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

RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 7.0:

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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 7.0 (v7.0), which replaces PM v6.0, effective the date of publication of this Transmittal.

Following are the content edits that make up PM v7.0:

- **Chapter 7 – Case Creation**

  - Ch. 7.7a (Example 9) has been modified to clarify that a claim for chronic silicosis is only evaluated under both Parts B and E when the claimant was employed in either Nevada or Alaska *during* the mining of underground tunnels. The language in v6.0 previously read:

    Example 9: If a claimant identifies chronic silicosis on the Form EE-2, the claim is evaluated under both Parts B and E only when the claimed employment was in underground tunnels in Nevada or Alaska. If the claimant employment is outside of these facilities, the claim is adjudicated under only Part E.

    It has been updated in v7.0 to:

    Example 9: If a claimant identifies chronic silicosis on the Form EE-2, the claim is evaluated under both Parts B and E only when the claimed employment was during the mining of underground tunnels in Nevada or Amchitka Island, Alaska. If the claimant employment is outside of these facilities, the claim is adjudicated under only Part E.

- **Chapter 12 – Representative Services**

  - Ch. 12.5 has been edited to clarify the role of the Claims Examiner (CE) in assessment of legal documents conveying authority for someone to serve on behalf of a named claimant. This change also includes a new Exhibit 12-2, Attorney-in-Fact Memorandum to File. As such, the remaining exhibits of Chapter 12 have been renumbered accordingly. The language in v6.0 previously read:

5. <u>Authority of an Attorney-in-Fact or Legal Conservator/Guardian</u>. A person with POA to act in the name of the claimant is an "attorney-in-fact." There are also other types of legal designations that may exist such as a conservator or guardian. In any of these situations, a written instrument must exist that grants legal authority for someone to act on behalf of another. The written instrument will include language that describes the specific authorities granted for one person to act on behalf of another, and can be different from one situation to another. A general POA authorizes one person to have complete authority to act on someone's behalf on all matters, including signing documents and forms. In a special or limited POA, the authority to act may be limited to particular topics. Therefore, if an individual claims to have POA or some other legal authority to act on behalf of a claimant, the CE or FAB staff person must obtain a copy of the document conferring such authority. He or she must carefully examine the document to determine the scope of the legal authority granted. The CE or FAB staff person is to recognize any POA or other legal appointment, if the document upon which that appointment is made, conveys broad powers for the appointee to act on behalf of the claimant.

Once the CE or FAB staff person receives a legal document for a person to act on behalf of a claimant, he or she will determine if that person is already registered in ECS as an attorney-in-fact, conservator or guardian and, if found in the registry, assign that person to the case record. If the CE or FAB staff person determines that a legal instrument designates an unregistered person to act on behalf of the claimant, they are to input into ECS the contact information for that individual. ECS requires a manager to validate the accuracy of any new attorney-in-fact, conservator or guardian added to ECS.

In those situations where the CE or FAB staff person determines that the legal authority of a person to act on behalf of a claimant is limited to a particular function that does not allow for engagement on the DEEOIC claim, he or she sends a letter to the claimant. The letter is to communicate what the concern(s) are regarding the appointment and is to specify what communication between the DEEOIC and the attorney-in-fact (or court-appointed representative) will and/or will not occur. In those situations where the CE or FAB staff person is unsure of the authority granted to a person to serve on behalf of a claimant or of the legal sufficiency of a document, he or she may consult with the Policy Branch for guidance.

a. Form EN-20. In any situation where a person other than the specified payee is signing Form EN-20, the CE must submit the documents purporting to grant such power for review by the SOL to ensure that they are valid under the applicable state law.

