U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, DC 20210

RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 6.0:

EEOICPA TRANSMITTAL NO. 22-01 April 4, 2022

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this Transmittal to notify staff of the publication of Federal (EEOICPA) Procedure Manual (PM) Version 6.0 (v6.0), which replaces PM v5.1, effective the date of publication of this Transmittal.

Following are the content edits that make up PM v6.0:

- **Chapter 1 - Definitions**

  - Ch. 1.2nn has been updated to remove outdated language regarding the handling of paper case files. The language in v5.1 previously read:

    nn. Mail and File (M&F) Staff are responsible for maintaining paper case files located at the DO and FAB. They are also responsible for assisting with the physical movement of case files within the DO or FAB, including taking receipt of incoming files or transferring files to other district or FAB offices.

    It has been updated in v6.0 to:

    nn. Mail and File (M&F) Staff are responsible for opening, sorting, and scanning incoming mail, and assigning the digital image of mail to the proper case in OIS.

- **Chapter 2 – The EEOICPA**

  - Ch. 2 is being reissued in its entirety, to include updated information regarding the organizational structure of the DEEOIC and the training of its staff.

  - Exhibit 2-1 has been updated to include recent DEEOIC office address changes.

- **Chapter 3 – General Provisions**

  - Ch. 3.3 has been added to include the requirements of the National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007, previously located in Chapter 8 – Case Maintenance.

- **Chapter 6 – Processing Mail**

  - Ch. 6.6a has been updated to remove outdated language regarding handling paper case files. The language in v5.1 previously read:

    a. Portable Media. The types of documents and evidence received by the DEEOIC in support of EEOICPA claims is varied and can occasionally consist of physical evidence which cannot be imaged into OIS, such as portable media, X-rays, etc. In such instances, the DO is to incorporate this information with the paper case file, making a notation in the electronic OIS record that physical evidence exists in the case. If no paper case file exists, a new file is to be created in which to store the physical evidence and is maintained by the DO.

  It has been updated in v6.0 to:

    a. Portable Media. The types of documents and evidence received by the DEEOIC in support of EEOICPA claims is varied and can occasionally consist of physical evidence which cannot be imaged into OIS, such as portable media, X-rays, etc. In such instances, the DO is to make a notation in the electronic OIS record that physical evidence exists in the case, and create a file in which the physical evidence is stored and maintained by the DO.

- **Chapter 7 – Case Creation**

  - Ch. 7.9 has been updated to clarify procedures for the handling of withdrawn claims for impairment benefits. The language in v5.1 previously read:

    a. To resume development on a withdrawn claim, the claimant must submit a signed letter to DEEOIC requesting the resumption of the withdrawn claim or submit a new signed EE-1 or EE-2 form for the same illness (es)/death previously under adjudication. DEEOIC will resume development by picking up where development left off at the time the claimant chose to withdraw. Therefore, if a RD concerning the claim in question was issued and the case forwarded to FAB, but then the claim was administratively closed while the case was at FAB due to claim withdrawal, a new RD should not be issued.

  It has been updated in v6.0 to:

    a. To resume development on a withdrawn claim, the claimant must submit a signed letter to DEEOIC requesting the resumption of the withdrawn claim or submit a new signed EE-1 or EE-2 form for the same illness(es)/death previously under adjudication. DEEOIC will resume development by picking up where development left off at the time the claimant chose to withdraw. Therefore, if a RD concerning the claim in question was issued and the case forwarded to FAB, but then the claim is withdrawn and administratively closed, a new RD should not be issued.

(1) An exception to the above general rule exists for handling withdrawn impairment claims. For a withdrawn impairment claim, DEEOIC will resume development of the claim at the stage that existed at the time of withdrawal, as long as the claim seeks a resumption less than 2 years from the impairment claim filing date. For any request to resume a withdrawn impairment claim that occurs two years or later after the prior filing date, DEEOIC will consider the request a new impairment request, entitling the claimant to obtain a new rating by his or her own physician or a CMC, and the withdrawn impairment claim will remain administratively closed. This means that any outstanding recommended decision issued in response to the prior claim's administrative closure will not be pending review by FAB.

- **Chapter 8 - Case Maintenance**

  - Content that previously existed within Chapter 8 – Case Maintenance, has been removed, because it provided guidance about handling paper files which is no longer applicable now that file records are maintained solely in an electronic image format. Content from Ch. 8 that remains relevant, specifically, the requirements of the National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007, which was previously located at Ch. 8.7 (v5.1), has been incorporated into Chapter 3 – General Provisions; specifically, Ch. 3.3. Chapter 8 will contain no content, but will remain as a placeholder chapter to avoid reordering the existing chronology of PM chapters.

- **Chapter 9 – Transfers and Loans**

  - Content that previously existing within Chapter 9 – Transfers and Loans, has been removed. Content from Ch. 9 that remains relevant, specifically, guidance on referring case records to the National Institute for Occupational Safety and Health (NIOSH), previously located at Ch. 9.5 (v5.1), has been incorporated into Chapter 17 – Development of Radiogenic Cancer Claims; specifically, Ch. 17.7d. Chapter 9 will contain no content, but will remain as a placeholder chapter to avoid reordering the existing chronology of PM chapters.

