



RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE
INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL:
CHAPTER 2-1800, FAB Decisions.

EEOICPA TRANSMITTAL NO. 13-02

January 2013

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 2-1800, FAB Decisions. This version incorporates changes that have arisen since last publication of Chapter 2-1800, FAB Decisions, to include:

- Provides additional guidance on the components of a Final Decision.
- Expands guidance specific to Conclusions of Law
- Gives additional information regarding when a Remand Order is appropriate.

Additionally, the following content, previously included in Chapter 2-1800, FAB Decisions, has been removed and can now be found in Chapter 2-1700, FAB Review Process.

- Objections
- Hearing Requests
- Conduct of the Hearing
- Post Hearing Actions


The following exhibits have been removed from the previous version of Chapter 2-1800, FAB Decisions:

- Certificate of Service
- Sample Acknowledgement Letter, Review of the Written Record
- Sample Acknowledgement Letter, Hearing
- Sample Hearing Notice to Claimant Who Filed an Objection
- Sample Hearing Notice to Claimant Who Did Not File an Objection
- Waiver of Rights to Confidentiality

- Waiver of Rights to Confidentiality (Media)

They have been replaced by the following exhibits:

- Exhibit 3, Medical Benefits Letter
- Exhibit 4, Sample Denial of Request for Reconsideration (No New Evidence or Argument Submitted)
- Exhibit 5, Sample Denial of Request for Reconsideration (New Evidence or Argument Submitted)



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

FILING INSTRUCTIONS:

File this transmittal behind Part 1 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees
List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

TABLE OF CONTENTS

<u>Paragraph and Subject</u>	<u>Page</u>	<u>Date</u>	<u>Trans. No.</u>
<u>Chapter 2-1800 FAB Decisions</u>			
Table of Contents.	i	01/13	13-02
1 Purpose and Scope.	1	01/13	13-02
2 Final Decisions.	1	01/13	13-02
3 Preparation of Final Decisions	4	01/13	13-02
4 Remand Orders.	8	01/13	13-02
5 Administrative Closure	12	01/13	13-02
6 Claimant Rights Following the Issuance of FAB Final Decisions	14	01/13	13-02
7 Alternative Filing, Part E	19	01/13	13-02

Exhibits

1 Sample Final Decision			
2 Medical Benefits Letter			
3 Sample Remand Order.			
4 Sample Denial of Request for Reconsideration (No New Evidence or Argument Submitted)			
5 Sample Denial of Request for Reconsideration (New Evidence and/or New Argument Submitted)			
6 Sample Cover Letter, Alternative Filing			

1. Purpose and Scope. The Act and its implementing regulations provide for administrative review of all recommended decisions (RDs). This Chapter describes the process by which the Final Adjudication Branch (FAB) performs that review and issues a Final Decision (FD) or Remand Order on claims filed pursuant to the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This chapter also describes the FAB process following a claimant's request for reconsideration of a FD.

2. Final Decisions. The FAB CE/HR reviews all evidence of record and the RD. Based upon that review, the FAB CE/HR issues an independent written decision addressing the appropriateness of the RD outcome. A final decision of FAB may accept the findings presented in the RD, whether the RD awards or denies benefits, or reverse the RD if it denies the claim and the FAB CE/HR determines that the claim should be accepted. If FAB disagrees with the outcome of the RD, but there is insufficient basis to warrant a reversal, it issues a separate type of decision called a Remand Order. Guidance relating to the issuance of Remand Orders comes later in the chapter. As part of the content of a final decision, the FAB CE/HR makes findings of fact and conclusions of law that support his or her position. There are several types of FDs:

a. Acceptances. When FAB receives a RD accepting a claim for benefits, the assigned CE/HR evaluates the evidence, and the written content of the RD to validate that the RD outcome is appropriate given the circumstances of the claim. In particular, the assigned FAB CE/HR is to determine whether the conclusion described in the RD is based on the proper application of EEOICPA legal, regulatory, or procedural standards to the facts of the case. Once the FAB CE/HR has determined the RD to accept was decided properly, he or she is to prepare a final decision listing the findings of fact and conclusions of law that permit the final approval of the claim.

(1) If the district office (DO) issued a RD accepting the claim in full and independent review by FAB concludes the acceptance is correct, FAB issues the FD awarding benefits in full.

(2) If the DO has issued a RD accepting one or more claim element(s) while denying and/or deferring other

2. Final Decisions. (Continued)

elements, the FAB issues the FD on the accepted portion of the claim as soon as possible to expedite the claimant's receipt of benefits. The FAB does not wait to issue the FD until the elements under development at the DO, or under contention due to denial, are decided.

b. Denials. When FAB receives a RD in which the DO denies the claim in full or in part, FAB reviews the RD and independently reviews the case to ensure that appropriate development has occurred, the case has been adjudicated consistent with the law, regulations, policies and procedures and that the assessment of evidence has been interpreted reasonably to allow for a negative outcome. Provided no technical or procedural errors exist, FAB issues a FD to deny the claim.

If the RD denies one claim element and defers another claim element pending further development, the designated CE2 continues to develop the claim element that is not before the FAB.

(1) For non-contested denials, absent any technical or procedural error, the FAB issues a FD accepting the RD findings and denying the claim for benefits in cases where no timely objection is filed or a waiver is received.

(2) For contested denials, the FAB considers the timely filed written objection by either conducting a hearing, if requested, or a review of the written record before a FD is issued, as appropriate.

c. Decisions Issued in Response to an Objection. After considering a timely filed written objection by conducting a hearing that has been requested or, in those cases in which no hearing has been requested, by reviewing the written record, FAB issues a decision based upon its review of the record, consideration of the objections, and any new evidence. The FAB can issue a FD, a remand order returning the case file to the DO for further development or some other action, or a FD reversing a RD denying benefits.

2. Final Decisions. (Continued)

Remand orders and FD reversals are discussed below and can be issued on both contested and non-contested claims.

(1) A review of the written record (RWR) is performed after a claimant has objected to the findings of a RD without requesting an oral hearing. The FAB will review the written record, the claimant's objection, and any additional evidence submitted to determine whether the RD findings can be adopted, reversed to accept the claim or remanded for further development. The FAB CE/HR must review all objections raised in the RWR objection letter and respond to each objection clearly and comprehensively. Once this review is complete, the FAB issues a decision based on its independent review.

(2) If the FAB conducts a hearing and satisfies all of the requirements of the hearing process (see Chapter 2-1700), a decision is issued. While the HR may entertain objections raised from several RDs at the hearing itself, one FAB decision will be issued that addresses each contested RD after the resolution of the entire hearing process.

(3) In the decision following a hearing, the HR outlines the facts of the case, lists and comprehensively addresses all of the objection(s) (whether raised in the hearing request letter, subsequent letters, hearing testimony, or hearing exhibits) and thoroughly discusses the findings and/or conclusions of the FAB.

d. Reversal. A reversal is a FD issued when the evidence shows that either the RD denied benefits in error or new and compelling evidence warrants overturning a RD denial and accepting a claim for benefits.

If there is evidence in the case that warrants a reversal, the FAB CE/HR reverses the decision with approval from the FAB Chief and issues a decision to the claimant without delay. If the claimant submits additional evidence, the FAB CE/HR reviews such evidence and determines whether it is sufficient to accept the case. If it is sufficient, and

2. Final Decisions. (Continued)

there are no outstanding development issues (such as SWC/Tort information), the FAB CE/HR may reverse the decision immediately and accept the case. If the evidence is sufficient to warrant further development, FAB remands the case.