When preparing documents for review by the SOL, the referring CE or staff person is to include as part of the referral package, a routine or terminal memo for review by the SOL (Exhibit 12-2). The referring CE or staff person uploads the memo to OIS and also sends a notification via OIS to the designated NO staff person. Upon receiving the notification in OIS, the NO staff person verifies the information and refers a printed copy

of the POA package to SOL. Once SOL processes the POA and returns the copy to the NO staff person, the NO staff person bronzes the Solicitor's response into OIS, indexing the document(s) as Category "Adjudication Documents." The Subject is "SOL opinion." The Description is "POA review memo from SOL for (payee name)." The document is to be left in an Unreviewed status in OIS for identification by the assigned CE. The CE will also update ECS with the OIS Document Identification Number of the Solicitor's response verifying that someone is permitted to sign the EN-20 on behalf of a claimant.

It has been updated in v7.0 to:

5. <u>Authority of an Attorney-in-Fact or Legal Conservator/Guardian</u>. A power of attorney (POA) is a legal authorization that gives a designated person, named as an agent or attorney-in-fact, the power to act for the claimant with respect to the subjects described in the POA. There are other types of legal designations that permit an individual to act in the name of the claimant including conservators or guardianships. In any of these situations, a written legal instrument must exist that grants legal authority for someone to act on behalf of the claimant. The written instrument will include language that describes the specific authorities granted to the attorney-in-fact to act on behalf of another and can be different from one situation to another. An attorney-in-fact may possess broad or limited authority to make decisions about the claimant's property, finances, investments, or medical care. In some instances, the authority conveyed in a legal instrument identifying an attorney-in-fact may only be effective when the claimant is determined to be incapacitated and unable to care for himself or herself in a particular way as set out in the instrument. In other situations, the agent or attorney-in-fact may be required to sign documents for the claimant using specified language.

To maintain situational awareness of individuals named as attorneys-in-fact and their permitted authority, DEEOIC must document a CE's review of submitted legal instruments that allow an attorney-in-fact or other designated individuals to act on behalf of a claimant. The assigned CE will perform such assessments and is responsible for preparing an attorney-in-fact memorandum to file (Exhibit 12.2) that describes the extent of authority one or more attorneys-in-fact have to act on behalf of a claimant. With the receipt of subsequent submissions of legal instruments relating to an attorney-in-fact designation, the CE is to conduct a review to determine if a supplemental attorney-in-fact memorandum is required that updates the status of individuals with a capacity to act on behalf of a claimant.

a. When reviewing a legal instrument that communicates an authority for someone to act on behalf of a claimant, the CE conducts a comprehensive review of the case file to determine whether an attorney-in-fact review memorandum already exists. This review will occur upon receipt of a legal instrument that communicates that an individual has some level of authority to act on behalf of a claimant. The CE also needs to assess any newly transferred cases with pending adjudication actions to identify properly any individual that may serve as an

attorney-in-fact for a claimant. If a HR or MBE receives a legal instrument relating to the naming of an attorney-in-fact during the course of their case adjudication duties, the HR or MBE is to notify the assigned CE in OIS that a document has been received requiring attorney-in-fact review.

(1) Should the CE ascertain that an existing attorney-in-fact memorandum to file exists that describes accurately the individual's ability to act on behalf of the claimant, the CE ensures the incoming legal instrument is categorized in OIS as reviewed complete and indexed properly.

(2) In those situations where the CE determines that no prior attorney-in-fact memorandum is contained in the case file record, or if information identified by the CE requires an update to a previously completed attorney-in-fact file memorandum, the CE will draft an additional memorandum to file. The memorandum is to identify the name and contact information (if available) of any named attorney-in-fact possessing authority to act on behalf of a claimant. Additionally, for each named attorney-in-fact, the CE will describe concisely the extent of authority each attorney-in-fact has to serve on behalf of the claimant. In most instances, the CE will find that the attorney-in-fact either has broad authority to act on behalf of the claimant, or that their authority is limited in some manner to certain functions such as medical decision-making. Once the memorandum is completed, the CE is to upload a signed, dated copy of the memorandum to OIS that the CE is to index as "Other Documents, POA." In the document index note field, the CE includes a standard phrase, "POA Scope of Authority."

