorization process is impermissible under the plain language of the Act.

C. The Proposed Preauthorization Process will Delay or Deny Care to Qualified Claimants.

The proposed requirement of the multi-step process required to complete Forms EE-17A and EE-17B[29] creates months of delay for a claimant to receive health care which could prevent the claimant from receiving this service entirely. First, claimants cannot have assistance from professional home health care providers trained in processing health care forms and ensuring that information is accurately conveyed. The Department instead excludes home health care providers from the claims process until the claimant needs care. But the Department already knows how difficult gathering the required evidence and demonstrating medical necessity is under the program - even under the existing regulations. For example, under Part E, claimants misunderstand their burden of proof, do not have the resources to develop and locate technical medical and scientific evidence linking their illnesses and work-related substances, and encounter unreliable data along the way.[30] Home health care providers are oftentimes the only support available to a claimant, and the most likely to understand the forms well enough to get the claimant the care she needs.[31] Under the proposed regulations, sick, elderly claimants must themselves navigate these forms to ensure medical and regulatory accuracy, and then submit these forms to the appropriate addressees.

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[27] The proposed forms impose a far more sequential process as opposed to the current authorization practice which allows for more parallel processing.

[28] Delaying care to claimants under the EEOICPA by creating these types of obstacles is no more acceptable than delaying care to our veterans. *See* Drew Griffin *et al.*, *Veterans Still Facing Major Medical Delays at VA Hospitals*, CNN INVESTIGATIONS (Oct. 20, 2015, 9:07 PM), http://www.cnn.com/2015/10/20/politics/veterans-delays-va-hospitals/.

[29] The attached flowcharts and table (Exhibit 2) summarize this process.

[30] *See* 2013 EEOICP, OFF. OF THE OMBUDSMAN ANN. REP. 42-43.

[31] PCM does not ignore the guidance and assistance provided by the DEEOIC Resource Centers. However, the Resource Centers do not have sufficient staff and do not have clinical and medical training to timely provide the necessary assistance.

Second, all of the information being requested in EE-17B is currently being provided by Letters of Medical Necessity, office visit notes, and authorization requests submitted by the health care provider. Most physicians who provide care under the Program have very few EEOICPA patients.[32] Physicians have stressed to the Department that they have limited time available to comply with the existing paperwork process under the program, and are even less inclined to do so to satisfy bureaucratic hurdles that force them to rewrite or clarify reports they believe are already adequate.[33] Therefore, the additions to the existing onerous process steps, requirements, and paperwork will likely dissuade physicians from taking on or continuing to serve these patients.

Third, the forms cannot be completed in one step. A claimant must provide certain information at each step, including information already in DEEOIC's possession. As previously mentioned, completion of both forms requires approximately 36 steps.[34] At each step, one of the two newly introduced forms is being mailed back and forth via U.S. Mail. Assuming immediate action upon receipt at each step and no human error, the estimated time to complete each of the 36 steps and mail the form is at best 3 days, and will result in authorization—in a best case scenario—60 days after the initial form was submitted. At any given step, any breakdown in the process will extend this time period; multiple breakdowns will exponentially delay care.

The care for which claimants would lose coverage under the preauthorization process is the very care they most urgently require.[35] In 2015 alone, PCM estimates that over 25 percent of its new patients had a period of time where their physician prescribed, and PCM provided, home health care services but authorization was not in effect at the time services commenced. In each of these cases, the DEEOIC subsequently agreed with the medical necessity of the care and provided authorization retroactive to the start of care. With the new proposed processes, each of these claimants would have been forced to forgo medically necessary and covered services until the conclusion of the lengthy preauthorization process. In a number of these cases, PCM provided care without authorization until the claimant passed away and then subsequently sought retroactive authorization in conjunction with the family of the deceased patient. These cases highlight that even under the existing and more claimant-friendly procedures, authorization delays are common

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[32] DEEOIC has acknowledged this characteristic of the EEOICPA Program: "The costs to providers whose charges may be reduced also will be relatively small because EEOICPA bills simply will not represent a large share of any single provider's total business. Since the small universe of potential claimants is spread across the United States and this bill processing system will cover only those employees who have sustained an occupational illness or a covered illness and required medical treatment on or after October 30, 2000, the number of bills submitted by any one small entity which may be subject to these provisions is likely to be very small." Performance of Functions; Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act,70 Fed. Reg. 33590, 33603 (June 8, 2005).

[33] *See* 2013 EEOICP, OFF. OF THE OMBUDSMAN ANN. REP 73.

[34] *See* Exhibit 2 (flowcharts and table).

[35] A common phrase in the health care industry—reiterated by Senators, Congressional Representatives and watchdog groups—is "Care delayed is care denied." *See, e.g.*, 155 CONG. REC. S7771-01 (daily ed. July 21, 2009) (statement of Sen. Murray); 157 CONG. REC. H3502-01 (daily ed. June 25, 2001) (statement of Rep. Green); 144 CONG. REC. H4705-01 (daily ed. June 17, 1998) (statement of Rep. Green); WILLIAM F. DEMENT, JR., DELAY, DENY, HOPE THEY DIE: WORLD TRADE CENTER FIRST RESPONDERS BATTLE FOR HEALTH CARE AND COMPENSATION (2011); NATIONAL UNION OF HEALTHCARE WORKERS, CARE DELAYED, CARE DENIED: KAISER PERMANENTE'S FAILURE TO PROVIDE TIMELY AND APPROPRIATE MENTAL HEALTH SERVICES (Nov. 2011), http://pavelvanegas.com/CareDelayedCareDenied.pdf.

because the DEEOIC requests additional information from home care providers, physicians, hospitals, or other medical professionals to ensure quality decisions.

Often, claimants need referrals to home health care on an emergency basis; for instance, upon discharge from a hospital or other medical facility, when terminal and facing end of life, or when an existing family caregiver becomes ill or passes away. In these circumstances, the present system allows for prompt authorization of a home health care request[36] or allows the provider to take a calculated risk and begin providing the much needed care knowing it may seek retroactive authorization. The proposed regulation fundamentally changes this process. The wait between initiating the process of completing the forms and actually receiving authorization for care could extend over several months; excluding home health care providers during that time disserves claimants twice over—they are denied support during the process, and they are less likely to receive the care for which they are qualified and in need as a result of the hurtful process. In short, the result is that those most in need of care are the least likely to receive it.

The subsequent prior authorization requirement will have grave impacts beyond just claimants that are seeking home health care services for the first time. Existing claimants who are currently authorized by the DEEOIC and receiving home health care services are required to have their care reauthorized at least every 6 months. These claimants routinely have episodes where their authorization expires for a period of time before the DEEOIC retroactively reauthorizes the care for a subsequent period. Under the new proposed preauthorization requirement, home care providers would be forced to cease providing care to these claimants until a reauthorization is issued. As a result, sick claimants would be denied home care services that were already established as medically necessary and authorized by the DEEOIC. This is especially concerning given that delay by the DEEOIC in processing requests for reauthorization is the most common reason for lapses in authorization. Throughout 2015, PCM provided care to approximately 10 percent of its patient census for a period where authorization had lapsed but was subsequently approved.

While the DEEOIC has proposed new forms, processes, and a prior authorization mandate, it has not indicated how it will timely or efficiently respond to the increased workload created by these new procedures. With home health care requests increasing 30% in the last two years alone[37], each of these requests requiring significant development, oversight, and staff time, and the number of electronic communications increasing by three-fold[38], there is significant risk that these new and onerous procedures will result in dangerous and unacceptable delays for the claimants most in need of medical services.