(1) A reversal can be issued when a case is denied in full or in part. In partial denials, the FAB may reverse to accept if the portion of the claim denied by the RD is found to be in posture for acceptance, a DO error is identified, or new evidence is received that warrants a reversal.

(2) A decision reversing the RD is used only where a denial is reversed to accept benefits. The FAB may not issue a reversal to deny benefits. The rationale for reversals must be clearly stated in the body of the decision and forwarded with the case file to the FAB Chief for review and approval. A reversal cannot be issued without such approval.

(3) When considering a reversal, FAB must be mindful of tort offset/SWC coordination and determine whether anyone received a settlement that might reduce the EEOICPA benefit.

3. Preparation of FDs. As with RDs, multiple FAB decisions are possible on one case. Given the requirement that any RD in which the DO decides the eligibility of any one claimant to receive benefits must include all claimants' party to the decision, a FD cannot be issued deciding any one claimant's eligibility to receive benefits without including all claimants with an interest in the claim as party to the decision. Accordingly, it is the responsibility of the FAB to remand any RD which does not comply with these procedures and instruct the DO to issue a new RD to address the eligibility of each party to the claim. This may require the reopening of certain claims, except in certain limited circumstances (see EEOICPA PM 2-1900).

FAB decisions are plainly written and provide the claimant with a descriptive explanation regarding the basis for the outcome. This ensures that the decision-making process is transparent. The FAB clearly identifies the Part of the Act under which

3. Preparation of FDs. (Continued)

benefits are awarded or denied so that the claimant clearly understands the decision. They include statutory/regulatory language in the conclusions of law when outlining the benefits being awarded or denied.

a. Three Components. The FAB representative must prepare three components before issuing a FD (a sample of a complete FD is shown as Exhibit 1):

(1) A cover letter explaining that a final decision has been reached. The cover letter must clearly identify what is being accepted or denied and under what Part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant.

(2) The FD. The FD contains a Statement of the Case, Findings of Fact and Conclusions of Law.

(3) Certificates of Service certify that each listed claimant and his or her authorized representative was mailed a copy of the FD and the date it was placed in the U.S. mail. A separate certificate of service is created for each claimant, but a claimant and his or her authorized representative may appear on the same certificate of service.

An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 2); and/or (2) an Acceptance of Payment form (EN-20), which is required before payment can be issued.

b. Formatting and Content, FD for Acceptances, Contested Decisions, Denials, and Reversals. Where a FD is prepared for an acceptance, contested decision, denial or reversal, it must contain the following sections in the following sequence:

(1) Statement of the Case. This section sets out the case history, relevant to the issue for determination, up to the point of the issuance of the FD, including FAB actions and other pertinent information in a

3. Preparation of FDs. (Continued)

clear, concise narrative. No analysis of the facts or law and no citations should appear in this section.

(2) Findings of Fact. This section is a recitation of all facts needed to reach the conclusions of law and the ultimate decision rendered by the FAB. The findings of fact are the most significant findings from the Statement of the Case that are needed to support the FD ruling. Each finding is numbered sequentially. The findings should draw conclusions from the evidence of record, and must not simply recite the statement of the case.

(3) Objections. This section contains a summary of any timely objection brought up by the claimant or authorized representative in connection with the recommended decision(s) before FAB, as well as FAB's response to these objections. The summary should mention all timely objections in a clear and orderly manner, but the summary does not need to be numbered and it may combine similar objections. All summarized objections must be responded to, with a discussion of FAB's analysis of the objections in respect to entitlement requirements and an explanation of whether the objections have an impact on the adjudication of the claim. In most situations, to fully respond to the objections, the Objections section will need to make reference to the Act, regulations, or procedures. Therefore, citations are necessary and appropriate in this section.

(a) Objections to NIOSH Dose Reconstruction Decisions. Detailed procedures for objections to the NIOSH process and referrals to the DEEOIC Health Physicist are found in EEOICPA PM 2-1700.

(1) Factual objections in FD. If the claimant submits a factual objection and the factual findings reported to NIOSH are supported by the evidence of record, the FAB CE/HR addresses the objections in the FD. No referral to the DEEOIC Health Physicist is necessary. If the factual findings

3. Preparation of FDs. (Continued)

reported to NIOSH do not appear to be supported by the evidence of record the FAB CE/HR refers the case to the health physicist for review. If the health physicist determines that a rework of the dose reconstruction is not necessary, the FAB CE/HR addresses the objection in the FD by outlining the findings of the health physicist. However, if the health physicist determines that a rework of the dose reconstruction is necessary, the FAB CE/HR remands the case to the DO.

(2) Technical Objections in FD. A technical objection involving either methodology or application must be referred to the DEEOIC Health Physicist. If the DEEOIC Health Physicist deems none of the technical objections plausible, the FAB CE/HR incorporates the findings on these technical issues into the FD.

However, if the DEEOIC Health Physicist determines that there is substantial factual evidence that NIOSH had not previously considered and/or that NIOSH should consider an issue relating to application of methodology, he or she notifies the FAB CE/HR, who then remands the case, after supervisory approval, to the DO with instructions to refer the case back to NIOSH. In most cases, NIOSH will perform a new dose reconstruction based on circumstances of the remand.

(3) Objections to Methodology in FD. When an objection is directed at NIOSH's methodology, the FAB CE/HR states in the decision that the objection cannot be addressed based on 20 CFR § 30.318(b) (methodology that NIOSH uses in arriving at reasonable estimates of radiation doses is binding on the FAB). The FAB CE/HR makes

3. Preparation of FDs. (Continued)

this statement only if so advised by the DEEOIC Health Physicist. Objections related to the content of NIOSH-IREP software are also related to methodology. However, the calculation of the probability of causation using the IREP software is the responsibility of the DEEOIC; therefore, FAB must address these objections in the FD.

(4) Conclusions of Law. This section contains the statutory and regulatory analysis used by the FAB reviewer to support his or her decision, referencing the findings of facts that support the conclusions of law. This section must be well-reasoned and provide appropriate legal citations. It should not, however, consist of a list of statutory and regulatory references without any explanation. This section also discusses any objection raised by the claimant in writing or through an oral hearing and includes FAB's response to the objection based on FAB's analysis of the objections and evidence of file. Finally, an overall legal conclusion supporting the decision must be reached. The conclusions of law must specifically identify whether or not benefits are being awarded or denied and under which Part of the Act.

c. Return of FD by Postal Service. Should FAB receive a returned FD, the FAB CE/HR will attempt to obtain the new or updated address for the claimant and re-mail the decision. More details regarding the handling of a returned FD are outlined in PM Chapter 2-1700.

4. Remand Orders. If the FAB determines that the claim(s) addressed in the recommended decision are not in posture for final decision, 20 C.F.R. § 30.317 gives FAB the authority to return cases to the DO without issuing a FD. A Remand Order is a written directive to the district office issued in lieu of a FD.

A Remand Order is written in narrative format to the claimant(s), but does not contain the normal sections of a FD (Statement of Case, Findings of Fact, and Conclusions of Law). However, where objections have been filed or a hearing has been

4. Remand Orders. (Continued)

held, the remand order should discuss and respond to the objections raised.

A Remand Order may instruct the DO to perform further development, address an error or other deficiency contained in a RD, address new evidence or a new claim received prior to the issuance of the FD, or address a change in the law, regulations, policies or procedures. A Remand Order can be warranted at any point during a review of the written record, before or after a hearing, or during the review of a RD.