An attorney-in-fact with authority to act on behalf of a claimant is not necessarily the equivalent of a properly designated AR and might not be entitled to case file copies. In those situations, even with the identification of an attorney-in-fact, the only individuals entitled to engage with DEEOIC for matters relating to claim adjudication may be the claimant or his or her designated AR. An exception exists for a claimant with an attorney-in-fact who has broad authority to act on behalf of the claimant in connection with his or her litigation, property, or with claims for government benefits. Under that scenario, the attorney-in-fact should be considered the designated AR and will be the primary point of contact for any claim adjudication business and will be entitled to any and all aspects of the case file as if he or she were the claimant.

(3) When the CE determines that the legal authority of a person to act on behalf of a claimant is limited to a particular function that does not allow for engagement on the DEEOIC claim, he or she sends a letter to the claimant. The letter is to communicate to the claimant the scope of authority the attorney-in-fact has to interact with DEEOIC. If the claimant disagrees with the CE's interpretation of the attorney-in-fact

authority to serve on their behalf, the CE will need to decide if further review is required including a referral to the Policy Branch for evaluation.

b. *Unless a POA exists that grants authority to an attorney-in-fact when the claimant is incapacitated and cannot handle their own affairs, the claimant retains the right to name a designated AR. An exception exists when either a guardian or conservator has been granted broad authority to act on behalf of the claimant due to the claimant's incapacitation to handle his or her own affairs by a court of competent probate jurisdiction. In these situations, the case file must contain a copy of the court order confirming the claimant's incapacitation which must also name a specific person to act on his or her behalf. The CE must determine if the guardian or conservator has the authority to make ALL decisions on behalf of, and act completely, in the stead of the claimant. In instances where the CE is unable to make that determination, the CE refers the matter to the Policy Branch for potential consultation with SOL. If it is determined the guardian or conservator possesses broad authority to act on behalf of an incapacitated claimant, then the guardian or conservator possesses the sole authority to designate another person as the AR to assist with claims adjudication functions. Any communications thereafter would be sent to that guardian or conservator and the designated AR (if any).*

c. *In any situation where a person other than the specified payee is signing the Form EN-20, the CE or a person designated by the district office to complete the referral must submit the documents purporting to grant such power for review by the SOL to ensure that they are valid under the applicable state law. The referrer prepares the POA referral package for SOL review. The referrer is to include in the referral package a completed Power of Attorney Memo to SOL (Exhibit 12-3). In addition to the Memo, the referrer is to include, a fully completed and signed EN-20, and a complete copy of the legal documents SOL must evaluate for legal sufficiency.*

The referrer should consolidate all documents into a single PDF and image the document into OIS. The referral package is indexed as Category: Adjudication Documents, Subject: SOL Opinion, Description: POA for SOL review. The document status is "Review Complete" in OIS. Notification in OIS is not needed.

The referrer must then send an email to zzOWCP-POA-PROCESSING@dol.gov confirming the POA referral. The referrer will attach the same image of the POA uploaded to OIS to the email and the email subject line should state clearly that the referral is Routine or Terminal. The referrer sets a reminder in ECS for follow-up after seven calendar days.

Time Frame: Within one hour of receipt for terminal claimants, the Policy Branch will send a reply to all parties in the email, advising of the receipt of the

POA and referral to SOL. Routine referrals require an email reply within 48 hours.

SOL will process the POA referral and email a copy of the opinion/decision to the appropriate parties. SOL will use the same email address as listed above (zzOWCP-POA-PROCESSING@dol.gov) to submit a copy of the completed referral. Upon receipt, the appropriate designee will scan and bronze the SOL response into OIS, indexing the document as Category: Adjudication Documents, Subject: SOL opinion, and Description: POA review memo from SOL for (payee name). The document status is "Unreviewed" in OIS.

The CE will review the document, mark as reviewed complete, and update ECS with the OIS Document Identification Number of the Solicitor's response verifying that someone is permitted to sign the EN-20 on behalf of a claimant.

- **Chapter 14 – Establishing Special Exposure Cohort Status**

  - Exhibit 14-1 has been updated to include EEOICPA Circular No. 21-03, Savannah River Site (SRS) Special Exposure Cohort (SEC) Class designation between October 1, 1972, and December 31, 1990.