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[36] EEOICPA BULLETIN NO. 09-05, PROCESSING CLAIMS FOR END-STAGE TERMINALLY ILL CLAIMANTS (Nov. 26, 2008), http://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/finalbulletinshtml/EEOICPABulletin09-05.htm.

[37] CONGRESSIONAL BUDGET JUSTIFICATION, EEOICPA, FY 2016, p. 13, http://www.dol.gov/sites/default/files/documents/general/budget/2016/CBJ-2016-V2-06.pdf.

[38] *Id.* at p. 20.

D. The Proposed Preauthorization Process Blocks Claimants from Home Health Care by Requiring Home Health Care Providers to Violate State Law and Industry Practice, or to Deny Care.

Home health care is an essential element in the health and safety of many sick nuclear workers. PCM understands that home health care may impose increased costs on the Department, but urges the Department to recognize Congress's insistence that government savings at the cost of claimants' health is inappropriate under the Act.[39] The effect of the proposed preauthorization process is to force home health care providers to choose between violating existing laws and denying care, both precipitating further government-imposed obstacles to claimants' access to needed care.

Home health care services are regulated by federal, state and local laws, and subject to the standards set by accrediting bodies; the proposed preauthorization process conflicts with these provisions. The proposed preauthorization process, combined with the delays imposed by Forms EE-17A and EE-17B, creates months of delay between a referral and the eventual preauthorization after the claimant completes the complex new paperwork process. This delay precludes compliance with the timeliness required in existing regulatory and industry authorities.

In stark contrast to the extended (at-best 60-day) process the Department now proposes, the industry standard for assessments for home health care is 48 hours. For example, under its regulations governing the comprehensive assessment of patients, Medicare[40] requires a nurse to determine the needs of the patient at the same time as the eligibility assessment, both of which must occur within 48 hours.[41] The Joint Commission on Accreditation of Health Care Organizations ("JCAHCO"), which is the nation's oldest and largest health care standards-setting and accrediting body, considers 48 hours the maximum period of time allowed between referral and performance of an initial assessment.[42] Therefore, home health providers will be putting their accreditation at risk when forced to choose between awaiting authorization under the proposed process or denying care altogether.

Adhering to the proposed initial claim process in section 30.403(c) also conflicts with state laws. Consistent with the federal requirements for initial assessment timing, PCM's home state of Colorado also requires initial assessments within 48 hours:

> A registered nurse shall conduct an initial assessment visit to determine the immediate care and support needs of the consumer. The initial assessment visit shall be held either within 48 hours of

[39] *See* 2006 Congressional Hearing, 12 (statement of Rep. Hostettler) ("Pinching pennies never looked so inappropriate as it does when addressing the plight of these workers.").

[40] Medicare standards effectively serve as the minimum *de facto* health care standards; the Centers for Medicare and Medicaid Services ("CMS") oversees approximately 65% of home health care services and expenditures. *See* NAT. ASS'N FOR HOME CARE & HOSPICE, BASIC STATISTICS ABOUT HOME CARE (2010), http://www.nahc.org/assets/1/7/10HC_Stats.pdf.

[41] 42 C.F.R. § 484.55(a)(1).

[42] JCAHO STANDARDS MANUAL, PC 01.01.01 – 01.02.03 (2016).

> referral, or within 48 hours of the consumer's return home, or on the ordered start-of-care date.[43]

Colorado is not unique. Other states conform to the Medicare and JCAHO standard of the 48 hour assessment requirement,[44] and the industry expects other states to follow suit in requiring a prompt initial home health care visit following a referral. This trend among the states will result in home health care providers violating states mandates and industry standards in its delivery of care because the initial home health care visit will be delayed until the authorization at the completion, subsequent to the 36-step process required by proposed section 30.403(c).

The proposed preauthorization process ignores the importance of ensuring timely delivery of home health care services to those in need. State and federal regulators, industry, and even the Medicare community have followed the practice of collaboration between provider and payor in the interest of efficient delivery of health care to a patient. Proposed section 30.403(c) unreasonably ignores the movement toward prompt health care post-referral by creating a complex, cumbersome system that only serves to hurt the very class of people it was intended to protect.

PCM urges the Department to remove the sweeping changes proposed under the new preauthorization process in section 30.403(c) and all references to it. The proposed regulation is impermissible under the plain language of the statute. The confusion and burden imposed by the new forms will likely cause otherwise qualified claimants to forego their statutory right to home health care and discourage their physicians from continuing to accept EEOICPA claimants. The proposed regulation would force home health care providers to choose between violating state law while awaiting preauthorization under federal law, or complying with state law and risking irreparable financial harm to their business; in either case, the claimant loses access to medically necessary home health care. PCM has been working with claimants and physicians to assist them in compliance with existing requirements since Director Leiton's July 15, 2011 directive.[45] While the current process involves some delay, particularly in the most urgent of home health care needs,

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[43] 6 COLO. CODE REGS. § 1011-1:XXVI-7, 7.9(A)(1).

[44] Examples of state regulations requiring prompt initial visits after referral include the following:

- Arkansas: "A registered nurse shall make the initial evaluation visit and initiate the plan of care and necessary revisions. The initial evaluation routinely must be performed within 72 hours of the initial referral or discharge from an inpatient facility." ARK. ADMIN. CODE 007.05.4-11(H)(1).
- Louisiana: "Admission procedures are as follows: 1. an initial visit shall be made by a registered nurse or an appropriate therapist who will perform the assessment and instruct the patient regarding home care services. This visit shall be made within 24 hours of referral unless otherwise ordered by physician . . . ." LA. ADMIN. CODE tit. 48, pt. I, § 9123(B)(1).
- Maine: "All referrals will be responded to by the Home Health Care Services Provider within twenty four (24) hours." 10-144-119 ME. CODE R. § 7.D.1.
- Vermont: "A home health agency shall respond with at least a telephone call to all referrals within twenty-four (24) hours, or as specified by physician order." 12-4 VT. CODE R. § 205:3.18. "The initial assessment visit shall be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the date the physician ordered care to start. The assessment shall be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care, unless otherwise ordered by the physician." 12-4 VT. CODE R. § 205:15.3.

[45] Letter from Rachel P. Leiton, Director, DEEOIC to DEEOIC Home Health Care Providers dated July 15, 2011, attached as Exhibit 3.

it allows for more timely care than do the proposed changes in section 30.403(c), which are simply unworkable.

III. Proposed Section 30.410. Can OWCP require an employee to be examined by a physician?
Proposed Section 30.411. What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

The Department proposes a new subsection (c) to section 30.410, which states: "OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a second opinion examination." The Department also proposes a new subsection (d) to section 30.411, which states: "OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a referee medical examination."

PCM recognizes that the Department seeks to memorialize existing practice, but notes that the Department must first consider what regulations are necessary to protect beneficiaries. Both of the proposed new subsections grant OWCP the right to administratively close the claim and suspend adjudication of any pending matters if the claimant "refuses to attend" a second opinion examination (in 30.410) and a referee medical examination (in 30.411). The proposed language appears to allow for cursory closure of a claim due to a claimant's failure to attend, rather than the claimant's refusal to attend a second or referee examination.