- **Chapter 12 – Representative Services**

  - Ch. 12.6 has been updated to clarify that Claims Examiners (CEs) have sole oversight of the Authorized Representative (AR) appointment process. The language in v5.1 previously read:

    6. <u>Interaction with Representatives</u>. After a claimant properly appoints a representative to handle his or her DEEOIC claim, the CE or FAB staff person contacts the representative by letter. In the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in the claims process. From that point forward, or until the claimant removes or changes the representative, the

CE or FAB staff person will communicate with the designated representative and copy them on all written interactions intended for the claimant. The CE or FAB staff are permitted to communicate with employees of the designated representative, including legal assistants, administrative staff, paralegals, or other individuals in the employment of the representative.

It has been updated in v6.0 to:

6. Interaction with Representatives. When a CE receives a document purporting to designate an authorized representative, the CE needs to review the document to ensure that the designation is valid, as outlined in Chapter 12.2. If a FAB HR or a MBE receives an AR designation document, the HR or MBE is to send an OIS notification of its receipt to the assigned CE.

In reviewing the designation letter, the CE is responsible for ensuring that the request fulfils the requirements for designation of an AR, including replacement of the existing AR, as discussed earlier in this Chapter. Once the CE confirms that the designation meets the requirement for designating the AR, the CE is to prepare and mail the AR a written acknowledgment of their designation (copy to the claimant). A standardized acknowledgment letter is available to the CE in CCAT. Within the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in the claims process. The letter also provides information concerning the DEEOIC conflict of interest policy. The CE must upload a copy of the outgoing letter properly in OIS. The CE is also responsible for updating ECS claimant information regarding the authorized representative in accordance with established coding procedure.

Once designated properly, DEEOIC staff may communicate with the designated representative and copy them on all written interactions intended for the claimant. DEEOIC staff may also communicate with employees of the designated representative, including legal assistants, administrative staff, paralegals, or other individuals in the employment of the representative.

- Ch. 12.7 has been updated to clearly define roles and responsibilities for identifying potential conflicts of interest, and the actions that must be taken when such a conflict exists. The language in v5.1 previously read:

7. Representative Conflict of Interest Guidance. Conflicts of interest can arise when a duly appointed AR has direct financial interests arising out of the acceptance of a claim, even if those interests are only potential in nature, aside from the representational fees permitted under EEOICPA. This is because those other financial interests may be more lucrative to an AR, and therefore may be more important, than the potential amount of the fee for representing a client with a claim before DEEOIC. These sorts of divided interests on the part of ARs might motivate representatives to act in a manner contrary to a claimant's best interests and are not allowed under this policy.

a. *Upon receipt of a signed notice of the appointment of an AR, the CE or FAB staff person sends an acknowledgment letter accompanied by the DEEOIC Conflict of Interest Policy.*

b. *If during any interaction with an AR or in review of case evidence, the CE or FAB staff person ascertains that the AR may have a conflict of interest, the CE should take immediate action to address the matter. A conflict of interest may exist if there is evidence that the AR is receiving financial benefits associated with the claim aside from the authorized fee permitted under the law. An incidence of conflict of interest includes evidence showing the AR works for or is contracted by an individual, organization or entity that concurrently receives monetary payment from DEEOIC for services, supplies or other resources affiliated with the claim. This includes a representative who is a family member or other relative of the claimant receiving a wage, contractual payment, or fee from a medical service provider that the DEEOIC has granted authorization to provide in-home health services for that claimant. In any instance where a CE or FAB staff person is unclear as to the existence of a conflict of interest, he or she may refer the matter via a policy referral to the NO Policy Branch. Upon receipt, the Policy Branch will work with the SOL to provide a written response.*

(1) *Upon receipt of credible evidence that a conflict of interest may exist, the CE or FAB staff person must prepare a notice to the designated AR, with a copy to the claimant (Exhibit 12-3). The notice is to include a descriptive explanation of the evidence that suggests that a conflict of interest may exist. The CE or FAB staff person is to request that the AR prepare a signed statement explaining his or her response to the evidence of a conflict of interest. Moreover, the CE is to state that if a conflict of interest does exist, the DEEOIC will no longer recognize the designation of the AR unless the conflict is eliminated. The letter is to include a statement allowing the AR 30 days to respond to the notice.*

(2) *When in receipt of the AR's response, the CE or FAB staff person must carefully evaluate the information provided, along with a review of the evidence of record, to determine whether a substantiated conflict of interest exists. If the AR acknowledges that a conflict of interest exists, he or she may resolve the conflict by either submitting a signed resignation as the AR, or submitting evidence of the relinquishment of whatever charges, position, job or duty creates a conflict with the role of AR. The claimant can also withdraw the authorization for that representative, in writing, and designate a new AR. Consent of the claimant will not remove a conflict of interest.*

(3) If the AR contends that the circumstances identified do not constitute a conflict of interest under DEEOIC's policy, or no response is forthcoming within 30 days of the initial notification, the CE or FAB staff must carefully weigh the evidence of record. Should the AR provide sufficient rationale that absolves him or her of any conflict of interest, the CE or FAB staff person notifies the representative, in writing, with a copy to the claimant, that no further action is necessary. However, if it is determined that there is compelling evidence of a conflict of interest, the CE or FAB staff person should conclude that DEEOIC will no longer recognize the designated AR as serving the interest of the claimant. Under this circumstance, the claimant is to be notified in writing that DEEOIC will no longer interact with the designated AR due to a conflict of interest.

c. Once a CE or FAB staff person has determined that a conflict of interest exists that disqualifies a designated AR from representing the claimant and appropriate notification of such has been reported to the claimant, no further interaction with or disclosure of information to the AR is permitted. The CE or FAB staff person is to remove the AR information from the ECS.

d. When a CE or FAB staff person removes a representative due to a conflict of interest, he or she should refer the name of the representative to the NO Policy Branch. Upon receipt, the NO Policy Branch will coordinate a review to determine if an additional investigation is required to assess potential conflict of interest in cases where the same representative exists.