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

  - Ch. 15.12a(2) has been modified to eliminate the need for supervisory signature/approval for Part E Causation/National Institute for Occupational Safety and Health (NIOSH) memorandum to file. This change also includes a new Exhibit 15-6, Toxic Development Complete Memorandum to File. The language in v6.0 previously read:

    (2) If the claim does not result in a positive outcome and the dose reconstruction has not been received, the CE completes a memo to file. The memo explains toxic development is complete but a decision cannot be issued until the dose reconstruction has been received so radiation exposure can be considered when issuing the decision. If the case involves multiple claimed conditions, the memo is not completed until all toxic development has been completed for all open conditions. This is important since the memo signifies no other development is required and no affirmative decisions can be issued based on the current evidence. Therefore, this memo is approved by the Supervisor or other office designee to confirm its appropriateness in the claim. The CE images the memo into OIS.

  It has been updated in v7.0 to:

    (2) If the claim does not result in a positive outcome and the dose reconstruction has not been received, the CE completes a memo (Exhibit 15.6) to file. The memo explains toxic development is complete, but a decision cannot be issued until the

dose reconstruction has been received so radiation exposure can be considered when issuing the decision. If the case involves multiple claimed conditions, the memo is not completed until all toxic development has been completed for all open conditions. This is important since the memo signifies no other development is required and no affirmative decisions can be issued based on the current evidence. The CE images the memo into OIS and enters the appropriate correspondence code into ECS.

- Exhibit 15-4 has been updated to include a new Section 8: COVID-19, which incorporates guidance previously provided in EEOICPA Bulletin No. 21-04 and EEOICPA Bulletin No. 22-02 for claims staff to presume that COVID-19 is a compensable consequential illness if certain presumptive criteria are satisfied. As such, the remaining sections of Exhibit 15-4 have been renumbered accordingly. The new language which makes up Section 8 reads:

  *8. **COVID-19**: This presumption allows for the acceptance of physician diagnosed COVID-19 as a consequential illness to a primary Part B occupational illness or Part E covered illness. Based on a list of underlying medical conditions that increase a person's risk of severe illness from COVID-19, compiled by the U.S. Centers for Disease Control and Prevention (CDC), DEEOIC accepts that COVID-19 is a consequence of any chronic health condition or risk factor that is identified by the CDC as being associated with severe COVID-19 disease when it follows or coincides with the onset of those conditions.*

  a. Upon receiving a claim for COVID-19, DEEOIC claims staff are to verify that the claimant has a previously accepted primary Part B or E illness that reasonably correlates to any disease the CDC has determined to be associated with severe COVID-19. The underlying medical conditions that increase a person's risk of severe illness from COVID-19 are listed on the CDC website.

  b. Once DEEOIC claims staff verify that the claimant has a previously accepted primary occupational or covered illness that reasonably correlates to one of the underlying medical conditions identified by the CDC as increasing the risk of severe COVID-19, COVID-19 is presumed to be a consequence of that primary condition. As such, COVID-19 may be accepted as consequential to that primary illness under Parts B and/or E. When COVID-19 is accepted as a consequential illness, the eligibility begin date is the date of diagnosis of COVID-19.

  c. If the claimant has not previously had an accepted primary occupational or covered illness that correlates with the conditions identified by the CDC as increasing the risk of severe COVID-19, no presumption may be made. Accordingly, the claim will require a well-rationalized and supported medical opinion from the claimant's physician or is to be

referred to a CMC for an opinion on the likelihood that COVID-19 is a consequence of the claimant's previously accepted primary illness.