In many cases, a claimant does not "refuse to attend" a second opinion or referee examination; rather, the claimant is simply too ill to travel. In PCM's experience, the Department most often requires the sickest beneficiaries to attend these examinations; but the sickest are also the most in need of home care, and the least able to travel. These beneficiaries oftentimes do not have family or friends available to take significant time away from their own jobs and families to drive 100 miles to these appointments and back, as well as wait during the examinations; meanwhile, many of these beneficiaries are unable to drive themselves. Compounding this difficulty is the great distance. The Department's current Procedural Manual strongly encourages examinations to take place within 100 miles of the claimant's residence, but the Department has often required them at locations over 100 miles away from their home.[46] Yet, even if the distance were more surmountable, and loved ones were abundant, beneficiaries often cannot travel in a standard vehicle. Many must travel with continuous medical support over such a long distance, including via ambulance. Those that can travel have arrived at examination facilities that cannot accommodate their medical needs and are thus inaccessible to the beneficiaries. The sickest beneficiaries are presented with significant, dangerous obstacles to attend second opinion examinations, and attendance is often impossible. Under the proposed additions, beneficiaries risk losing coverage because they are simply too sick to travel.

PCM requests that the Department clarify how it will determine whether a patient "refuses to attend" a second or referee medical examination, and to take into account the difficulty beneficiaries encounter in attending these examinations. First, the Department should amend the

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[46] *See* EEOICPA BULLETIN NO. 03-01(5), MEDICAL SECOND OPINIONS (May 2, 2003), http://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/finalbulletinshtml/bulletin_03-01_Medical_Second_Opinion.htm.

regulations to require that OWCP provide reasonable travel accommodations, including ambulance service as needed, and hold examinations in facilities which accommodate beneficiaries' medical needs. Second, the Department should revise the regulation to follow the final claims process requiring notice with opportunity for review as proposed in sections 30.310–30.319, and should include the Procedure Manual 30-day notice and 100-mile factors to assess whether a beneficiary did "refuse to attend" an examination.

IV. Section 30.601. Who may serve as a representative?

The Department proposes to modify subsection 30.601 regulating who may serve as a representative (commonly referred to as the "Authorized Representative"). Under the existing regulations, the use of Authorized Representatives is restricted where an Authorized Representative's service would violate any applicable provision of law. Under the proposed regulation, the use of Authorized Representatives would also be restricted where the service would violate the standards regarding conflicts of interest adopted by OWCP.

PCM supports the existing restriction on illegal appointments, but requests clarification on the proposed addition regarding OWCP's conflict of interest standards. The Department has not indicated what constitutes "the standards regarding conflicts of interest adopted by OWCP." If the Department intended to refer to the standards articulated in Final Bulletin 14-04, PCM notes that Final Bulletin 14-04 presupposes that any financial interest by an Authorized Representative constitutes a conflict of interest.[47] Imposing this broad brush prohibition against representatives from having any financial interest bars both health care providers and paid family member caretakers, either of whom may be a vital advocate to an EEOICPA claimant.

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[47] Final Bulletin 14-04 states:

> As an authorized representative of a claimant under the EEOICPA, you are prohibited from having private, non-representational direct financial interests, other than your fee for serving as a representative, in regard to your client's claim with DEEOIC. Because the "role" of an authorized representative is so important, DEEOIC will consider you to have a prohibited "conflict of interest" if you could directly benefit financially from your client's EEOICPA claim due to something ***other than*** your statutorily limited fee for representing your client in connection with his or her EEOICPA claim. For example, you will be considered to have a prohibited conflict of interest if, in addition to being your client's authorized representative, you are also being paid by DEEOIC, directly or indirectly, as a provider of authorized medical services to your client. Because there is an obvious conflict of interest that will arise in this sort of situation, DEEOIC will not recognize you as an authorized representative should this occur, and will inform the claimant of the need to designate another person as his or her authorized representative who does not have such a conflict. If you are in a position to directly benefit financially from your client's EEOICPA claim, you are required to notify DEEOIC and withdraw as representative.

EEOICPA BULLETIN NO. 14-04, AUTHORIZED REPRESENTATIVE CONFLICTS OF INTEREST (JULY 1, 2014) (emphasis in original), http://www.dol.gov/owcp/energy/regs/compliance/PolicyandProcedures/finalbulletinshtml/EEOICPABulletin14-04.htm.

Home health care companies in particular should not be barred from serving as Authorized Representatives. They have experience in navigating complex federal benefits programs, presenting EEOICPA claims, and appealing their denials. The claimants and their families most likely do not have this experience, while privately-retained counsel are discouraged from serving as the Authorized Representative due to EEOICPA's provision capping attorney fees.[48] By prohibiting home health care companies from participating in the approval and appeals process for these claims, the Department blocks claimants from the most appropriate advocate for their care.

Additionally, a family member who is serving as a care provider is also in the best position to serve as the Authorized Representative. The family member is intimately familiar with the claimant's clinical needs, medical history, physicians and care coordination. Incorporating Final Bulletin 14-04 through the proposed rule would force a family member to choose between serving as the care provider or the Authorized Representative.

Finally, PCM notes that other federal health care benefit programs allow heath care providers to serve as advocates.[49] For example, Medicare providers are specifically permitted to represent beneficiaries in Medicare appeals, provided that they agree not to accept a fee for representation,[50] and in certain circumstances agree to not pursue payment for the medical services they provided if the appeal is unsuccessful.[51] Medicare providers are also considered a party to the benefit decision and are therefore allowed to appeal in their own right, without being required to involve the beneficiary in what is essentially a billing matter.[52] Moreover, if a provider or supplier is not considered a party, the beneficiary may assign appeal rights to them, so that the provider or supplier can still work with Medicare directly to have services covered (as long as the provider is willing to waive the right to collect from the beneficiary).[53] Incorporating Final Bulletin 14-04 through the proposed rule would impose a stricter conflict of interest standard than used by any other federal benefit program.

PCM requests that the Department clarify to which conflict of interest standards it is referring. If the Department is referring to the standards articulated in Final Bulletin 14-04, PCM requests that the Department remove the addition of "or the standards regarding conflicts of interest adopted by OWCP" from section 30.601 in its entirety.

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[48] 20 C.F.R. § 30.603.

[49] *See, e.g., McClure v Vice Pres., Human Resources, Union Carbide*, No. Civ.A. HO30054, 2005 WL 1214645, at *13 (S.D. Tex. May 20, 2005) (ERISA); 20 C.F.R. § 10.701 (Federal Employees' Compensation Act); 20 C.F.R. § 404.1705(b) (Social Security disability insurance claims).

[50] MEDICARE CLAIMS PROCESSING MANUAL CH. 29 – APPEALS OF CLAIMS DECISIONS § 270.1.2.A (2014) ("A provider or supplier that furnished items or services to a beneficiary may represent that beneficiary on the beneficiary's claim or appeal involving those items or services. However, the provider or supplier may not charge the beneficiary a fee for representation in this situation. Further, the provider or supplier representative being appointed as representative must waive any fee for such representation.").

[51] MEDICARE CLAIMS PROCESSING MANUAL CH. 29 – APPEALS OF CLAIMS DECISIONS § 270.1.2.A (2014).

[52] [52] MEDICARE CLAIMS PROCESSING MANUAL CH. 29 – APPEALS OF CLAIMS DECISIONS § 210 (2014).

[53] MEDICARE CLAIMS PROCESSING MANUAL CH. 29 – APPEALS OF CLAIMS DECISIONS §§ 270.2.1, 270.2.2 (2014).

V. Section 30.700. In general, what responsibilities do providers have with respect to enrolling with OWCP, seeking authorization to provide services, billing and retaining medical records?

In subsection (a) of 30.700, the Department seeks to add the requirement that, "By completing and submitting this form [Form OWCP-1168], providers certify that they satisfy all applicable federal and state licensure and regulatory requirements that apply to their specific provider or supplier type." Due to the common regulatory goals of Sections 700 and 400, the language should be analogous in both sections.