FAB is to use reasonable discretion when assessing a case for remand. If the RD provides sound reasoning and thorough discussion of how it reached its conclusions and does not include material factual errors or erroneous application of law, the FAB must respect the DOs adjudicatory function. If FAB can make a reasonable determination that the outcome of the case would not be materially affected regardless of further development, FAB should exercise its discretion and not issue a Remand Order

Should the FAB find a technical, procedural, or some other error requiring a remand order, the FAB returns the case file to the DO with specific instructions in the remand order as to how to proceed further. Remand orders are largely issued in instances where further development is required at the DO level. FAB does not issue a remand order where FAB personnel can conduct minor development to resolve the issue at hand.

a. Change in Law, Regulations or Policies. If FAB determines that a RD outcome is erroneous in light of a recent change in the law, regulations, or policy, FAB may remand the case. When this occurs, the Remand Order is to include specific narrative content explaining the basis for returning the case to the district office. For example, newly designated Special Exposure Cohort class, changes to Department of Energy facility or atomic weapon employer facility coverage, date or facility changes to the list of residually contaminated sites, modified program information on toxic substance or occupational health effects data or other regulatory or policy changes that could affect the claim outcome.

4. Remand Orders. (Continued)

b. Erroneous Application of Law, Regulations, Policies or Procedures. If FAB determines that the recommended determination in the RD resulted from a misapplication of the law, regulations, policies or procedures, FAB may remand the case. The Remand Order identifies the misapplication of law, regulations, policies or procedures and describes how it effects the adjudication of the case. To expedite a favorable decision, the FAB CE/HR can reverse the decision without issuing a Remand Order, following procedures set forth in subpart 2.d of this chapter.

c. Receipt of New Medical Evidence or a New Claim for a Previously Unclaimed Illness. If while the case is at FAB, new medical evidence or a new claim for a new illness is received that is material to the recommended denial, FAB may remand or reverse to accept the claim, as applicable.

For example, if the RD denies a claim for chronic beryllium disease (CBD) on the basis of a lack of medical evidence and the claimant later submits medical evidence establishing CBD, the FAB may remand the claim or reverse the RD if all elements of the adjudicatory process are complete.

If a claim for a new illness is received, the case will be remanded for development of the newly claimed illness if it will affect the outcome of the issue before the FAB. If filing of the new claim will not affect the issue before the FAB, the FAB can issue a FD and return the new claim to the DO for further development. If the FAB is not immediately ready to issue the FD, then the Co-Located Unit (CE2) should create the new claim and begin development while the case is at FAB.

d. Receipt of Other New Evidence. If FAB receives new evidence that was not a part of the file when the RD was issued and that is material to the recommended determination (such as employment evidence, survivorship evidence, or evidence of a SWC/tort suit); FAB may remand the case or reverse the RD if it is advantageous to the claimant. The Remand Order will describe the new evidence and its possible effect on the adjudication of the case.

4. Remand Orders. (Continued)

e. Evidence Already in File. If the RD fails to properly address material evidence in the file and the failure could have an effect on the adjudication of the claim, FAB may remand the case. The Remand Order will describe the evidence and its possible effect on the adjudication of the case. If advantageous to the claimant, and all adjudicatory issues are complete, FAB may reverse the RD and accept the claim.

For example, if evidence in the file sufficiently supports a diagnosis of a claimed cancer but the cancer was not included in the dose reconstruction, FAB may remand the case for a re-work of the dose reconstruction.

f. Miscalculation of Tort Offset or SWC Coordination. If FAB determines that the RD contains a finding of fact or conclusion of law that is based on a material miscalculation of the offset arising from a tort lawsuit or SWC coordination, FAB may remand the case.

(1) If a case is remanded for this reason, FAB includes its calculation worksheet in the file and a supplemental explanation of what FAB considers the evidentiary basis for its calculation.

(2) If FAB determines that the miscalculation was relatively minor and was not favorable to the claimant, FAB may exercise its discretion and issue a FD which corrects the calculation in the claimant's favor, without a remand.

g. Where a case is at FAB for review of one claim element and a remand order is issued on another claim element; the designated CE2 addresses the remand order. If there are no outstanding issues before FAB, the remand order and case file is returned to the DO that issued the RD. FAB may also issue remand orders in part, returning one portion of the claim to the DO for further action and issuing a FD on other portions of the claim.

h. Format of Remand Order. A Remand Order follows a narrative format and is directed to the district office which issued the RD. It includes a brief discussion of the

4. Remand Orders. (Continued)

claim's adjudicatory history when pertinent to the matter at hand, the basis for the remand, any explanation and supplemental documentation required and an explanation of the actions to be undertaken by the DO. A sample Remand Order is shown in Exhibit 3.

i. Notification and Transfer of File. When a Remand Order is issued, FAB inserts into the case file a copy of the Remand Order, certificate of service, and any supporting calculations or supplementary documentation. FAB sends a copy of the Remand Order, certificate of service, and cover letter to the claimant and the authorized representative, if any.

(1) The cover letter explains the Remand Order and the DOs responsibility for preparing a new RD after further development. Additionally, the cover letter advises the claimant to which office the case file is being forwarded, and provides the address and telephone number of that office. See Exhibit 3.

(2) A certificate of service, which certifies the Remand Order was mailed on a certain date, is also prepared for each individual recipient, attesting to the date the remand order is sent, and is also included in Exhibit 3.

(3) Upon issuance of a Remand Order, FAB transfers the case file to the DO that issued the RD.

j. Challenging a Remand Order. No procedure allows a claimant to directly challenge a Remand Order, but each District Director (DD) has the authority to formally challenge a FAB Remand Order with the DEEOIC Director if sufficient cause exists to do so. In such instances, the DD prepares a memorandum to the Director of the DEEOIC outlining his or her concerns and the case file is transferred to the Office of the Director for review.

5. Administrative Closure. If FAB determines that an individual claim requires administrative closure, a Remand Order is not necessary. These situations include:

5. Administrative Closure. (Continued)

a. Claimant Withdraws Claim. If a claimant advises the DEEOIC that he or she wishes to withdraw the claim, the FAB administratively closes the claim and drafts a memo to the file explaining the reason for the closure. Additionally, the FAB is to send a letter to the claimant advising him/her of the administrative closure.

b. Claimant Dies. If the claimant dies after the issuance of a RD but prior to issuance of the FD, the decedent's claim is administratively closed by the FAB. In the case of a single claimant, the FAB returns the claim to the DO to pursue survivor claims. In situations involving multiple claimants, the case is remanded to the DO for the issuance of a new recommended decision which reallocates benefits. However, if the RD is recommending denial of all claims, the FAB may issue a FD to the remaining survivors, denoting the administrative closure of the decedent's claim.

c. Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained by the Co-Located Unit within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.

d. State Workers' Compensation (SWC)/Tort/Fraud Statements (EN-16) Not Obtained. Where signed statements are required regarding tort lawsuits, SWC claims and any possible fraud committed in connection with an application for or receipt of any federal or state workers' compensation benefit, and the claimant has not submitted such statements within 30 days of the issuance of the RD, the FAB administratively closes the claim. A memo to the file is drafted explaining the reason for the closure, and a letter is sent to the claimant advising him/her of the administrative closure.

5. Administrative Closure. (Continued)

In instances involving multiple claimants and one or more claimants have not submitted the required EN-16, the FAB issues a FD to the claimants who have submitted a signed EN-16, denoting the administrative closure of the claimant(s) who failed to submit an EN-16. The share of compensation of the claimant(s) whose claim(s) has been administratively closed will be held in abeyance.