- Exhibit 15-4, Section 9: Hearing Loss, has been updated to modify the employment requirements for hearing loss claims to create an alternate pathway for employees who did not work in a "qualifying" labor category. The language in v6.0 previously read:

*8. **Hearing Loss**: The Part E causation standard for hearing loss can be satisfied if the three following criteria (a, b and c) are satisfied:*

a. Medical: The file contains a diagnosis of bilateral sensorineural hearing loss (conductive hearing loss is not known to be linked to toxic substance exposure).

b. Employment: The verified covered employment must be within at least one specified job category listed below (or any combination thereof) for a period of 10 consecutive years, completed prior to 1990. The labor categories are the following:

- *Boilermaker*
- *Chemical Operator*
- *Chemist*
- *Electrician/Electrical Maintenance/Lineman*
- *Electroplater/Electroplating Technician*
- *Garage/Auto/Equipment Mechanic*
- *Guard/Security Officer/Security Patrol Officer (i.e., firearm cleaning activities)*
- *Instrument Mechanic/ Instrument Technician*
- *Janitor*
- *Laboratory Analyst/Aide*
- *Laboratory Technician/Technologist*
- *Lubricator*
- *Machinist*
- *Maintenance Mechanic*
- *Millwright*
- *Operator (most any industrial kind, the test being whether the operator position is one in which there is potential for solvent exposure)*
- *Painter*
- *Pipefitter*
- *Printer/Reproduction clerk*
- *Refrigeration Mechanic/HVAC Mechanic*
- *Sheet Metal Worker*
- *Utility Operator*

Employees often present evidence that they were in a labor category that is the "equivalent" of one of those listed here. When a claimant makes a claim that a job the employee performed is synonymous to one of the qualifying labor categories listed above, and a CE conducted SEM labor category alias search does not provide assistive information, the CE can seek assistance in evaluating the claim by taking one of two actions.

(1) Referral to the SEM mailbox. The SEM team has access to site documentation that can assist in making determinations of equivalency, ***or***

(2) Submission of an IH referral. After a review of the evidence submitted and through the use of their expert knowledge of industrial processes, an IH can opine whether jobs are equivalents.

In a case in which a finding of equivalency is established, DEEOIC staff may not use a finding in one case as a generalization for use in other claims, because of the variability of job tasks and labor categories across the DOE complex during the history of atomic weapons production.

c. Exposure: Evidence in the file must not only establish that the employee worked within a certain job category listed above, but that the employee was concurrently exposed to at least one of the specified organic solvents listed below:

- *Carbon Disulfide*
- *Ethyl Benzene*
- *Methyl Ethyl Ketone*
- *Methyl Isobutyl Ketone*
- *N-hexane*
- *Styrene*
- *Toluene*
- *Trichloroethylene*
- *Xylene*

In addition to thoroughly reviewing records from the case file to establish such exposure, the CE can also use SEM to identify the employee's potential exposure to one or more of the listed toxic substances during employment in one of the qualifying labor categories (prior to 1990). The CE must carefully screen the evidence to apply appropriate SEM search filters that correlate to the employee's work history, including labor category, work process or site/area filters. With a well-designed SEM search that correlates to the employee's work history in a qualifying labor category, any identified potential exposure to one of the noted toxins above is sufficient for the CE to accept for application in the hearing loss standard. The CE must make a similar finding separately for each labor category in which the employee worked for the continuous 10-year period prior to 1990. When necessary, the CE may also consult with a DEEOIC Industrial Hygienist to

obtain assistance in determining if the evidence establishes the employee's exposure to one or more of the necessary toxic substances.

d. Challenges to the DEEOIC Standard. This standard described in this section represents the sole evidentiary basis a CE is to use in making a decision concerning whether it is "at least as likely as not" that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateral sensorineural hearing loss. Claims filed for hearing loss that do not satisfy the standard outlined in this section cannot be accepted, because it represents the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance. As is usual for all claims, the CE is to undertake development on any hearing loss claim that does not meet the criteria described in this procedure, which entails communicating to the claimant the evidence necessary to meet the standard (medical+employment+exposure). As part of that development, the CE is to notify the claimant of his or her ability to challenge the scientific underpinnings of the DEEOIC hearing loss standard.