To construct Sections 400 and 700 congruously, Section 700 should be revised to eliminate extraneous and vague requirements, to require final determination by a state regulatory body, and to provide the necessary cross-reference of the sections. Specifically, Section 700 should not require that providers satisfy "all applicable regulatory requirements" without further definition of such "regulatory requirements," which are neither defined nor clarified through this or other provisions. It is possible that adherence to applicable federal and state licenses provides the necessary safeguards without extraneous provisions. As discussed more fully above in the comments to Section 400, the pertinent state regulatory body must determine whether an entity has satisfied applicable state licensure and regulatory requirements.[54] The interrelationship between these two sections should be specified. PCM requests that this section be revised as follows:

> (a) [B]y completing and submitting this form, providers certify that they satisfy all applicable federal and state license requirements, **as determined by the applicable Federal or State regulatory body as further specified in Section 400(c)**, that apply to their specific provider or supplier type. . . .

Subsection (b) of 30.700 appears to provide an enforcement tool for DEEOIC in its implementation of the proposed preauthorization requirement set forth in the proposed changes to Section 30.403. As set forth in the comments to Section 30.403, preauthorization cannot be required as a condition of payment for care in this program because preauthorization conflicts with the statutory mandates of EEOICPA, would result in delay of care to claimants and presents the likelihood of health care providers violating state law. The proposed additional language of subsection (b) has no purpose if the proposed changes to Section 30.400 are removed.

Subsection (c) of 30.700 introduces the requirement of electronic billing. To date, it has not been a requirement for providers to submit bills electronically. This proposed rule change represents a substantive change from current practice. To appreciate the magnitude of this proposed change, it is necessary to recognize that the referenced billing process includes submission of Form OWCP-1500 with the supporting medical evidence. Often, the supporting medical evidence can exceed one thousand pages of documentation. Due to the volume of this

[54] As one of many possible examples, home health care companies are regulated and audited by many state health care regulatory bodies. From time to time, it is not unusual for a state health care regulatory body to issue a deficiency and provide time for correction of noted deficiencies by the home health care provider. PCM does not believe that DEEOIC intends to require informing or involving DEEOIC during an allegation of a deficiency by a state regulatory body as a condition of certification to provide services under EEOICPA. However, in its currently proposed form, involvement of DEEOIC could be interpreted as a requirement.

medical evidence, and the limitations of the current DEEOIC electronic billing system, it is often more advantageous to submit the voluminous billing via U.S. Mail. The proposed changes to subsection (c) of 30.700 do not address whether the practice of submitting bills with supporting medical evidence via U.S. Mail is prohibited. However, if it is the intention to impose the requirement of electronic billing as the sole billing method, health care providers would require both sufficient time for this conversion and reassurances regarding system capacity. Any transition to electronic billing should include additional clarity, including sufficient information regarding the billing system capability, proposed training by DEEOIC, and suggested timeframe sufficient for providers to acquire or adapt systems compatible with DEEOIC's bill processing portal. Allowing providers adequate information and time for the conversion to a new billing process or system would assure that the benefits needed by the ill claimants are not interrupted.

VI. Section 30.701. How are medical bills to be submitted?

The Department proposes to amend section 30.701 to include revisions to subsection (c), regarding professional charges billed by providers. The Department proposed to amend subsection 30.701(c)(1)(ii) as follows:

> OWCP may adopt a Home Health Prospective Payment System (HHPPS), as developed and implemented by the Centers for Medicare and Medicaid Services (CMS) within HHS for Medicare, while modifying the allowable costs under Medicare to account for deductibles and other additional costs that are covered by EEOICPA. If adopted, home health care providers will be required to submit bills on Form OWCP–04 or UB–04 and to use Health Insurance Prospective Payment System codes and other coding schemes.

The proposed change is vague and uncertain, at best. The Department does not identify whether it will, in fact, develop a new payment system, what factors it will consider in determining whether to develop a new payment system, a timeline for evaluating and/or implementing such a system, or provide any other details that would inform providers or claimants what to expect, how this might impact claimants, or when this supposed change (if any) might occur. PCM requests that the Department clarify if it will institute a subsequent rulemaking to implement these procedures, or if it will use another method to effect the change. PCM is thus unable to fully comment on the implementation of the proposed change.

Instituting a new payment system is a significant change in the payment scheme for home health care services provided under the EEOICPA Program. A change in the payment scheme will significantly alter both access to home health services and covered services for beneficiaries, but the Department has not provided sufficient detail for the public to determine the impacts on ill EEOICPA beneficiaries or their medical providers. Without additional detail, PCM cannot fully evaluate whether the proposed adoption of the Medicare HHPPS will result in diminished access to home health care benefits, thereby undermining the mandates of the Act.

Absent further information regarding the implementation of the HHPPS, PCM provides the following comments regarding the distinction between HHPPS from EEOICPA. EEOICPA is

a remedial program and Medicare is an entitlement program; the rights and responsibilities that flow therefrom are necessarily different. First, the Medicare program is designed to fill a specific gap in health insurance coverage, which is limited to a defined set of covered services, subject to deductibles, copays and other designed limits for an estimated 49 million beneficiaries.[55] On the other hand, the EEOICPA program has the specific purpose of covering all medically necessary services prescribed by a qualified physician, which are likely to cure, give relief, or reduce the degree for the period of that illness[56] for less than 20 thousand living beneficiaries.

Second, the eligibility requirements for home health care benefits under EEOICPA and Medicare are distinct. An EEOICPA beneficiary is eligible for home health care services whether or not such care includes skilled care as long as it is medically necessary and prescribed by a qualified physician;[57] a Medicare beneficiary is not.[58] EEOICPA covers home health care services, including 24-hour-a-day care and care provided solely by home health aides or attendants; Medicare effectively prohibits full time, 24-hour-a-day care and only covers services that include the provision of at least one skilled service. A Medicare beneficiary must be "homebound," as that term is defined by Medicare; an EEOICPA beneficiary has no such limitation.[59] An EEOICPA beneficiary is eligible for services beyond the limitations set forth by Medicare both in terms of frequency and length of visits but also for unpredictable durations. In summary, an EEOICPA beneficiary is eligible for all medically necessary services prescribed by a qualified physician, while a Medicare beneficiary is not.

Third, the HHPPS implement payment mechanisms, tools, and programs that are inapplicable to EEOICPA beneficiaries. HHPPS provides bundled payments[60] for each anticipated 60-day episode of care; but due to EEOICPA beneficiaries' chronic and varying long-term needs, home health care is typically authorized in 180-day increments. HHPPS uses the Outcome and Assessment Information Set ("OASIS") tool to predict the amount of care a beneficiary receives based on personal, social, and medical data. But the tool could not predict the needs of custodial care under EEOICPA because Medicare does not cover that service. Further, the OASIS tool does not account for the Act's provisions on covered versus non-covered illnesses. OASIS determines prospective payments premised on a database of millions of beneficiaries over several decades experiencing mostly acute conditions; a comparable volume of data on which to premise prospective payments under EEOICPA is impossible to obtain because there are less than twenty thousand living claimants, most with chronic as opposed to acute, conditions.[61] Yet another distinction is the programs' use of therapy services; over 40% of Medicare beneficiaries receive

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[55] The Henry J. Kaiser Family Foundation, State Health Facts, Total Number of Medicare Beneficiaries, http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/.

[56] 42 U.S.C. § 7384t(a).

[57] 20 C.F.R § 30.403.

[58] To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act.