It has been updated in v6.0 to:

7. <u>Representative Conflict of Interest Guidance</u>. Conflicts of interest can arise when a duly appointed AR has direct financial interests arising out of the acceptance of a claim, even if those interests are only potential in nature, aside from the representational fees permitted under EEOICPA. This is because those other financial interests may be more lucrative to an AR, and therefore may be more important, than the potential amount of the fee for representing a client with a claim before DEEOIC. These sorts of divided interests on the part of ARs might motivate representatives to act in a manner contrary to a claimant's best interests and DEEOIC cannot permit such a circumstance to exist.

a. During any routine case development or adjudication activity conducted by a CE, HR, or a MBE, evidence may reveal a potential conflict of interest. With the identification of any information, obtained through routine claims development or adjudication activity, that suggests a conflict of interest may exist involving a designated AR, the CE, HR, or MBE then becomes responsible for undertaking action to address the matter, as outlined below.

b. A conflict of interest may exist if there is evidence that the AR is receiving financial benefits associated with the claim aside from the authorized fee permitted under the law. An incidence of conflict of interest includes evidence showing the AR works for, or is contracted by, an individual, organization or entity that concurrently receives monetary payment from DEEOIC for services, supplies or other resources affiliated with the claim. This includes a representative who is a family member or other relative of the claimant receiving a wage, contractual payment, or fee from a medical service provider that the DEEOIC has granted authorization to provide in-home health services for that claimant. Consent of the claimant does not absolve a conflict of interest.

c. With the identification of any potential conflict of interest, action is required to evaluate the matter further. Conflict of interest situations that arise during a review of a file by the HR or MBE require that the HR or MBE document the situation with a note into ECS (using the COI note type). The HR or MBE is to then send an email notice to the assigned CE (with a courtesy copy to the District Director or designee) explaining the circumstances of a potential conflict of interest. As the HR or MBE is not responsible for any assessment of the potential conflict, aside from the identification of evidence that suggests a potential conflict of interest, the HR or MBE does not upload the email notice to the CE into OIS.

d. Potential conflicts of interest identified during a case review by the CE, or referred to the CE by a HR or MBE, require careful examination of the evidence. It is the role of the CE to conduct a review of the evidence to determine whether sufficient evidence exists to conclude reasonably that a conflict of interest may exist. Upon review, should the CE determine that there is no valid basis for further action with regard to a potential conflict of interest, the CE is to document their findings in a memo to the file.

If the CE determines that a potential conflict of interest exists, he or she is to conduct a comprehensive review of the case file to ensure that the conflict has not been evaluated and resolved previously. If there has been no previous effort to address the situation, then the CE must prepare a notice to the designated AR, with a courtesy copy to the claimant (see Exhibit 12-3 for an example letter). The notice is to include a descriptive explanation of the evidence that suggests that a conflict of interest may exist. The CE is to request that the AR prepare a signed statement responding to the inquiry that explains his or her response to the situation. Moreover, the letter is to state that if a conflict of interest does exist, the DEEOIC will no longer recognize the designation of the AR unless the AR takes appropriate action to eliminate the conflict. The letter is to include a statement allowing the AR 30 days to respond to the notice.

e. Once the CE has issued a notice to an AR that a possible conflict of interest exists, the responsibility of assessing any subsequent response is the responsibility solely of the CE. Once the CE sends the letter to the AR regarding the potential conflict of interest, the AR may respond, or the AR may elect not to respond.

(1) Acknowledgement of a conflict by an AR requires that the AR submit a signed, written notice removing themselves as the designated AR or providing evidence that they have relinquished whatever financial arrangement, position, job or duty that created the conflict. The claimant also retains the capacity to remove the authorization of the representative at any time, and designate a new AR.

(2) If the AR contends that the circumstances identified do not constitute a conflict of interest under DEEOIC's policy, or no response is forthcoming within 30 days of when the development letter (Exhibit 12-3) was sent, the CE must carefully weigh the evidence of record. Should the AR provide sufficient rationale that absolves him or her of any conflict of interest, or if a weighing of the evidence of record leads to a finding that there is no conflict of interest, then the CE notifies the representative, in writing, with a copy to the claimant, that no further action is necessary.