If the claimant wants to challenge one or more of the criteria of the standard, the claimant has the burden of establishing, through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data. If a claimant seeks to argue that the standard is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. At a minimum, the claimant must produce epidemiological evidence (medical health science journals, articles, periodicals or other peer-reviewed publications) that specifically identifies or references a toxic substance, as defined by DEEOIC's regulations, which the evidence describes as having a health effect of bilateral sensorineural hearing loss. If the entire published article(s) are not provided, then the citation(s) must include: Journal Name, Author Last Name, Year Article Published, Title of Article, Volume (#) and Pages (#-#). Upon receipt of such evidence, the CE may refer the matter to the National Office Medical Health Science Unit for evaluation. The CE does not need to refer to the National Office cases where claim submissions do not present evidence that satisfies the minimal standard for consideration.

It has been updated in v7.0 to:

*9. **Hearing Loss**: Hearing loss is established as a covered illness under Part E, because epidemiological evidence establishes that 10 consecutive years of exposure to specific organic solvents combined with consistent concurrent exposure to noise above 85 decibels can have a bilateral sensorineural hearing loss health effect. By regulations, DEEOIC cannot recognize noise as a toxic substance. As such, hearing loss induced solely by noise is not a covered illness. However, epidemiological evidence indicates*

that humans with combined exposure to solvents and noise have greater incidences of hearing loss than would be expected as compared to people who had exposures only to solvents or only to noise (but not both). Therefore, an additive effect occurs in the case of combined exposure to noise and solvents, which allows for hearing loss to arise potentially from a toxic substance exposure. Under this circumstance, hearing loss may be considered a covered illness.

In alignment with epidemiological data, for hearing loss to be considered a covered illness, the evidence must satisfy the following three criteria:

a. *Medical: A qualified physician has diagnosed bilateral sensorineural hearing loss (conductive hearing loss is not known to be linked to toxic substance exposure).*

b. *Exposure: Evidence must document that the employee had potential exposure to one or more of the following toxic substances for at least 10 consecutive years of verified employment:*

- *Carbon Disulfide*
- *Ethyl Benzene*
- *Methyl Ethyl Ketone*
- *Methyl Isobutyl Ketone*
- *N-hexane*
- *Styrene*
- *Toluene*
- *Trichloroethylene*
- *Xylene*

In addition to thoroughly reviewing records from the case file to establish such exposure, the CE can also use SEM to identify the employee's potential exposure to the listed toxic substances. The CE must carefully screen the evidence to apply appropriate SEM search filters that correlate to the employee's work history, including labor category, work process or site/area filters. With a well-designed SEM search that correlates to the employee's work history, an identified potential exposure to one of the noted toxins above is sufficient to proceed with further examination of the hearing loss claim. When necessary, the CE may also consult with a DEEOIC IH to obtain assistance in determining if the evidence establishes the employee's exposure to one or more of the necessary toxic substances.

c. *Employment: The employee meets one of two employment criteria:*

(1) *The 10 consecutive years of verified covered employment with potential exposure to a qualifying toxic substance must be completed prior to 1990, and also must be within at least one specified job category listed below (or any combination thereof) that DEEOIC accepts as having consistent exposure to noise in excess of 85 decibels.*

- *Boilermaker*
- *Chemical Operator*
- *Chemist*
- *Electrician/Electrical Maintenance/Lineman*
- *Electroplater/Electroplating Technician*
- *Garage/Auto/Equipment Mechanic*
- *Guard/Security Officer/Security Patrol Officer (i.e., firearm cleaning activities)*
- *Instrument Mechanic/ Instrument Technician*
- *Janitor*
- *Laboratory Analyst/Aide*
- *Laboratory Technician/Technologist*
- *Lubricator*
- *Machinist*
- *Maintenance Mechanic*
- *Millwright*
- *Operator (most any industrial kind, the test being whether the operator position is one in which there is potential for solvent exposure)*
- *Painter*
- *Pipefitter*
- *Printer/Reproduction clerk*
- *Refrigeration Mechanic/HVAC Mechanic*
- *Sheet Metal Worker*
- *Utility Operator*

Employees often present evidence that they were in a labor category that is the "equivalent" of one of those listed here. When a claimant makes a claim that a job the employee performed is synonymous to one of the qualifying labor categories listed above, and a CE conducted SEM labor category alias search does not provide assistive information, the CE can seek assistance in evaluating the claim by taking one of two actions.