When a consequential injury is to be accepted, the CE must get a new signed EN-16 SWC/Tort/Fraud affidavit from the claimant for that consequential injury.

FAB's responsibilities in obtaining the appropriate EN-16 forms are described in further detail in Chapter 3-400.3(b) and 3-500.6(c).

6. Claimant Rights Following the Issuance of FAB FDs. A claimant may seek review of a FD by filing a request for reconsideration or by filing a request for reopening of the claim. This section discusses requests for reconsideration and provides guidance relating to the initial receipt of requests for reopening.

a. Receipt of a Request for Review.

(1) A request for reconsideration will be considered timely if it was filed within 30 calendar days of the date of issuance of the FD. Pursuant to 20 C.F.R. § 30.319(b), the request will be considered to be "filed" on the date the claimant mails it to the FAB, as determined by the postmark, or on the date the written request is actually received by the DO or FAB, whichever is the earliest determinable date. A request for reopening may be filed at any time after the FD is issued.

(2) Any correspondence from a claimant or authorized representative which is received in the DO or FAB within 30 calendar days after the FD is issued, and which contains either an explicit request for reconsideration or language which could be reasonably interpreted as intent to disagree with the FD will be considered a timely request for reconsideration.

6. Claimant Rights Following the Issuance of FAB FDs. (Cont.)

If new evidence is received in the DO or FAB within 30 calendar days after the FD issuance, and the new evidence relates to an issue which was adjudicated and denied in the FD, this new evidence will be considered a timely request for reconsideration. If the DO receives the request for reconsideration, it must be sent to National Office (NO) FAB for handling.

(3) Upon receipt of correspondence or new evidence which constitutes a timely filed request for reconsideration, FAB will send a letter to the claimant acknowledging receipt of the correspondence or evidence and advising that such receipt is considered a timely filed request for reconsideration.

(4) If correspondence received within 30 calendar days of the FD specifically requests a reopening instead of reconsideration, it will be handled as a reopening request by the DO. If both reconsideration and reopening are requested, FAB will process the reconsideration request first and then forward the claim to the DO to process the reopening request.

(5) A request for reopening may take several forms:

(a) Any correspondence or evidence containing or accompanied by a specific request for reopening, which is received at any time after the issuance of the FD, will be treated as a reopening request.

(b) If correspondence or evidence is received without a specific request for reopening after the deadline for a timely reconsideration request, and the FD denied the claim to which the correspondence or evidence relates, the evidence is reviewed for possible reopening.

If FAB determines that such correspondence or evidence meets the evidentiary requirements set forth in 20 C.F.R. § 30.320(b), the FAB-DO district manager or the FAB-NO Branch Chief will prepare a memorandum to the EEOICP Director

6. Claimant Rights Following the Issuance of FAB FDs. (Cont.)

outlining the relevant claim history and the nature of the evidence and forward the case file to the EEOICP Director for review for possible reopening.

Should the evidentiary requirements not be met, FAB will associate the correspondence or evidence with the case file. In either case the claimant will not be notified of the actions taken by the FAB, because the claimant has not requested a specific action.

(6) Upon receipt of a request for review:

(a) Any request for reconsideration, along with the case file, is forwarded to FAB and assigned to a FAB CE/HR for review. A reconsideration request will not be assigned to a FAB CE/HR who issued the FD for the specific claim element being addressed in the reconsideration request. Additionally, should the claimant specifically request that the reconsideration be addressed by a different FAB office, every effort should be made to accommodate the claimant.

The FAB CE/HR will screen the case to determine if the correspondence constitutes a request for reconsideration and, if so, if the request was timely filed.

(b) All requests for reopening received in the DO are initially reviewed by the DD. If a reopening request is received in FAB, the FAB-DO district manager or FAB-NO Branch Chief will transfer the request, any supporting evidence, and the case file to the DD for review.

(7) Upon receipt of a timely request for reconsideration, the FD in question will no longer be deemed "final" until a decision is reached on the reconsideration request. Receipt of a request for reopening does not have a similar effect and the

6. Claimant Rights Following the Issuance of FAB FDs. (Cont.)

subject FD remains "final" until such time as the EEOICP Director issues an order reopening the claim.

(8) A reconsideration request does not come with further reconsideration rights but only reopening rights or right to file suit in District Court. Therefore, if FAB denied a request for reconsideration and the claimant subsequently files another request for reconsideration of the same FD, FAB will not entertain the subsequent request. A letter explaining to the claimant that reconsideration rights attach only once to a FD is signed by the FAB chief.

b. Processing an Untimely Request for Reconsideration.

(1) Any initial reconsideration request which is filed after the above-noted deadline is an untimely filed request for reconsideration.

(a) No letter is sent to acknowledge receipt of an untimely request for reconsideration. FAB issues a Denial of Request for Reconsideration advising the claimant that the request for reconsideration was not filed within 30 days of the issuance of the FD and must be denied.

(b) If FAB concludes that any evidence received with an untimely request for reconsideration may warrant a reopening, FAB may forward the request to the District Director of the DO with jurisdiction over the claim for review.

(2) If an untimely filed request for reconsideration is accompanied by a specific request for reopening, FAB issues a Denial of Request for Reconsideration based on the untimely filing. The FAB CE/HR then forwards the reopening request with the case file to the DD of the office with jurisdiction over the claim for review for possible reopening.

c. Adjudicating a Timely Request for Reconsideration.

Requests for reconsideration typically come in a number of different forms. To determine the appropriate action to be

6. Claimant Rights Following the Issuance of FAB FDs. (Cont.)

taken in response to the request, the FAB CE/HR must review the request and, if appropriate, any accompanying argument or evidence.

(1) If the request for reconsideration simply states that the claimant disagrees with the FD and provides no new argument or evidence in support of their request, the CE/HR may simply deny the request for reconsideration on the grounds that no argument or evidence was submitted that would alter the FD. See Exhibit 4.

(2) If the request for reconsideration raises new legal arguments with respect to the FD but includes no new evidence, the CE/HR reviews the FD and considers the arguments made by the claimant. The reviewer must examine the evidence of record and the FD challenged by the claimant. See Exhibit 5.

(a) If the arguments do not change the outcome of the FD under review, the request for reconsideration is denied with appropriate and specific response to the arguments made in the request. FAB does not make any factual findings.

(b) If the arguments made in the request for reconsideration support a conclusion that there was a misapplication of the law, regulations or procedures in the FD, the request for reconsideration may be granted, and the case remanded to the district office or a new FD issued by the FAB reversing to accept the claim.

(3) If the request for reconsideration includes evidence which is duplicative, or essentially duplicates that which is already in the file and was previously considered in the FD, the request is denied with an explanation of how the new evidence does not change the outcome of the claim.

(4) If the request for reconsideration includes new, probative evidence which would alter the outcome of the FD, the request for reconsideration is granted.

6. Claimant Rights Following the Issuance of FAB FDs. (Cont.)

d. Effect of denial or grant of reconsideration on finality.

(1) If the FAB denies the request, the FAB decision which was the subject of the request will be considered "final" on the date the request is denied. No further requests for reconsideration of that particular FD of the FAB will be considered.

(2) If the FAB grants the request for reconsideration and issues a new FD, that decision will become final on the date of its issuance. Accordingly, the FAB will consider subsequent requests for reconsideration pertaining to that decision.