(3) Should the CE decide that there is compelling evidence establishing the existence of a conflict of interest, DEEOIC can no longer recognize the designated AR as serving the interest of the claimant. Under this circumstance, the CE prepares a written notice explaining to the claimant that DEEOIC will no longer interact with the designated AR, because of an established conflict of interest. The letter is to describe the evidence that establishes the existence of the conflict. Moreover, the letter is to provide instruction for the claimant to designate an alternative AR, and also should provide guidance on re-designating the removed AR, so long as the circumstance that created the conflict no longer exists. The CE issues the letter solely to the claimant. With the publication of the letter, the CE is to remove the AR designation information from ECS for the identified claimant. The CE should create a correspondence in ECS and add a correspondence note documenting removal of the AR, effective the date of the letter. The CE is to also upload a memo into OIS documenting the removal of the AR. The CE is to ensure the OIS description fields describe clearly that the CE has removed the authorized representative's designation because of the identification of a conflict of interest.

f. If a CE removes an AR due to a conflict of interest, the CE is to notify the DD by email. The DD will then forward the notification to the PMB. The PMB will undertake an investigation to determine if the AR serves as a representative under other claims. The PMB will then notify the Policy Branch so it may coordinate with NAFO to evaluate those claims to determine if a conflict of interest exists in those instances as well.

g. During the evaluation of any claim for a conflict of interest by a CE, should assistance be necessary, the CE may refer the matter to the Policy Branch for evaluation. The Policy Branch will undertake additional review of the situation and may confer with SOL to ascertain the proper action to be undertaken.

- **Chapter 13 – Establishing Covered Employment**
  - Ch. 13.15d has been updated to specifically identify the eight branches of uniformed service personnel. The language in v5.1 previously read

d. Uniformed Members of the Military. A claimant cannot obtain EEOICPA benefits based upon service in the military. If the claimant provides information or identifies himself/herself as military personnel, the CE sends a letter to the claimant stating that uniformed military personnel are ineligible for benefits under the EEOICPA. Only civilian employees who performed services on the premises of DOE facilities, via contracts, are DOE contractor employees.

It has been updated in v6.0 to:

d. Uniformed Services of the United States. A claimant cannot obtain EEOICPA benefits based upon service in one of the eight commissioned Federal Uniformed Services of the United States. If the claimant provides information or identifies himself/herself as U.S. uniformed service personnel, the CE sends a letter to the claimant stating that uniformed service personnel are ineligible for benefits under the EEOICPA. Only civilian employees who performed services on the premises of DOE facilities, via contracts, are DOE contractor employees. The eight commissioned Federal Uniformed Services of the United States include:

(1) United States Army;

(2) United States Marine Corps;

(3) United States Navy;

(4) United States Air Force;

(5) United States Coast Guard;

(6) United States Space Force;

(7) Commissioned Corps of the United States Public Health Service;

(8) National Oceanic and Atmospheric Administration Commissioned Officer Corps.

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**

  - Ch. 15.14 has been updated to clarify guidance on validating Site Exposure Matrices (SEM) results prior to the issuance of a recommended, or final, decision denying a claim for lack of causation. The language in v5.1 previously read:

    14. Before Issuing RD and FD. Since changes to SEM can happen at any time, a new SEM search is to be conducted before the RD is released to ensure that no substantive changes have occurred. The CE is to image the new search results into OIS to clearly document that a new review took place. The FAB reviewer also completes a new SEM search before issuing the FD and bronzes the results into OIS.

    It has been updated in v6.0 to:

    14. Validating SEM Data Prior to Issuance of RD and FD. Since changes to SEM health effect and exposure data may occur at any time, in instances where the application of SEM data is a factor in the decisional outcome, the CE or HR must verify that a change to SEM has not occurred that would potentially alter the decision outcome immediately prior to decision issuance. When the CE or HR determines that data validation is necessary, they are to perform a new filtered SEM search specific to the features of the claim under review. The outcome of this search is then imaged into OIS to document either that no change has occurred to alter the decision outcome or that the outcome of the new SEM search warrants additional development.

- **Chapter 17 – Development of Radiogenic Cancer Claims**

  - Ch. 17.7d has been added to the guidance on the NIOSH case referral process that previously existed within Chapter 9 – Transfers and Loans. The language in v5.1 previously read:

    d. Case Referred to NIOSH.

    (1) All findings made by the CE must be supported by the evidence in file and documented in the NRSD. The CE forwards a copy of the entire case file with the NRSD to NIOSH.

    (2) The CE advises the claimant in writing that he or she has sent the case to NIOSH for dose reconstruction (Exhibit 17-3).

    It has been updated in v6.0 to:

d. Referring Case Records to NIOSH. As part of the dose reconstruction process, NIOSH must review certain employee's medical and employment records. All findings made by the CE must be supported by the evidence in the file and documented in the NRSD. When referring cases to NIOSH for a dose reconstruction, the entire case file is electronically transmitted to NIOSH via the Secure Access Management Service (SAMS). Upon receipt, NIOSH sends the DO an electronic confirmation of receipt for each NIOSH referral received via the SAMS portal.

(1) Schedule. Each DO typically send cases on designated days based on the following weekly schedule:

Tuesday:	*Jacksonville*
Wednesday:	*Cleveland*
Thursday:	*Denver*
Friday:	*Seattle*

Occasionally, a terminal claim or a high volume of claims will necessitate the submission of additional NIOSH referrals outside of the schedule noted above.