(a) Referral to the SEM mailbox. The SEM team has access to site documentation that can assist in making determinations of equivalency, or

(b) Submission of an IH referral. After a review of the evidence submitted and using their expert knowledge of industrial processes, an IH can opine whether jobs are equivalents.

In a case in which a finding of labor category equivalency is established, DEEOIC staff may not use a finding in one case as a

generalization for use in other claims, because of the variability of job tasks and labor categories across the DOE complex during the history of atomic weapons production.

(2) Upon review of the available case evidence, if the CE determines that the evidence establishes that the employee had any 10-year period of consecutive (applies to any time period and any labor category) employment during which the employee had exposure to a qualifying toxic substance, the CE refers the claim to an IH who will apply their subject matter expertise to decide whether the employee concurrently had consistent daily exposure to noise of at least 85 decibels.

d. <u>Challenges to the DEEOIC Hearing Loss Standard</u>. This standard described in this section is the sole evidentiary basis a CE is to use in deciding whether it is "at least as likely as not" that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateral sensorineural hearing loss. Claims filed for hearing loss that do not satisfy the standard outlined in this section cannot be accepted, because it represents the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance. As is usual for all claims, the CE is to undertake development on any hearing loss claim that does not meet the criteria described in this procedure, which entails communicating to the claimant the evidence necessary to meet the standard (medical/exposure/employment). As part of that development, the CE is to notify the claimant of his or her ability to challenge the scientific underpinnings of the DEEOIC hearing loss standard.

If the claimant wants to challenge one or more of the criteria of the standard, the claimant has the burden of establishing, through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data. If a claimant seeks to argue that the standard is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. At a minimum, the claimant must produce epidemiological evidence (medical health science journals, articles, periodicals, or other peer-reviewed publications) that specifically identifies or references a toxic substance, as defined by DEEOIC's regulations, which the evidence describes as having a health effect of bilateral sensorineural hearing loss. If the entire published article(s) are not provided, then the citation(s) must include: Journal Name, Author Last Name, Year Article Published, Title of Article, Volume (#) and Pages (#-#). Upon receipt of such evidence, the CE may refer the matter to the National

Office MHSU for evaluation. The CE does not need to refer to the National Office cases where claim submissions do not present evidence that satisfies the minimal standard for consideration.

- **Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions**

  - Ch. 18.12c-d has been edited to remove the reference to assumed exposure, and make the distinction that it is the CE's role to make a factual finding of exposure that a physician must then judge as sufficient to meet the criterion for establishing a covered illness under Part E. The language in v6.0 previously read:

    c. Silicosis Employment and Exposure Criteria, Part E. Silica exposure in the performance of duty is assumed if the employee was present at a DOE or RECA Section 5 facility where silica is known to have been present. There are no required number of days of employment under Part E. The initial occupational exposure to silica dust needs to precede the onset of silicosis by at least 10 years. However, there are instances where an employee's initial occupational exposure to silica dust can be great enough to result in the onset of silicosis prior to 10 years. Therefore, the CE reviews the employment evidence and weighs the exposure evidence, accordingly, when making causation determinations.

    The provisions regarding separate treatment for chronic silicosis set forth in §7384r of the Act for Part B do not apply to Part E. Therefore, for purposes of evaluating the employee's Part E claim for silicosis, the element of causation is not presumed unless it was determined that the employee was entitled to compensation under Part B for silicosis (see §7385s-4(a)) or the Secretary of Energy has made a positive determination of causation (see §7385s-4(b)). In all other cases of claimed silicosis under Part E, the employment and exposure criteria applicable to all other claimed illnesses under Part E shall also apply to silicosis claims; that is, the employee must have been a DOE contractor employee and it must be "at least as likely as not" that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the employee's silicosis and it must be "at least as likely as not" that the exposure to such toxic substance was related to employment at a DOE facility.