[59] *Compare* 42 C.F.R. § 409.42 (describing the requirements for Medicare coverage of home health services, including confinement to the home) *with* 20 C.F.R. § 30.505 (EEOICPA regulation has no home confinement requirement for personal care services under 42 U.S.C. § 7384t(a)).

[60] Under Medicare, each 60-day episode of care also includes a for multiple Medicare Covered Services, including skilled nursing services, therapies and medical supplies. Conversely, many of the EEOICPA beneficiaries do not utilize therapy services because their conditions are not expected to improve.

[61] *See generally* 2013 EEOICP, OFF. OF THE OMBUDSMAN ANN. REP (there are an estimated 20,000 living EEOICPA beneficiaries).

therapy services, whereas only a very small percentage of EEOICPA beneficiaries receive such services.[62]

Claimants risk losing mandated benefits under the proposed regulation. Even with a modification of "the allowable costs under Medicare to account for deductible and other additional costs that are covered by EEOICPA," claimants risk substantial losses of benefits. Absent further clarification, the proposed regulation is likely inconsistent with the Act.

PCM requests that the Department clarify how it will implement the change proposed in the new subsection 30.701(c)(1)(ii) to allow PCM a meaningful opportunity to comment. In the alternative, PCM requests that the Department withdraw the proposed revision to subsection 30.701(c)(1)(ii).

VII. Section 30.715. What are the grounds for excluding a provider under this part?

The Department proposes to include "additional, reasonable bases" for excluding providers[63] in new subsections (i) and (j) where a provider has:

> (i) Failed to inform OWCP of any change in their provider status as required in § 30.700.
>
> (j) Engaged in conduct related to care of an employee's occupational illness or covered illness that OWCP finds to be misleading, deceptive or unfair.

The current version of the regulations allow for provider exclusion after: (a) a conviction, (b) a suspension or debarment, (c) making a false claim, (d) submitting excessive bills, (e) failing to reimburse employees, (f) submission of inaccurate medical reports, (g) improper treatment, and (h) improper collections.

PCM supports the Department's exclusions relating to existing acts or omissions; the proposed additions, however, are overbroad. PCM urges the Department to consider the impact these additions will have on a qualified claimant's ability to receive care. First, proposed new subsection 30.715(i) would result in an elderly, ill claimant losing statutorily mandated benefits due to an administrative glitch by a physician, hospital, or health care provider. A misplaced paper by a secretary of either the provider or the OWCP could cause the same penalty that would be applied to an intentional felony. Similarly, proposed section 30.715(j) would give OWCP broad discretion to determine whether a provider's conduct relating to care is "misleading, deceptive or unfair" without identifying what factors OWCP considers in its assessment, or how these factors are distinct from the existing regulations covering conduct warranting exclusion in subsections 30.715(a)–(h).

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[62] Brief of AARP, the National Legislative Association on Prescription Drug Prices, Community Catalyst and Prescription Policy Choices, as Amici Curiae in Support of Appellees, Urging Affirmation, IMS Health Inc. v. Sorrell, Nos. 09-1913cv(L), 09-2056-cv(CON), 2009 WL 8379439 (2d Cir. Sept. 16, 2009).

[63] NOPR, at pp. 72,300-301.

PCM strongly urges the Department to withdraw proposed subsections 30.715(i) and (j) in their entirety. New subsections 30.715(i) and (j) would change the exclusion process from one based upon violations of statute to a punishment for administrative oversight and a nebulous catchall based upon OWCP's undefined interpretation of conduct. In the alternative, PCM requests that the Department define "misleading, deceptive, or unfair" and clarify the process through which OWCP would make its findings.

VIII. Sections 30.717–724. OWCP Exclusion Procedures

Proposed sections 30.717 through 30.724 amend the Program's exclusion procedures. Proposed section 30.717 changes the exclusion process by triggering investigation where a provider "may have" engaged in certain enumerated activities. Proposed section 30.719(c) imposes a 20-day limit on the time for a provider to request to inspect and to request copies of information in the record. Proposed section 30.724(h) states that the Director for Energy Employees Occupational Illness Compensation decision is final, "and shall not be subject to further review."

With regard to Section 30.717, PCM supports the Department's goal of implementing a rigorous process to protect sick and elderly workers from being preyed upon. But PCM requests that the Department consider the adverse impact that the proposed regulation will have on legitimate health care providers, from whom claimants need reliable care. Combined with proposed sections 30.715(i) and (j) discussed above, proposed section 30.717 would subject providers to an OIG investigation if they may have failed to notify the agency of their status or may have engaged in unfair conduct. This expansion of OWCP and OIG discretion will result in significant and expensive adverse impacts on legitimate providers.

PCM supports the extension of the timeframe in proposed section 30.719(b), and requests the Department provide similar consideration to the impacts of the shortened timeframe for requesting access to information as in proposed section 30.719(c). The existing regulations did not impose a timeframe on providers to request access, and the preamble to the proposed rule has not indicated a reason for the shortened timeframe. The impact of the shortened timeframe is to truncate the opportunity for a provider to meaningfully review information relevant to the adjudicatory process.

PCM urges the Department to revise the proposed changes to Section 724 to codify the provider's appeal rights to a United States Court of Appeals. The proposed regulations suggest that Director Leiton has final, unreviewable authority to exclude a provider and block access to necessary home health care for thousands of claimants. The Director would have authority over the Department's Administrative Law Judges and over the Department's Office of the Inspector General. Conversely, exclusions implemented by the OIG may be appealed to Department of Health and Human Services Administrative Law Judge, which is in turn subject to review by the HHS Departmental Appeals Board and judicial review. PCM notes that the Department has not explained the rationale supporting the distinct, unreviewable process proposed in section 30.724(h).

PCM requests the Department to remove "or may have" from proposed subsection 30.717(c). PCM also requests that the Department withdraw its proposed changes to subsection 30.719(c). Finally, PCM urges the Department to modify sections 30.719–30.724(h) consistent

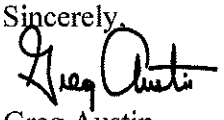
with the OIG exclusion process and to codify the provider's appeal rights to a United States Court of Appeals.

PCM is aware of only one home health care entity exclusion since the inception of the program 15 years ago. Given this fact, and given OIG's broad exclusionary powers over all federal health care programs (including the EEOICPA)[64] and detailed procedures, is unclear why the exclusion procedures are being proposed. If the proposed rules in Section 717 – 724 are not withdrawn, PCM suggests modifying the regulations to incorporate by reference OIG's rules and procedures, which will ensure a fair and appropriate process for addressing these types of issues.

IX. Conclusion

PCM believes that the beneficiaries of the Program will be better served and the Department's administrative burden reduced through a collaborative relationship with providers. Providers have a vested interest in submitting claims that will be paid. With providers integrated into the process, claims examiners are more likely to receive eligible claims. The proposed rules allow less provider participation while imposing a more burdensome and confusing process on claimants. The Department should use its authority instead to create a more effective claims analysis process. This alternative approach would better protect claimants while serving the stated goal of improving administration of the Act. PCM strongly urges the Department to withdraw or clarify the proposed regulations consistent with these comments and with the Department's stated goal of improving administration of the Act.[65]

Sincerely,



Greg Austin

Encl.

[64] *See* 42 U.S.C. § 1320a-7b(f)(1).
[65] NOPR, at p. 72,297.

Exhibit 1

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

JUL - 5 2011

Singularity Health Law, PLLC
Gregory L. Piche', Attorney At Law
3144 Newton Street
Denver, CO 80211

Dear Mr. Piche':

This is in response to your May 11, 2011 letter concerning retroactive authorization for in-home health care services.