(2) Following the receipt of the confirmation emails from NIOSH, the DO prepares a manifest of cases and the type of referrals (initial, amended, or supplemental) electronically transmitted that day to NIOSH. The manifest is uploaded to the SAMS portal in the same manner the NIOSH referrals were submitted. NIOSH uses this manifest to reconcile the receipt of each referral submitted via the SAMS portal. For any claims submitted outside of the schedule noted above, a new manifest is prepared and submitted electronically via the SAMS portal for NIOSH reconciliation purposes.

(3) The CE advises the claimant in writing that he or she has sent the case to NIOSH for dose reconstruction (Exhibit 17-3).

- **Chapter 21 – Impairment Ratings**

  - Ch. 21.8a has been updated to clarify the role of the CE in considering whether medical disorders named in an impairment have an association to a covered illness of the central or peripheral nervous system. The language in v5.1 previously read:

8. <u>Impairment Ratings for Certain Conditions</u>.

a. Mental Disorders.

(1) Upon receipt of a claim for a mental impairment, the CE must determine whether the claimed impairment originates from a documented physical dysfunction of the nervous system.

(2) Once it has been established that an employee's mental impairment is related to a documented physical dysfunction of the nervous system, the employee obtains an impairment evaluation from the physician based on Table 13-8 of Chapter 13 in the 5th Edition of the AMA's Guides.

(3) If the mental impairment is not related to a documented physical dysfunction of the nervous system, it cannot be rated using the 5th Edition of the AMA's Guides. The CE explains this to the employee and provides the employee 30 days to submit documentation from a physician to establish a link between the exposure to a toxic substance at a covered facility and the development of a mental impairment. The report from the employee's physician must contain rationalized medical analysis establishing that the mental impairment has a relationship to neurological damage due to a named toxic exposure. Speculation or unequivocal statements from the physician reduce the probative value of a physician's report, and, in such situations, the CE may refer the case to an occupational CMC.

It has been updated in v6.0 to:

8. <u>Impairment Ratings for Certain Conditions</u>.

a. Emotional or Behavioral Impairment.

(1) Upon receipt of an impairment rating that includes a psychiatric component(s) related to an emotional, mood, or behavioral disturbance, the CE must determine whether the psychiatric component(s) originates from a covered illness involving a dysfunction of the central and/or peripheral nervous system. In accordance with Chapter 13 of the AMA's Guides 5th Ed., a central or peripheral nervous system impairment may be assigned due to a documented dysfunction of the brain, cranial nerves, spinal cord, nerve roots, and/or peripheral nerves and muscles. Psychiatric manifestations and impairment produced by a neurological dysfunction are ratable; however, a physician must provide a well-rationalized opinion that links the psychiatric features to a documented neurological condition accepted as resulting from an occupational toxic substance exposure.

(2) In those instances where the CE receives an impairment rating that includes impairment assigned due to an emotional, mood, or behavioral disturbance, the evidence must establish that the psychiatric features manifest from a covered illness of the central or peripheral nervous system. In the absence of such evidence, the

CE will need to initiate development with the rating physician (CMC or claimant's chosen physician). The CE will need to request that the rating physician explain whether the psychiatric component of the proposed impairment originated from an accepted covered illness involving a dysfunction of the central and/or peripheral nervous system. If not, the physician must exclude any impairment assigned due to the named psychiatric features.

(3) If the CE receives a response from the CMC that does not address clearly whether the identified psychiatric features of a proposed impairment relate to dysfunction of the central or peripheral nervous system, the CE will refer the matter to the National Office Policy Branch for review and corrective action by the assigned Contracting Officer Representative. If a claimant's chosen physician does not respond to development or provides a response that the CE does not weigh as well-rationalized, the CE is to seek out a new impairment rating by referring the matter to a CMC.

- Ch. 21.7a has been updated to remove outdated language regarding Xerox's Stored Image Retrieval (SIR) system. The language in v5.1 previously read:

a. Required Medical Evidence. Since the CMC will not conduct a physical examination, the employee's ADL or equivalent information is required. The CMC or the employee's physician can collect ADL information from a variety of sources, including the use of ADL worksheet (Exhibit 21-3), patient interview, or other techniques. The ADL or equivalent information should be completed within the last 12 months before the impairment evaluation. The CE also checks Xerox's Stored Image Retrieval (SIR) system to provide the most current medical record to the CMC. If the employee is under nursing care, the CE provides all nursing notes from the past 30 days to the CMC for review. In addition to the ADL or its equivalent, some conditions require specific medical evidence before a CMC can complete the impairment evaluation (Exhibit 21-4.) If Exhibit 21-4 does not identify the condition to be rated, the CE is to consult with a CMC to determine what medical information is required as outlined in the AMA's Guides.

It has been updated in v6.0 to:

a. Required Medical Evidence. Since the CMC will not conduct a physical examination, the employee's ADL or equivalent information is required. The CMC or the employee's physician can collect ADL information from a variety of sources, including the use of ADL worksheet (Exhibit 17-3), patient interview, or other techniques. The ADL or equivalent information should be completed within the last 12 months before the impairment evaluation. The CE also checks OIS to provide the most current medical record to the CMC. If the employee is under nursing care, the CE provides all nursing notes from the past 30 days to the CMC

for review. In addition to the ADL or its equivalent, some conditions require specific medical evidence before a CMC can complete the impairment evaluation (Exhibit 17-4.) If Exhibit 17-4 does not identify the condition to be rated, the CE is to consult with a CMC to determine what medical information is required as outlined in the AMA's Guides.