(3) If the FAB grants the request for reconsideration and remands the case to the district office for further development, the claimant(s) will receive a new RD with the full rights that go with a RD and a new FD.

7. Alternative Filing, Part E. If a claimant is denied as an ineligible survivor under Part E, he or she has the right to alternatively receive a non-decision determination regarding the employee's claimed illness (es). FAB advises the claimant of this right in the cover letter of the FD (see Exhibit 6 for a sample cover letter). Additional information regarding Alternative Filing can be found in PM Chapter 2-1200, Establishing Survivorship.

SAMPLE FINAL DECISION COVER LETTER - ACCEPTANCE

Dear Claimant Name:

Enclosed please a Final Decision on your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The district office recommends acceptance of your claim for Burkitt's lymphoma under both Part B and Part E of the Act.

I have enclosed the Acceptance of Payment form (EN-20), which is required before the Office of Workers' Compensation Programs can issue payment to you. You must complete the form in permanent ink and there can be no cross outs or other marks. Do not use white out or correction tape. Any alteration of the form will result in it being rendered unusable for purposes of issuing payment. If you make a mistake or need another form, please contact the district office handling your claim. You must submit the form with an original signature. Faxes or another copied version of the EN-20 is not acceptable. A second copy of the form is attached in case a mistake is made. Only one form needs to be returned. Please check with your financial institution before returning the form to us to verify the routing number and your account number so that your money arrives promptly and to the correct account.

Please email the completed and signed original EN-20 to:

U.S. Department of Labor
DEEOIC, District Office
P.O. Box XXXX
City, State ZIP

Please be advised that the final decision on your claim may be posted on the agency's website if it contains significant findings of fact or conclusions of law that might be of interest to the public. If it is posted, your final decision will not contain your file number, nor will it identify you or your family members by name.

Any future correspondence, inquiries, or telephone calls should be directed to the (District Office) district office. Thank you for your cooperation.

Sincerely,

Hearing Representative
Final Adjudication Branch

SUPERSEDED

EMPLOYEE: [Name]
CLAIMANT: [Name]
FILE NUMBER: [Number]
DOCKET NUMBER: [Number]
DECISION DATE: [Date]

NOTICE OF FINAL DECISION

This decision of the Final Adjudication Branch (FAB) concerns the above claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA or the Act), as amended, 42 U.S.C. § 7384 et seq. For the reasons set forth below, the claim for benefits under Part B and Part E of the Act for Burkitt's lymphoma is approved.

STATEMENT OF THE CASE

On February 6, 2012, the claimant filed a Form EE-1 under the Act. He claimed that he developed non-Hodgkin's lymphoma as a consequence of his employment at multiple Department of Energy (DOE) facilities.

In support of his claim, he submitted a Form EE-3 indicating that he was employed at the Hanford Plant in Richland, Washington from 1976 to 1987, and at the Savannah River Site (SRS) in Aiken, South Carolina from June 1984 to July 1985. A representative of DOE confirmed that he was employed at Hanford by the Bechtel Corporation, a DOE subcontractor, from December 6, 1982 to December 30, 1983, by the J.A. Jones Company, a DOE subcontractor, from January 27, 1987 to February 28, 1987 and by Kaiser Engineers Hanford, a DOE contractor, from March 1, 1987 to May 1, 1987. Also, union dispatch records and occupational medicine records provided by the DOE establish that the claimant was employed at Hanford by the Bechtel Corporation from June 2, 1977 to March 23, 1978. In addition, radiation exposure monitoring records provided by the DOE establish that he was

employed at the SRS, a DOE facility, by B.F. Shaw Company, a DOE subcontractor, from November 26, 1984 to June 23, 1985.¹

Also in support of his claim, the claimant submitted a hematopathology report, signed by Dr. Jonathan Roller, documenting a diagnosis of non-Hodgkin's lymphoma on November 1, 2011. A subsequent oncology visit report from Dr. Thomas Jacobsen, dated February 27, 2012, confirms a specific diagnosis of Burkitt's lymphoma, a form of non-Hodgkin's lymphoma, based on the particular characteristics of the malignant lymphocytes.

On October 9, 2012, the Seattle district office issued a recommended decision to accept the claim for Burkitt's lymphoma under Parts B and E of EEOICPA, finding that the claimant is a member of the Special Exposure Cohort (SEC) who was diagnosed with a specified cancer after beginning employment at a DOE facility. The district office also recommended that the claimant be awarded compensation in the amount of \$150,000.00 under Part B, and medical benefits for the treatment of Burkitt's lymphoma retroactive to February 6, 2012 under both Part B and Part E of the Act.

The claimant submitted a Form EN-16, dated October 16, 2012, declaring that he had neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which he would be eligible to receive compensation under the Act. He also declared that he had neither filed for nor received any state workers' compensation benefits on account of the claimed illness. And finally, the claimant declared that he had neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

On October 22, 2012, FAB received the claimant's written notification indicating that he waived all rights to file objections to the findings of fact and conclusions of law in the recommended decision.

Based on an independent review of the evidence of record, FAB hereby makes the following:

¹ Hanford is a covered DOE facility from 1942 to the present. The SRS is a covered DOE facility from 1950 to the present. See DOE Office of Worker Advocacy Covered Facility List at: <http://www.hss.doe.gov/healthsafety/fwsp/advocacy/faclist/showfacility.cfm> (verified by the FAB on November 21, 2012).

FINDINGS OF FACT

1. On February 6, 2012, the claimant filed a claim for benefits under the Act for non-Hodgkin's lymphoma due to employment at DOE facilities.
2. The claimant was employed at Hanford, a DOE facility, by the Bechtel Corporation, a DOE subcontractor, from June 2, 1977 to March 23, 1978 and December 6, 1982 to December 30, 1983, by the J.A. Jones Company, a DOE subcontractor, from January 27, 1987 to February 28, 1987 and by Kaiser Engineers Hanford, a DOE contractor, from March 1, 1987 to May 1, 1987. In addition, he was employed at the SRS, a DOE facility, by B.F. Shaw Company, a DOE subcontractor, from November 26, 1984 to June 23, 1985.
3. The claimant was diagnosed with Burkitt's lymphoma, a form of non-Hodgkin's lymphoma, on November 1, 2011.
4. The claimant has neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which he would be eligible to receive compensation under the Act. He has neither filed for nor received any state workers' compensation benefits on account of the claimed illness, and he has neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

Based on these findings of fact, FAB hereby makes the following:

CONCLUSIONS OF LAW

If a claimant waives any objections to all or part of the recommended decision, FAB may issue a final decision accepting the recommendation of the district office, either in whole or in part. 20 C.F.R. § 30.316(a) (2012). The claimant waived his right to file objections to the findings of fact and conclusions of law in the recommended decision.

Under Part B of the Act, an individual is a "covered employee with cancer" if that individual is a member of the SEC who

contracted a specified cancer after beginning employment at a DOE facility. 42 U.S.C. § 73841(9)(A).

On August 23, 2012, the Secretary of Health and Human Services designated the following class of employees for addition to the SEC in a report to Congress:

All employees of the DOE, its predecessor agencies, and their contractors and subcontractors who worked at Hanford in Richland, Washington, from July 1, 1972 through December 31, 1983, for a number of work days aggregating at least 250 work days, occurring either solely under this employment, or in combination with work days within the parameters established for one or more other classes of employees in the SEC.

See EEOICPA Circular No. 12-16 (issued September 22, 2012).