I regret any miscommunication that may have occurred with regard to our medical authorization process. Let me affirm that authorization for in-home health care services already provided may be granted retroactively, potentially back to the date that the claim was filed with DEEOIC. However, and as you are aware, authorization for these services is dependent on the submission of medical documentation that establishes the medical necessity of the care that was provided as a consequence of an accepted work-related illness.

Thank you for bringing this matter to my attention, and I hope this is responsive.

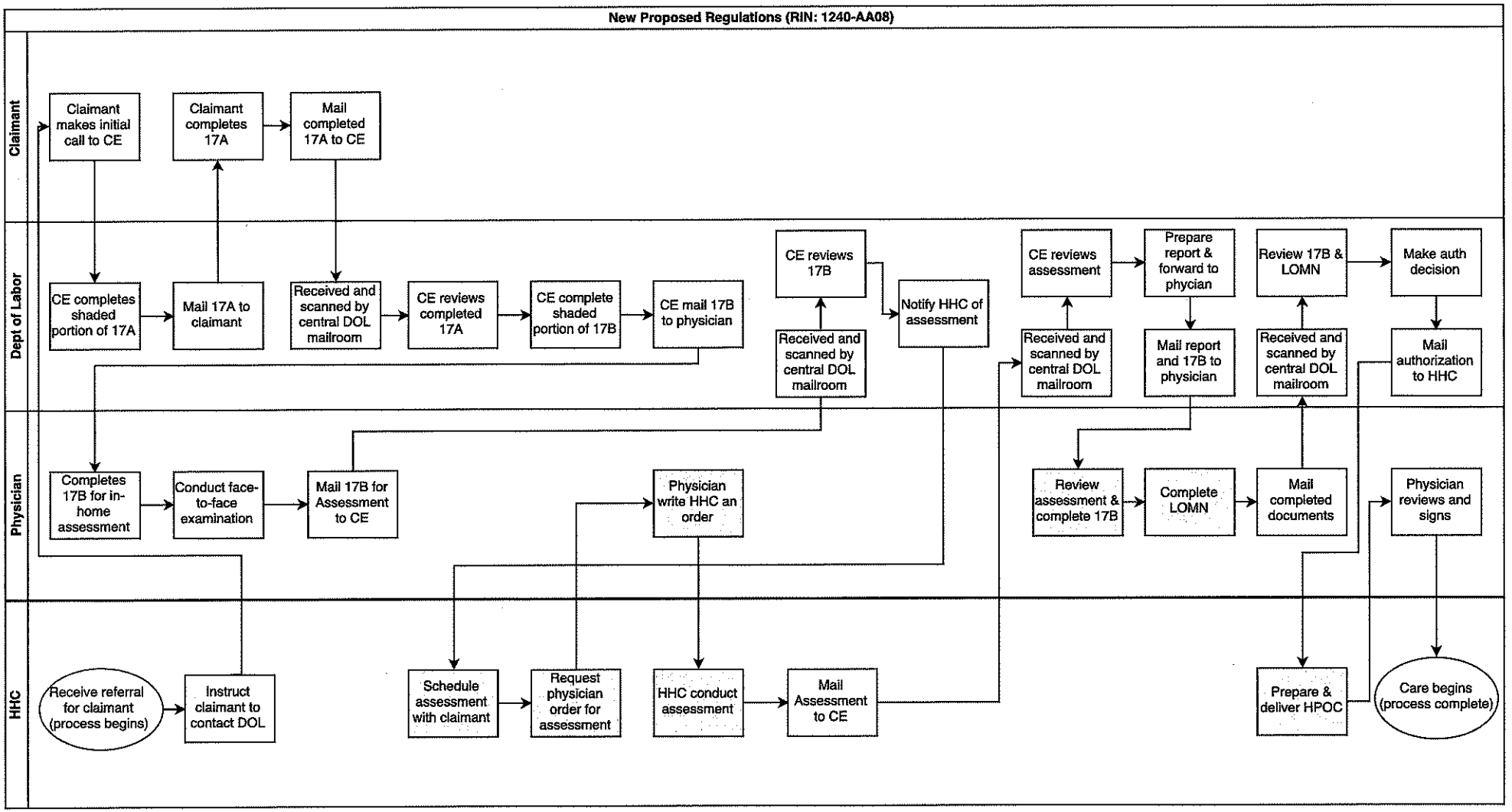
Sincerely,

Rachel P. Leiton

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

Exhibit 2

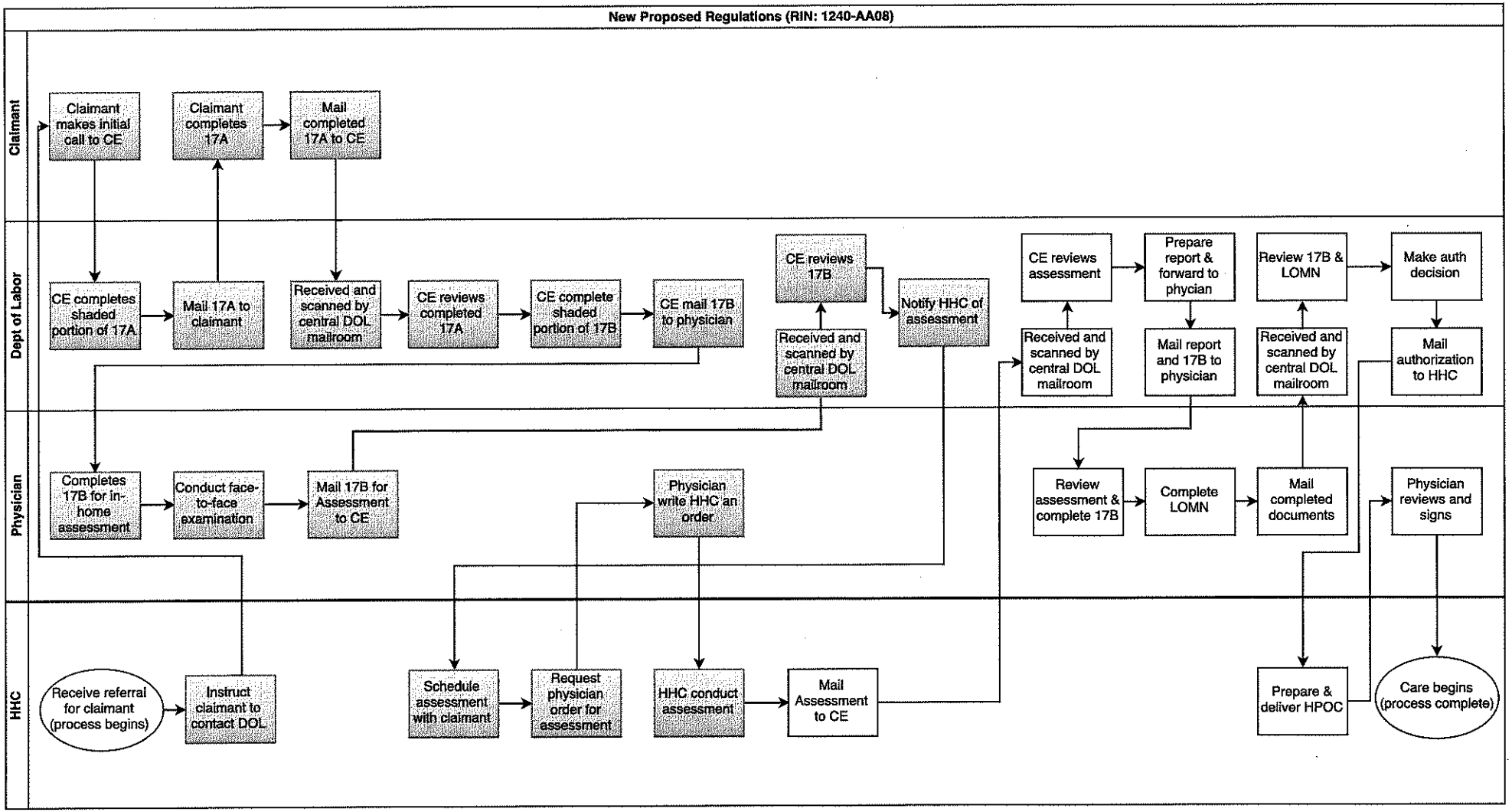
Proposed process for claimant to receive home healthcare services if section 403(c) is implemented



Highlighted yellow boxes represent the current steps that must be completed before a claimant can begin receiving care.