- Ch. 21.16b has been updated to clarify procedures for the handling of withdrawn claims for an increase to impairment benefits. The language in v5.1 previously read:

  b. Untimely Requests for Re-evaluation. If the two-year date is within three months or less of the two-year mark, the CE may initiate development of the impairment claim. However, a RD cannot be issued until the two-year mark. In this circumstance, the CE informs the employee in writing that he/she is not eligible for an impairment decision until at least the two-year mark. The language can be included with the development letter or as a separate letter if all development is completed.

  If the employee submits an untimely request for re-evaluation more than three months prior to the two-year mark, the CE administratively closes the impairment claim. This two-year wait period applies even if the employee submits a new impairment report with a rating that is higher than the previous impairment award. The CE sends a letter to the employee explaining the administrative closure and the two-year wait requirement. The letter informs the employee to resubmit a new claim at or after the two-year mark.

It has been updated in v6.0 to:

b. Untimely Requests for Re-evaluation. If the two-year date is within three months or less of the two-year mark from the date of the last award of impairment benefits, or less than 2 years from the filing date of a withdrawn impairment claim, the claimant may file a claim to seek a new impairment rating. This may occur by filing a new EE-11A, or by submitting a written request to pursue a new rating. Under this circumstance, the CE may initiate development, including seeking information whether the claimant wants to obtain a new rating from his or her own physician or a CMC. However, the CE may not issue an RD regarding the impairment claim until the two-year mark from the prior impairment award, or from the filing date of a previously withdrawn impairment claim. The CE may communicate this information in any development that may occur under this circumstance.

If an employee submits an early request for new re-evaluation more than three months prior to two years from a prior award of impairment, the CE administratively closes the impairment claim. This two-year wait period applies even if the employee submits a new impairment report with a rating that is higher than the previous impairment award. The CE sends a letter to the employee

explaining the administrative closure and the two-year wait requirement. The letter informs the employee to resubmit a new claim at or after the two-year mark.

Should the employee submit a request to resume development of a previously withdrawn impairment claim more than three months prior to two years from the prior date of impairment filing, the CE is to reinitiate development of the impairment claim at whatever status existed on the date of withdrawal. This may include returning the file to FAB for it to consider the finalization of an outstanding recommendation regarding the prior impairment claim. A resumption of a withdrawn claim under this scenario does not require DEEOIC to authorize a new impairment rating by the claimant's chosen physician or a CMC.

- **Chapter 23 – Consequential Conditions**

  - Ch. 23.10a has been updated to clarify that any acceptance of a consequential illness linked to a primary illness requiring coordination must be addressed through a recommended decision (RD). The language in v5.1 previously read:

    a. Acceptances. If the consequential condition is going to be accepted, the CE accepts the consequential condition under Parts B and E, if the primary underlying condition is also accepted under both Parts. The CE notifies the claimant in a letter decision. All letter decisions should contain two signature blocks; one for the CE who drafted the letter, and one for his or her supervisor (or another management official designated by the DD), who will certify the sufficiency of the decisional outcome. Exhibit 23-2 provides a sample decision letter for approvals of consequential conditions.

    The CE should be aware that once he or she accepts a consequential condition by letter decision, any pending claim for that same condition being affiliated with a toxic substance exposure can be administratively closed. For example, when a letter accepting glaucoma as a consequential condition occurs, there is no need to then issue a recommended accept/deny for glaucoma based on toxic substance exposure. The "Eligibility Begin" date for consequential conditions is the filing date of the underlying accepted condition.

  It has been updated in v6.0 to:

    a. Acceptances. If the consequential condition is going to be accepted, the CE accepts the consequential condition under Parts B and E, if the primary underlying condition is also accepted under both Parts. The CE notifies the claimant in a letter decision. All letter decisions should contain two signature blocks; one for the CE who drafted the letter, and one for his or her supervisor (or another management official designated by the DD), who will certify the sufficiency of the decisional outcome. Exhibit 23-2 provides a sample decision letter for approvals of consequential conditions.

The CE should be aware that once he or she accepts a consequential condition by letter decision, any pending claim for that same condition being affiliated with a toxic substance exposure can be administratively closed. For example, when a letter accepting glaucoma as a consequential condition occurs, there is no need to then issue a recommended accept/deny for glaucoma based on toxic substance exposure. The "Eligibility Begin" date for consequential conditions is the filing date of the underlying accepted condition. An exception exists for any acceptance of a consequential illness that requires coordination as outlined in Chapter 32.4. In those instances, the CE must issue a RD to accept the consequential illness and describe any applicable coordination applied.

- **Chapter 24 – Recommended Decisions**

  - Exhibit 24-1: Sample Recommended Decision, Accept, has been updated to reflect updated formatting.

  - Exhibit 24-2: Sample Recommended Decision, Deny, has been updated to reflect updated formatting.

- **Chapter 25 – FAB Review Process**

  - Content that comprised Ch. 25.3, Organization (v5.1) has been relocated to Ch.2.3c to consolidate organizational information within one PM chapter. As such, the remaining sections of Ch. 25 have been renumbered accordingly.

- **Chapter 30 – Home and Residential Health Care**

  - Exhibit 30-4: Billing Codes has been updated to include clarification regarding the T1020 code for 24-hour care.