The claimant was employed at Hanford by a DOE subcontractor for a period in excess of 250 work days between July 1, 1972 and December 31, 1983. Therefore, he is a member of the SEC. Also, Burkitt's lymphoma is a specified cancer, provided the onset of the condition occurred at least five years after the initial exposure to radiation during covered employment. 20 C.F.R. § 30.5(ff)(5)(ii). The claimant began working at Hanford on June 2, 1977, and was diagnosed with Burkitt's lymphoma on November 1, 2011. Therefore, he was diagnosed with a specified cancer over 5 years after beginning employment at a DOE facility.

Accordingly, the claimant is a "covered employee with cancer" under Part B in accordance with 42 U.S.C. § 73841(9)(A), and his Burkitt's lymphoma is an "occupational illness" in accordance with 42 U.S.C. § 73841(15). As such, he is entitled to compensation in the amount of \$150,000.00 and medical benefits under Part B, retroactive to February 6, 2012; the date of filing.

Further, since the claimant was employed by DOE contractors and subcontractors at covered DOE facilities during covered time periods, and given the acceptance of his Part B claim, that acceptance is treated for the purposes of Part E of the Act as a determination that he contracted his illness through work-related exposure to a toxic substance at a DOE facility. 42 U.S.C. § 7385s-4(a). As such, the FAB finds that the claimant

is also a "covered DOE contractor employee" under Part E, and his Burkitt's lymphoma is a "covered illness" under Part E. As a covered DOE contractor, the claimant is also entitled to medical benefits for his Burkitt's lymphoma under Part E.

In summary, the claim for benefits under Part B and Part E of EEOICPA for Burkitt's lymphoma is approved. The claimant is awarded \$150,000.00 under Part B and medical benefits for the treatment of Burkitt's lymphoma, retroactive to February 6, 2012, under Part B and Part E of the Act.

Washington, D.C.

Name
Hearing Representative
Final Adjudication Branch

Sample Medical Benefits Letter

DATE

NAME AND ADDRESS

Dear CLAIMANT NAME:

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), you are entitled to medical benefits for treatment of your MEDICAL CONDITION (ICD-9 codes: ICD-9 CODES), effective February 29, 2012. Covered medical services are payable in accordance with the fee schedules and medical benefits policies established under the Energy Employees Occupational Illness Compensation Program (EEOICP). Your medical benefits coverage includes payment to medical providers for services such as medical appointments, hospitalizations, home health care services (see attached Notice Regarding Home Health Services), medical appliances, supplies, and drugs that are prescribed by a qualified physician and approved by the EEOICP.

Within the next few weeks, you will be receiving additional information regarding your medical benefits coverage. This will include a medical benefits identification card, which you will need to show to your physician or other enrolled medical provider you chose to treat your covered condition. This card will be accompanied by instructions and a phone number to call to activate the card. The card will instruct your physician, hospital, durable medical equipment supplier or other health care providers to bill the EEOICP directly, so that you will not have to pay for medical treatment covered under the program. There are no deductibles for services or equipment as long as the services are billed by an EEOICP enrolled medical provider.

To bill us directly, providers must be enrolled in the Program. For information about enrollment and billing, please have your provider contact us at the address and telephone number listed at the end of this letter, or give us your provider's phone number when you call to activate your medical benefits identification card. We will call and explain the Program to your provider(s) and give them the necessary forms required for submitting bills for reimbursement.

To request reimbursement for out of pocket medical expenses associated with treatment of your accepted condition, you must submit the following forms: (OWCP-915 Form, *Claim for Medical Reimbursement Under the Energy Employees Occupational Illness Compensation Program Act*), and (OWCP-957 Form, *Medical Travel Refund Request*). Both forms are enclosed for your convenience and include instructions for completing these forms and submitting any additional required documentation.

Please mail completed forms to:

U.S. Department of Labor
Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

If you or your provider(s) have questions regarding submission or payment of bills, or require any other medical bill program assistance, contact a representative toll free at 1-866-272-2682.

Sincerely,

Hearing Representative

Enclosures:

OWCP-915

OWCP-957

Notice Regarding Home Health Care Services

Note: if the EEOICP pays less than the billed amount (in accordance with the fee schedule), you are **not** responsible for payment of the difference to a provider. Providers and claimants may submit requests for reconsideration of fee determinations in writing, with accompanying documentation to the address supplied in this letter.

Claim for Medical Reimbursement

U.S. Department of Labor
Office of Workers' Compensation Programs



Provide all information requested below. DO NOT FILL IN SHADED AREAS. Read the attached information in order to ensure the submission of all required documentation. Maintain a copy of all documentation for your records.			OMB No. 1240-0007 Expires: 12/31/2012		
PERSONAL INFORMATION					
Name		OWCP File Number			
Last	First	M.I.			
Address		Telephone Number			
Street/P.O. Box/Apt No.					
City		State	Zip Code		
PROVIDER INFORMATION					
Name of Doctor's Office, Hospital, Pharmacy or Medical Supply Company where expense was incurred. (A separate OWCP-915 must be filed for each provider)					
Description of Charge (Medical appointment, name of prescription drug, description of medical product/ supply)	Date of Service (MM/DD/YYYY)		Amount Paid by Claimant	Have you included Proof of Payment for each item?	
	From	To		YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
			Total Reimbursement		
I certify that the information above is correct and that the reimbursement requested is for expenses paid by me for the treatment of my covered condition. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.					
I authorize any provider named above to release information to the US Department of Labor, OWCP if necessary for the proper adjudication of this claim.					
Signature _____			Date _____		

Form OWCP-915
September 2009

INSTRUCTIONS FOR USE OF FORM OWCP-915
<ul style="list-style-type: none"> • This form is to be used to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted condition. Form OWCP-915 can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies. • Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred. • Please print clearly and legibly. Reference your OWCP file number on all documentation. Maintain a copy of the completed OWCP-915 and supporting documentation for your records.
DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT
<p>Prescription Medication</p> <ol style="list-style-type: none"> 1. Completed OWCP-915 2. A paper pharmacy billing form, which must be attached to the OWCP-915 and must include the following information: <ol style="list-style-type: none"> a. Name, address and telephone number of pharmacy b. Pharmacy provider number c. Prescription number d. Name of claimant e. Date of purchase f. Eleven Digit National Drug Code (NDC#) g. New prescription or refill number h. Quantity of medication (e.g. # of pills or ml/cc) i. Amount paid by employee per medication 3. Proof of payment (can include cash receipt, cancelled check or credit card slip) <p>Medical Expense other than prescription medication</p> <ol style="list-style-type: none"> 1. Completed OWCP-915 2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-04. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount paid by the claimant must be indicated. The OWCP-1500 or OWCP-04 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed OWCP-1500 or OWCP-04 from the provider rendering service. <i>Without a fully completed OWCP-1500 or OWCP-04, the OWCP is not able to process a reimbursement.</i> 3. Proof of payment (can include cash receipt, cancelled check or credit card slip) <p>Travel</p> <p>Do not use Form OWCP-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on Form OWCP-957.</p>
Public Burden Statement
<p>Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.</p>

Form OWCP-915
September 2009

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq., 30 USC 901 et seq., 38 USC 613, 42 USC 7384d, E.O. 9397 and E.O. 13179. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

Form OWCP-915
September 2009

Medical Travel Refund Request

U.S. Department of Labor
Office of Workers' Compensation Programs



Reset Print

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 108. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1240-0037
Expires: 10/31/2013

1. Claimant's Name (Last, First, Mi.):
2. Case/Claim Number

3. Payee's Name if different from claimant's name (last, first, mi.). (See instruction no. 3 on the back of form)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code).