Exhibit 2

Proposed process would violate industry standards and various state laws



Initial Assessment must be completed within 48-72 hours of referral to comply with industry standards and various state laws.

Exhibit 2

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

Step	Description	Concerns/Notes	Minimum Estimated Days	PCM Estimated Days	Max. Estimated Days
1	Home Health Company receives referral for sick EEOICPA claimant needing care	• Referrals come from many sources for claimants with varying care needs	NA	NA	NA
2	Home Health Care Company instructs claimant to contact DOL to request EE-17A form	• Depending on the condition of the claimant, they may be unable to contact the DOL themselves. In these cases an effort would need to be made to locate the Authorized Representative, if one exists, to contact the DOL and request the form. • See Home Health Care Time Estimate	1	2	5
3	Claimant contacts Claim Examiner to request EE-17A Form because of medical need	• Claimants will be unfamiliar with this new requirement which may lead to delays in getting the process started • Claimants may not know the appropriate person or office to contact to request the form • Claim Examiner are often not available and a claimant must leave a message, which could result in further delays in simple requesting the form • See Claimant Time Estimate	1	5	15
4	Claim Examiner completes shaded portion of EE-17A form	• See Thread Action Time Estimate	2	4	6
5	Partially completed EE-17A form is mailed to claimant	• See Mail Time Estimate	1	2	3
6	Claimant completes unshaded portions of EE-17A	• Seriously ill claimants will have the most significant hardship in completing the form • Claimants with multiple treating physicians may be confused about which physician to list, leading to additional questions and delays • Claimant will be required to supply envelope and stamp and complete • Claimant is providing information that is more than likely already known to the DOL • See Claimant Time Estimate	1	5	15
7	Completed EE-17A form is mailed to DOL Central Mail	• See Mail Time Estimate	1	2	3

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

	Room				
8	Completed EE-17A form is received and scanned by DOL Central Mail Room	• Additional delays are possible because of the inherit risks associated with this manual process (lost, misclassified, keying errors, etc.) • See Thread Time Estimate	2	4	6
9	Claim Examiner reviews completed EE-17A form	• Claimants are likely to experience even longer delays if the completed form contains any errors or missing information • See Thread Time Estimate	2	4	6
10	Claim Examiner completes the shaded portions EE-17B	• See Thread Time Estimate	2	4	6
11	Partially completed EE-17B form is mailed to claimant's treating physician	• See Mail Time Estimate	1	2	3
12	Physician completes unshaded portions of EE-17B form, requesting an in-home assessment	• Because this form or associated process does not align with industry practices, the form will need to be completed multiple times. The three required fields; date of face-to-face examination, in-home assessment requested, and letter of medical necessity attached occur at different times and are a sequential activities • The instructions on the form indicate the in-home assessment is optional but industry standards and state laws require a home health care company to complete a comprehensive assessment in order to admit a patient. • See Physician Involvement Time Estimate	1	2	5
13	Physician conducts face-to-face examination	• This step is not allotted any estimate time because it is difficult to determine where this examination would fall in these sequential steps. • It must be noted that there is a possibility that the requirement that the examination be held within 60 days of the authorization will be incongruous with this laborious process.	0	0	0
14	Partially completed EE-17 B form is mailed to DOL	• See Mail Time Estimate	1	2	3

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

	Centralized Mail Room				
15	Completed EE-17B form is received and scanned by DOL Central Mail Room	• Additional delays are possible because of the inherit risks associated with this manual process (lost, misclassified, keying errors, etc.) • See Thread Time Estimate	2	4	6
16	Claim Examiner reviews the partially completed EE-17B form	• See Thread Time Estimate	2	4	6
17	Claim Examiner notifies the home health provider they are authorized for payment to conduct an initial in-home assessment	• The form EE-17A or EE-17B do not contain the name of the home health care provider selected by the claimant, so this will likely delay the process • It is not clear who at the home health care company the DOL claims staff will contact, which may lead to miscommunication and delays • See Thread Time Estimate	2	4	6
18	Home Health Company contacts claimant to schedule in-home assessment	• At this point the home health company has not had contact with the claimant in many days or weeks, so they will need to contact the claimant to determine if they are still alive, not in a facility and still in need of care under the program to schedule an assessment • See Home Health Care Time Estimate	1	2	5
19	Home Health Company contacts treating physician to request an order to conduct the initial in-home assessment	• Industry practices, professional nursing standards, and home health state laws require an in-home assessment and a corresponding physician's order • See Home Health Care Time Estimate	1	2	5
20	Physician writes order for in-home assessment as required by state laws, industry practice, and nursing licensure	• Physician offices typically serve many patients, so there can be challenges in contacting the office and requesting a written assessment order. • This must be completed after the home health care company has contacted the claimant and determined they are still alive, not in a facility and still in need of care under the program	1	2	5

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

		• See Physician Time Estimate			
21	Home Health Company conducts initial in-home assessment	• At this point the home health care company would be aware of a patients needs but would not being doing anything to address them, which would violate industry practices, professional nursing standards, and home health state laws • See Home Health Care Time Estimate	1	2	5
22	Home Health Company mails completed initial in-home assessment to DOL Central Mail Room	• See Mail Time Estimate	1	2	3
23	Initial in-home assessment is received and scanned by DOL Central Mail Room	• Additional delays are possible because of the inherit risks associated with this manual process (lost, misclassified, keying errors, etc.) • See Thread Time Estimate	2	4	6
24	Claim Examiner reviews the initial in-home assessment	• See Thread Time Estimate	2	4	6
25	Claim Examiner prepares report for physician as described in Form EE-17B "Additional Instructions to Physician"	• This is a new step in the process and raises many questions about the qualifications of the person creating the "report". Is the person a medical professional, are they licensed in the state the claimant is located, will they be making recommendations in the report, how will they account for not personally examining the claimant? • See Developmental Action Time Estimate	10	30	40
26	Claim Examiner mails the completed initial in-home assessment and/or report to the treating physician, along with another partially completed EE-17B form	• See Mail Time Estimate	1	2	3
27	Physician reviews initial in-home assessment and completes 17B form for second time	• Because this form or associated process does not align with industry practices, the form will need to be completed multiple times. The three required fields; date of face-to-face examination,	1	2	5