- **Chapter 32 – Coordinating State Workers' Compensation Benefits**

  - Ch. 32.4 has been edited to clarify that because compensation for a consequential illness arises from the existence of a covered illness, it is subject to coordination. The language in v5.1 previously read:

    4. <u>When Coordination is Required</u>. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary receives benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, and then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.

Similarly, where there is an election to receive the employee's benefits by the survivor (refer to Chapter 20.12b for specific requirements for a survivor who elects to receive the employee's benefits rather than survivor benefits), coordination is required if the employee received SWC benefits for the same covered illness. Coordination is required because the survivor is taking the place of the employee in this situation. For example, if the employee received a SWC payment for asbestosis and the survivor elects to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the benefits payable to the survivor.

In cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits awarded to the survivor through the date of the employee's death are subject to coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.

It has been updated in v6.0 to:

4. <u>When Coordination is Required</u>. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary receives benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, and then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.

Similarly, where there is an election to receive the employee's benefits by the survivor (refer to Chapter 20.12b for specific requirements for a survivor who elects to receive the employee's benefits rather than survivor benefits), coordination is required if the employee received SWC benefits for the same covered illness. Coordination is required because the survivor is taking the place of the employee in this situation. For example, if the employee received a SWC payment for asbestosis and the survivor elects to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the benefits payable to the survivor.

In cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits awarded to the survivor through the date of the employee's death are subject to coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.

Compensation awarded from the acceptance of a consequential illness is subject to coordination, if it arises from a covered illness for which coordination applies. For example, if a claim for asthma is accepted as a consequence of the covered illness of asbestosis under Part E, and the claimant received SWC benefits for asbestosis, all Part E benefits awarded to the claimant for medical benefits, wage-loss and impairment due to asbestosis and asthma must be coordinated.

- **Chapter 33 – Compensation Payments**

  - Ch. 33.3d has been updated to clarify that validation of an EN-20 signed by a Power of Attorney is not limited to a particular staff person. The language in v5.1 previously read:

    d. Signature by POA. If the EN-20 contains a signature by a POA, the FO conducts a document review to ascertain whether the individual who signed the EN-20 has the legal authority to sign on behalf of the payee. To accomplish this, the CE identifies and reviews the legal document authorizing an individual as POA. If such a document does not exist in the case file, the FO/CE undertakes development to obtain this information. Upon receipt of a document identifying the designated POA, the FO/CE prepares a cover memorandum and sends the memorandum, the EN-20, and the POA documents (via facsimile) to the NO Policy Branch, for referral to the SOL. The DO memorandum requests a review of the POA documents to determine their legal sufficiency as they pertain to the signing of an EN-20. The person preparing the memorandum ensures that it is uploaded into OIS. At the time of referral to the Policy Branch, the FO/CE enters a 7-day "reminder" in ECS.

  It has been updated in v6.0 to:

    d. Signature by POA. If the EN-20 contains a signature by a POA, the designated DEEOIC staff person responsible for payment validation, including the CE or FO, conducts a document review to ascertain whether the individual who signed the EN-20 has the legal authority to sign on behalf of the payee. To accomplish this, they must identify and review the legal document authorizing an individual as POA. If such a document does not exist in the case file, the designated staff person undertakes development to obtain this information. Upon receipt of a document identifying the designated POA, the designated staff person prepares a cover memorandum and sends the memorandum, the EN-20, and the POA documents (via facsimile) to the NO Policy Branch, for referral to the SOL. The DO memorandum requests a review of the POA documents to determine their legal sufficiency as they pertain to the signing of an EN-20. The person preparing the memorandum ensures that it is uploaded into OIS. At the time of referral to the Policy Branch, the designated staff enters a 7-day "reminder" in ECS.

- Ch. 33.3b has been edited to include new procedures for validating that a payee is eligible to receive payment prior to ECS payment creation including validating the payee's eligibility to receive payment through the Do Not Pay Portal. The language in v5.1 previously read:

b. Initial Review of the EN-20. Once the completed EN-20 saved into the OIS case record, the document automatically appears in the OIS Unreviewed Document Tab of the ECS-assigned staff person for initial review.

(1) Accuracy of Payment Data. The CE or designated staff person reviews the signed EN-20, in OIS, (or the original document if so desired,) to determine if the form contains correct payment data, and that the form has been correctly completed by the payee, examining each of the following items:

(a) Case ID

(b) Payee name. The payee name must be listed as one of the account holder names provided in the Account Information section. In the event the payee name is not listed as an account holder, or the CE has additional questions, he/she contacts the payee for clarification. If it is determined that the payee wants his/her payment to be deposited in a third-party account, a Payment Memorandum is prepared, and uploaded into OIS, explaining the name variance. (The only exception to this requirement is when the EN-20 is signed by an approved POA and the payment is being deposited in the POA's bank account.)

(c) Payee SSN.

(d) Verification of Account Information: "type account" block is checked ("C" for checking, "S" for savings) and the routing and account numbers are listed correctly, with no trace-overs, or corrections.