Special instructions: 1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is REQUIRED by BLACK LUNG for verification of each service date and type.

Form with multiple sections (5a-7e) for travel details, expenses, and physician verification. Includes checkboxes for One-way/Round Trip, Travel From/To (Hospital, Office/clinic, Lab, Home), and expense categories (Taxi, Bus/Train, Tolls/Pkg, Lodging, Meals, Other). Includes 'DOL USE ONLY' and 'FOR BLACK LUNG USE ONLY' sections for TOS/Procedure Code, Care Rendered, and Diagnosis.

8. Payee's Certification: I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement or misrepresentation to obtain reimbursement from OWCP is subject to civil penalties and/or criminal prosecution.

Claimant's/Payee's Signature

Date

Form OWCP-957
Rev. Aug 2003

Notice Regarding Home Health Services

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), you are eligible for those services, appliances, and supplies prescribed or recommended by a qualified physician, which are likely to cure, give relief to, or reduce the degree or the period of the accepted illness.

Home health care is one of the many medical benefits you may receive for an accepted illness under the EEOICPA. Home health care includes both in-home skilled nursing care, and the services of a home health aide to assist you with activities of daily living, related to your accepted condition(s). Examples of these daily activities include assistance with mobility around the house, dressing, feeding and food preparation, and accompanying you to medical appointments.

It is important for you to be well informed about your EEOICPA benefits as they relate to home health care services. This begins with an explanation of the benefits you are entitled to, and the information you and your doctor will be asked to provide before home health care can be approved.

- A request for home health care must be submitted to the District Office servicing your claim. Your claim number should be clearly noted on any request. There are no restrictions on when you can apply for home health care once a work-related illness is accepted in your claim; however, services are authorized based upon the presentation of medical evidence from your treating physician confirming the need for care due to an accepted illness.
- Written authorization for home health care must be obtained prior to any service provider entering your residence to conduct services in connection with the accepted work-related illness, except in certain emergency situations.
- When you initially request home health care, the physician treating you for a work-related illness accepted in your claim will be asked to supply a written explanation of the care you require, called a Plan of Care. This plan of care must explain the need for in-home health care as it relates to the accepted illness (es) in your claim. Your physician is to clearly specify the level of care required (skilled

nursing care, home health aide, etc.); the frequency of care required (i.e., number of hours per day or week for each type of care); and the time period for which you will require in-home care. Medical evidence presented by a physician who has not personally treated your accepted work-related illness, or who is otherwise unfamiliar with your treatment needs, is of reduced probative value in assessing home health care requests.

- Once approval is granted for home health care, you are free to choose from any licensed medical provider of the services you require, as long as the provider is enrolled with the Division of Energy Employees Occupational Illness Compensation (DEEOIC). Moreover, you are free to change providers at any time. The DEEOIC neither endorses nor sponsors any home health care provider, or any other entity providing medical services.
- Approval for home health care is granted for up to six-month periods and must be renewed with the submission of updated medical information from your treating physician. Changes to an approved level of home health care must be requested in writing and must be accompanied by medical documentation from your treating physician explaining the basis for any alteration in your current plan of care.
- The DEEOIC may conduct reviews of home health care authorizations using medical consultants, field nurses, or other forms of inquiry with your treating physician at any given time.

As with all forms of health care, you play an important role in determining the appropriate level of care and the types of services being provided to you. If you have questions regarding home health care, direct your concerns to the District Office servicing your claim.

SAMPLE REMAND ORDER COVER LETTER

Date

Claimant Name
Address

Last 4 Digits of File Number:

Dear Claimant:

Enclosed please find the Remand Order concerning your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act.

Please note that the remand order is directed to the EEOICP district office. Unless you are contacted by that office for additional information, you are not required to take any action at this time. I regret any inconvenience caused to you by this remand.

Your file is being returned to:

U.S. Department of Labor, DEEOIC
XXXXX District Office
Address
City, State Zip

Future correspondence, inquiries, or telephone calls may be directed to the district office. Thank you for your cooperation.

Sincerely,

Hearing Representative
Final Adjudication Branch

EMPLOYEE: [Employee's Name]
CLAIMANT: [Claimant's Name]
FILE NUMBER: [Last 4 digits of file #]
DOCKET NUMBER: [Docket Number]
DECISION DATE: [Decision Date]

REMAND ORDER

This order of the Final Adjudication Branch (FAB) concerns your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or the Act), 42 U.S.C. § 7384 *et seq.* Your case is remanded to the EEOICP district office for consideration of the new medical evidence received that established a cancer diagnosis.

On November 9, 2005, you filed a claim for survivor benefits under the Act, based upon the claim that the employee contracted skin cancer, seizures and heart problems while employed at the Iowa Ordnance Plant. You submitted no medical evidence to establish that the employee was diagnosed with cancer.

On May 16, 2006, the district office issued a recommended decision concluding that there was insufficient evidence to establish an occupational illness under Part B of the Act and that there was insufficient evidence to establish a covered illness under Part E of the Act. Therefore, it was recommended that your claim for survivor benefits under the Act be denied. On May 30, 2006, you filed objections to the recommended decision and requested a hearing.

On August 18, 2006, a hearing was conducted on your objections. At, and subsequent to, the hearing, you submitted additional medical evidence. The medical records, specifically a pathology report of November 12, 2001, support a finding that the employee was diagnosed with basal cell carcinoma, i.e. skin cancer. This new evidence is sufficient to warrant further development of the claim.

Pursuant to 20 C.F.R. § 30.317: "At any time before issuance of its final decision, the FAB may . . . return the claim to the district office for further development and/or issuance of a new recommended decision without issuing a final decision, whether or not requested to do so by the claimant." Therefore, the May 16, 2006 recommended decision is vacated and the case is being returned to the EEOICP district office for further development and issuance of a new recommended decision.

Washington, DC

Hearing Representative
Final Adjudication Branch

CERTIFICATE OF SERVICE

I hereby certify that on _____, a copy of the Remand Order was sent by regular mail to the following:

Claimant Name
Claimant Address

Hearing Representative
Final Adjudication Branch

SUPERSEDED

Sample Denial of Reconsideration Request (No New Evidence or
Argument Submitted)

EMPLOYEE:

[Employee's Name]

CLAIMANT:

[Claimant's Name]

FILE NUMBER:

[Last 4 digits of file #]

DOCKET NUMBER:

[Docket Number]

DECISION DATE:

[Decision Date]

NOTICE OF DENIAL OF REQUEST FOR RECONSIDERATION

This is in response to your letter of January 29, 2011 requesting reconsideration of the January 12, 2011 Final Decision of the Final Adjudication Branch (FAB). For the reasons set forth below, your request for reconsideration is denied.

The January 12, 2011 Final Decision found that your lung cancer was "not at least as likely as not" related to your employment at the Pinellas Plant. It was on this basis that your Part B claim was denied under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Further, the final decision was based on the evidence of file, which included the dose reconstruction report, your letters of objection, the hearing transcript and comments you submitted regarding the hearing transcript.

As you have not submitted any new argument or evidence which justifies reconsideration of the January 12, 2011 final decision, I must deny your request. Accordingly, the decision of the FAB denying your Part B claim is final on the date of issuance of this denial of your request for reconsideration. 20 C.F.R. § 30.319(c)(2).

Washington, D.C.