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

		in-home assessment requested, and letter of medical necessity attached occur at different times and are a sequential activities • See Physician Involvement Time Estimate			
28	Physician prepares letter of medical necessity	• A physician typically relies, in part, on a home plan of care developed by the home care nurse when writing the letter of medical necessity, but the DOL process is attempting to exclude the home care provider from the process • See Physician Time Estimate	1	2	5
29	Physician mails completed EE-17B form, attached letter of medical necessity, and any additional medical evidence to DOL Central Mail Room	• See Mail Time Estimate	1	2	3
30	Completed EE-17B form and letter of medical is received and scanned by DOL Central Mail Room	• Additional delays are possible because of the inherit risks associated with this manual process (lost, misclassified, keying errors, etc.) • See Thread Time Estimate	2	4	6
31	Claim Examiner reviews the EE-17B form and letter of medical necessity	• See Thread Time Estimate	2	4	6
32	Claims Examiner conducts the adjudication process	• See Decision Time Estimate	5	30	75
33	Claim Examiner notifies claimant, physician, and home health care provider of approved home care services via US Mail	• See Mail Time Estimate	1	2	3
34	Home Health Company completes a Home Plan of Care and hand delivers to physician	• Industry practices, professional nursing standards, and home health state laws require home plan of care • See Home Health Care Time Estimate	1	2	5
35	Physician reviews, edits, and signs Home Plan of Care which are the orders for care	• Industry practices, professional nursing standards, and home health state laws require home plan of care • Care must begin at this point • See Physician Involvement Time Estimate	1	5	10

Step-By-Step Process of Implementation Of Pre-Authorization Process Resulting From Implementation and Use of Forms EE-17A and EE-17B

36	Care begins	• Because the home care provider has been intentionally excluded from the process, there is risk of delays in recruiting, training, and staffing caregivers	NA	NA	NA
	TOTAL DAYS		57 Days	153 Days	290 Days

Step-By-Step Process of Implementation Of Pre-Authorization Process
Resulting From Implementation and Use of Forms EE-17A and EE-17B

Minimum, PCM, Maximum Time Estimate Assumptions

Mail: For any step in this process where a document is mailed via U.S. Mail, the assumption is that the minimum number of days for mailing is 1, PCM estimates 2 and the maximum number of days assumed is 3. **(Mail Time Estimate)** However, it is likely that delays will be experienced as a result of the normal time to deliver mail, not to mention the occasional lost or delayed mail delivery. Also, serious concerns are raised for Claimants that are in the hospital or some other medical facility and therefore not at home which means they will not be able to receive the mail in a timely manner.

Threads by Department of Labor = Assumption 3: For any action to be taken on a thread by the Claims Examiner, the assumption is that the minimum number of days will be 2 based on the Performance Standard that in 80 -85 % of assigned cases, actions taken on active threads are within 5 calendar days. PCM estimate 4 days for processing of a thread. The maximum number of days is 6, based on the Performance Standard that in 80-85% of assigned cases, the CE completes all actions taken on thread in 5 days. **(Thread Action Time Estimate)**

Developmental Action by Department of Labor: For any developmental action to be taken by the Claims Examiner, the assumption is that the minimum number of days will be 10, PCM estimates 30 and the maximum number of days is 40 based on the Performance Standard that in 80 -85 % of assigned cases, actions taken on active threads are within 35 calendar days. **(Developmental Action Time Estimate)**

Physician Involvement: For any step in this process which involves a physician taking action, the minimum number of days is 1, PCM estimates 2 and the maximum is 5. This is based on PCM's experience and information as a leading home health care provider under the EEOCIPA Program. However, this estimate may be conservative; currently there are claimants who have been awaiting physician action for more than 60 days. **(Physician Involvement Time Estimate)**

Home Health Care Company Involvement: For any step in this process which is to be taken by a Home Health Care Company, the minimum number of days to complete the task is 1, PCM estimate 2 and the maximum number of days is 5. This is based on the experiences of PCM as a leading home health care provider under the EEOCIPA Program. **(Home Health Care Company Time Estimate)**

Decision by Department of Labor: For any decision on Home Health Care, , the assumption is that the minimum number of days is 5, PCM anticipated 30 and the maximum number of days is 75 based on the Performance Standard that in 80 -85 % of assigned cases, the CE completes the decision within 75 days from receipt of the thread request. **(Decision Time Estimate)**

Claimant Action: For any action taken by an EEOICPA claimant, the minimum number of days assumed for response is 1, PCM estimates 5 and the maximum number of days assumed for claimant action is 15. This is based on PCM's experience and information as a leading home health care provider under the EEOCIPA Program. **(Claimant Time Estimate)**

The estimated times do not account for any missed communication exchange. However, for return phone calls by Department of Labor, the assumption is that the minimum number of days will be 1, PCM estimates 2 and the maximum number of days is 3 based on the Performance Standard that in 93 -95 % of assigned cases, phone calls are returned within one work day, defined as the next business day.

Exhibit 3

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

7/15/2011

Act For Health, Inc.
1600 Emerson Street
Denver, CO 80218-1102

Dear DEEOIC Home Health Care Provider 070037799:

We are writing to all home health care providers enrolled with the Division of Energy Employees Occupational Illness Compensation (DEEOIC) as part of a continuing effort to inform you of the information we require in order to approve requests for home health care services. This requested information is essential to the expeditious review of home health care requests for beneficiaries approved under our program.

DEEOIC procedures stipulate that requests for home health care services must be accompanied by a plan of care and supporting medical documentation which clearly demonstrates that the physician requesting care, or writing a letter of medical necessity, has personally met with and evaluated a claimant to determine his or her home health care needs. The medical rationale from the doctor must logically correspond to the type and level of care being requested. In the absence of this information, authorization for the requested services may be delayed or denied.

After a recent evaluation of our home health care procedures, the following additional guidance is being provided to you, to reinforce our existing procedures and to ensure that there is direct engagement between the authorizing physician and the DEEOIC patient in connection with home health care requests:

Physical Examination - DEEOIC requires a physician to have conducted a recent physical examination of the patient in support of any request for home health care services. A recent physical examination is defined as a face-to-face encounter, between the requesting physician and the DEEOIC approved patient, within 60 days prior to the submission of a home health care authorization request. Any letter of medical necessity or Plan of Care requesting home health care must identify the name, address and telephone number of the requesting physician accompanied by his or her signature. In addition, the physician is to submit a written, narrative medical report which

documents the result of the examination to include pertinent history and physical findings, specific functional limitations associated exclusively with the accepted work-related illnesses, medical rationale supporting the requested level and duration of home health care, and a discussion of the specific duties to be performed by a home health care nurse or home health aide. This discussion should include but not be limited to the patient's particular needs regarding the administration of medication, medical monitoring, dressing changes, medical equipment checks, and activities of daily living, such as bathing and personal hygiene, meal preparation and feeding, and assistance in ambulating about the household.

Home health care authorization requests not accompanied or supported by the requested medical evidence may be delayed or denied. Submission of prescription forms, or other documentation signed by a physician who has not physically examined the patient will be of reduced probative value in assessing requests for home health care services. Payment for home health services rendered prior to written authorization will require the submission of appropriate medical documentation to support the medical necessity of care due to the accepted condition. You may bill DEEOIC for preparation of a report, in addition to billing for customary medical services (e.g., office visits, diagnostic testing, laboratory services, etc.) provided during an examination, as long as they relate to an accepted condition. Reimbursement for services will be in accordance with the Office of Workers' Compensation Program fee schedule.

DEEOIC is committed to ensuring the continued success of its medical benefits program, which includes home health care services. Our goal is to work together with our enrolled providers and approved beneficiaries to ensure that the medical benefits afforded under our program are handled in a fair and expeditious manner.

If you have any questions regarding the home health care authorization procedures, please feel free to contact the DEEOIC bill processing agent, ACS, at 866-272-2682.

Thank you for your continued cooperation.

Rachel P. Leiton
Director
DEEOIC