(e) EN-20 is signed and dated by the payee. (If the form is signed by an individual with POA, refer to the POA approval process below). If a minor child is the payee, a parent or legal guardian must sign the EN-20. For a parent to sign on behalf of a minor child, the case must document that the person signing the form is a biological or adoptive parent. If the minor child has a legal guardian, the guardian will need to document their legal authority to serve on behalf of the child before DEEOIC may authorize payment. Any individual signing on behalf of a minor child under a court appointment of guardianship must present the legal instrument permitting their authority to sign the EN-20. This

document must then undergo review in accordance with the POA review procedure discussed in this chapter to ensure its legal sufficiency.

It has been updated in v6.0 to:

b. Initial Review of the EN-20. Once the completed EN-20 saved into the OIS case record, the document automatically appears in the OIS Unreviewed Document Tab of the ECS-assigned staff person for initial review.

(1) Accuracy of Payment Data. The CE or designated staff person reviews the signed EN-20, in OIS, (or the original document if so desired,) to determine if the form contains correct payment data, and that the form has been correctly completed by the payee, examining each of the following items:

(a) Case ID

(b) Payee name. The payee name must be listed as one of the account holder names provided in the Account Information section. In the event the payee name is not listed as an account holder, or the CE has additional questions, he/she contacts the payee for clarification. If it is determined that the payee wants his/her payment to be deposited in a third-party account, a Payment Memorandum is prepared, and uploaded into OIS, explaining the name variance. (The only exception to this requirement is when the EN-20 is signed by an approved POA and the payment is being deposited in the POA's bank account.)

(c) Payee SSN.

(d) Verification of Account Information: "type account" block is checked ("C" for checking, "S" for savings) and the routing and account numbers are listed correctly, with no trace-overs, or corrections.

(e) EN-20 is signed and dated by the payee. (If the form is signed by an individual with POA, refer to the POA approval process below). If a minor child is the payee, a parent or legal guardian must sign the EN-20. For a parent to sign on behalf of a minor child, the case must document that the person signing the form is a biological or adoptive parent. If the minor child has a legal guardian, the guardian will need to document their legal authority to serve on behalf of the child before DEEOIC may authorize payment. Any individual signing on behalf of a minor child under a court appointment of guardianship must present the legal

instrument permitting their authority to sign the EN-20. This document must then undergo review in accordance with the POA review procedure discussed in this chapter to ensure its legal sufficiency.

(f) Validating Eligibility of Payee to Receive Payment. The FO (or designated alternate) is to validate that the named payee is not disqualified, potentially, from receiving payment due to their identification on the Bureau of Fiscal Services Do Not Pay (DNP) Portal. This portal provides status information on individuals, named as deceased on the SSA Death Master File (DMF), Department of Defense Death Data, American InfoSource Death Data – Obituary (AIS-OBIT), American InfoSource Death Data – Probate (AIS-PROB), and Department of State Death Data. The FO or designee will document the outcome of the DNP search in the case file. With a positive return, indicating the potential death of a payee, the FO or designee, suspends payment processing and sends an email notification to the responsible CE requesting confirmation of the payee's eligibility to receive payment. Once the CE determines the eligibility status of the payee, the CE will either proceed with payment processing for a living payee or administratively close the claim due to a payee's death.

- Ch. 33.5 has been edited to remove language regarding checks being requested on the EN-20, which is no longer an option on the EN-20. The language in v5.1 previously read:

5. <u>Creating the Check Payment</u>. After review by the FO, check requests are routed directly to the CE, who reviews the claimant's address listed on the EN-20, and verifies this address against case file documents, the current address displayed in ECS, and any change of address requests in the case record. If the claimant provides a different mailing address on the EN-20, from the current address of record, and indicates this is a "Payment Only address," the CE contacts the claimant by telephone to determine if the change of address is permanent, or if it is a one-time payment-only address. An appropriate call note is added to the ECS record.

a. Permanent Change. If the payment address provided on the EN-20 represents a permanent change of address, the CE instructs the claimant to submit a separate signed document requesting a permanent change of address.

b. Temporary Change. If the payment address is a temporary address for that payment only, the CE advises the payee that any permanent change of address will be processed upon submission of a separate written and signed request.

It has been updated in v6.0 to:

> *5. <u>Creating the Check Payment</u>. After review and approval by the FO, check requests are routed directly to the CE, who reviews the claimant's address provided in the check request letter, and verifies this address against case file documents, the current address displayed in ECS, and any change of address requests in the case record. If the claimant provides a different mailing address, from the current address of record, the CE contacts the claimant by telephone to determine if this represents a change of address, or if it is a one-time payment-only address. An appropriate call note is added to the ECS record.*
>
> *a. Permanent Change. If the payment address provided in the payment letter represents a permanent change of address, the CE instructs the claimant to submit a separate signed document requesting a permanent change of address.*
>
> *b. Temporary Change. If the payment address is a temporary address for that payment only, the CE advises the payee that any permanent change of address will be processed upon submission of a separate written and signed request.*

- Exhibit 33-1: Payment Transaction Form for Expedited Processing (EPPTF) has been updated to reflect updated formatting.
- Exhibit 33-2: Payment Transaction Form for 3rd Party Expedited Payments (EPPTF) has been updated to reflect updated formatting.
- Exhibit 33-3: Payment Transaction Form for Exception Processing has been updated to reflect updated formatting.

RACHEL POND Digitally signed by RACHEL POND Date: 2022.04.04 12:31:15 -04'00'

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