Hearing Representative
Final Adjudication Branch

Sample Denial of Reconsideration Request (New Evidence and/or
New Argument Submitted)

EMPLOYEE: [Employee's Name]
CLAIMANT: [Claimant's Name]
FILE NUMBER: [Last 4 digits of file #]
DOCKET NUMBER: [Docket Number]
DECISION DATE: [Decision Date]

NOTICE OF DENIAL OF REQUEST FOR RECONSIDERATION

This is a response to your request for reconsideration of the July 1, 2011 final decision of the Final Adjudication Branch (FAB) under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) which denied your Part E claim for sleep apnea consequential to sarcoidosis. The FAB received your request and determined that it was timely filed. 20 C.F.R. § 30.319 (2011). On August 15, 2011, the FAB acknowledged receipt of your request for reconsideration. However, the evidence of record shows that, to date, you have not submitted any additional evidence.

In your request for reconsideration, you stated, "The opinion of Dr. Smith and the Contract Medical Consultant (CMC) conflicted, which would require that the matter be sent to a third physician for a referee opinion, and it was an error not to do so." The Federal (EEOICPA) Procedure Manual Chapter 2-0800.13 provides guidance when making a determination as to when a claim is to be referred for a referee opinion:

In most instances, careful weighing of the medical evidence should allow for resolution of the issues without having to resort to a referee or "impartial" specialist. However, where the weight of medical evidence is divided equally between the opinion of the treating doctor and that of the second opinion physician, a referee opinion must be obtained...a conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in

the medical record by considering all factors, to include each physician's specialty and qualifications, completeness and comprehensiveness of evaluations and rationale, and consistency of opinions.

The FAB weighed the medical evidence and determined that the conflicting medical opinions were not of equal weight. In such cases, a referee specialist examination is not necessary. I have reviewed the evidence of record, including the CMC report and the medical evidence you have submitted and the opinion of Dr. Smith. I have determined that the report of the CMC is of greater weight and probative value because Dr. Smith failed to provide a complete and comprehensive medical report. The FAB noted that the district office requested such a report; however none was provided. Accordingly, the FAB gave consideration to the relative value of the opposing opinions, including considering the rationale and consistency of the respective opinions, and determined the CMC's report should be granted more weight.

Additionally, in your request for reconsideration you stated, "The treating physician who examined and treated the claimant was not given proper weight over a CMC who never saw the claimant." According to the EEOICPA Procedure Manual, in evaluating the merits of medical reports, greater value is assigned to a well-rationalized opinion which is based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. The FAB notes that Dr. Smith stated in his report that he "believed your sleep apnea was indirectly related to your lung disease." Dr. Smith continued, "I do not have any concrete evidence to prove this, but it is my opinion." As such, Dr. Smith's opinion is not based on complete factual and medical information, but is instead subjective. In contrast, the opinion of the CMC was found to be well-rationalized, supported by the medical evidence in this case and cites recent scientific and medical literature in support of his conclusion. Further, the EEOICPA Procedure Manual outlines that the opinion of an expert in the relevant medical field is to be granted greater value. Dr. Smith is a general practitioner specializing in geriatric medicine. The CMC is an expert in occupational medicine.

Your request for reconsideration goes on to object to the handling of your claim by the Hearing Representative (HR). You state that the HR "applied the wrong standard of proof by a

preponderance of evidence instead of the at least as likely as not standard in the Conclusions of Law." The Regulations at 20 C.F.R. § 30.111(a) state that the claimant bears the burden of proving, by a preponderance of evidence, the existence of all criteria necessary to establish eligibility under the EEOICPA. To establish eligibility for a consequential condition under Part E, you must prove by preponderance of the evidence that the diagnosed illness, in this case sleep apnea, occurred as a result of an accepted illness. This is established by a fully-rationalized medical report by a physician which shows the relationship between the claimed consequential condition and the accepted illness. The "at least as likely as not" standard cited in your request only pertains to causation determinations for primary illnesses, which is not at issue in your claim for a consequential illness.

Finally, the request for reconsideration renewed your previous objections to the June 9, 2010 recommended decision of the Denver district office. These objections were previously considered by the FAB and were addressed in the July 1, 2011 final decision.

The EEOICPA is administered according to the Act itself, 42 U.S.C. § 7384, et seq., the associated Code of Federal Regulations, 20 C.F.R. Part 30, Bulletins, Circulars and the Federal EEOICPA Procedure Manual. The FAB has thoroughly reviewed your case file and finds that your claim has been properly adjudicated according to the Act and its associated regulations, policies and procedures.

The Federal (EEOICPA) Procedure Manual Chapter 2-1800 provides that a timely request for reconsideration may be denied if it does not contain sufficient probative evidence or substantiated argument that directly contradicts a material finding of fact or conclusion of law set forth in the final decision. You have not submitted a new argument or evidence that directly contradicts the conclusions reached in the July 1, 2011 final decision. As such, your request for consideration is denied. The denial of your Part E claim for sleep apnea is final on the date of

issuance of this denial of your request for reconsideration. 20
C.F.R. § 30.319(c).

Denver, Colorado

Hearing Representative
Final

Adjudication

Branch

SUPERSEDED

SAMPLE COVER LETTER, ALTERNATIVE FILING - DENIAL

Dear Claimant Name:

Enclosed please find the Notice of Final Decision which denies your claim for compensation and benefits under the Energy Employees' Occupational Illness Compensation Program Act (EEOICPA). If you disagree with this decision, you may request reconsideration. Such a request must be in writing and must be made within 30 days of the date of issuance of this decision. It must clearly state the grounds upon which reconsideration is being requested. In order to ensure that you receive an independent evaluation of the evidence, your request for reconsideration will be reviewed by a different Final Adjudication Branch hearing representative than that who issued the final decision. Your request for reconsideration should be sent to:

U.S. Department of Labor
DEEOIC
Final Adjudication Branch
Attn: FAB OPS
P. O. Box XXX
CITY, STATE ZIP CODE

If your claim was denied because you have not established covered employment or a covered illness and you have new evidence of either covered employment or a covered illness, you may request a reopening of your claim. If your claim was denied because a cancer was not causally related to work-related exposure to radiation and you can identify either a change in the probability of causation guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort, you may also request a reopening of your claim.

These requests to reopen your claim must be in writing and be sent, along with your supporting information, to the following address:

U.S. Department of Labor
DEEOIC, DISTRICT DIRECTOR
P.O. BOX XXX
CITY, STATE ZIP CODE

While you do not meet the statutory definition of an eligible survivor as set out under Part E of the EEOICPA, you may seek an alternative filing review pursuant to 42 U.S.C. § 7385s-4(d). You may request such a review by writing to:

U.S. Department of Labor
DEEOIC, DISTRICT DIRECTOR
ADDRESS

Alternative filing reviews can also be conducted by the district office upon request. In these reviews, the district office will assess a facility where alleged employment and exposure took place and render a determination as to potential causation. Should you wish to receive this type of review, the district office will provide you with a determination. Please note, however, that such a determination does not change your eligibility for benefits or establish causation under the Act, and is not subject to further agency or judicial review.

Please be advised that the final decision on your claim may be posted on the agency's website if it contains significant findings of fact or conclusions of law that might be of interest to the public. If it is posted, your final decision will not contain your file number, nor will it identify you or your family members by name.

Except as provided above, all future correspondence, inquiries or telephone calls should be directed to the district office. Thank you for your cooperation.

Sincerely,

Hearing Representative

Enc: Notice of Final Decision