    Silicosis is a nonmalignant respiratory disease covered under RECA Section 5. Therefore, for purposes of evaluating the Part E silicosis claim of a uranium employee covered under Section 5 of RECA, the DOJ verifies covered employment, and the CE makes the causation determination under §7385s-4(c) as to whether the employee contracted silicosis through exposure to a toxic substance at a Section 5 mine or mill.

    (1) Exceptions – Acute, Accelerated, and Complicated Silicosis. The extreme nature, function, or duration of exposure can trigger various forms of silicosis. The CE determines whether or not the employee's occupation entailed such exposure that the disease manifested into an acute,

accelerated, or complicated form due to such exposure. These forms of silicosis are not covered under Part B, but are covered under Part E based upon the CE's review of the totality of the evidence.

(2) Employment and Exposure Evidence. The CE obtains evidence of employment and exposure from various sources. The DOJ verifies employment for RECA Section 5 claimants. The CE obtains other evidence from DAR records, DOE FWP records, SEM, employment records, OHQ findings, affidavits, and from the claimant.

d. Medical Evidence, Part E. A physician's written diagnosis and date of initial onset is required to establish silicosis. When there is insufficient evidence of exposure, diagnostic testing, and/or diagnosis, the CE requests additional information from the claimant and affords the claimant sufficient time to respond.

Where no diagnosis exists, but the required employment element is met and evidence of a lung disease is presented, the CE requests additional medical evidence to establish the diagnosis of silicosis from either the claimant and/or the treating physician, or makes a referral to a CMC if the requested evidence is not the CMC opinion and the evidence of file to make a factual determination as to the diagnosis and/or causation.

It has been updated in v7.0 to:

c. Silicosis Employment and Exposure Criteria, Part E. The provisions regarding separate treatment for chronic silicosis set forth in §7384r of the Act for Part B do not apply to Part E. For purposes of evaluating the employee's Part E claim for silicosis, the element of causation is not presumed unless it was determined that the employee is entitled to compensation under Part B for silicosis (see §7385s-4(a)) or the Secretary of Energy has made a positive determination of causation (see §7385s-4(b)).

In claim situations in which the Part B requirements for establishing silicosis do not apply to Part E, the CE is to proceed with the normal procedure for Part E claim adjudication, including making a finding that the employee is a qualified DOE contractor or subcontractor employee with potential exposure to silica. The CE's finding of potential exposure is established with a careful examination of relevant case evidence including information communicated in the DAR records, DOE FWP records, SEM, employment records, OHQ, affidavits, and claimant written submissions. Once the potential exposure to silica is established, the CE may refer the case to an Industrial Hygienist to obtain a characterization of the level, extent, and frequency of silica exposure.

d. Medical Evidence, Part E. Silicosis is a nonmalignant respiratory disease which can be diagnosed with different characterizations including references to the nature of the disease as acute, accelerated, chronic and complicated. As with

any other Part E illness, the medical evidence must contain a written medical diagnosis for silicosis including the date of its initial onset. A written diagnosis for silicosis should be based on a qualified physician's interpretation of available clinical or diagnostic evidence. In the absence of a silicosis diagnosis, the CE is to undertake development to obtain such evidence from the claimant or their physician; or refer the matter to a CMC.

To establish whether diagnosed silicosis is a covered illness under Part E, absent the acceptance of the claim for the illness under Part B or the application of any Part E causation presumption that the program publishes, the CE must obtain a medical opinion from a qualified physician that documents that it is "at least as likely as not" that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the employee's silicosis and it must be "at least as likely as not" that the exposure to such toxic substance was related to employment at a DOE facility. The CE is to permit the claimant the opportunity to obtain such evidence from a physician of their choosing before taking any action to refer the matter to a CMC. The CE must weigh any physician opinion received to determine if it is well-rationalized as defined in program procedure.

- **Chapter 23 – Consequential Conditions**

  - Ch. 23.10a has been modified to remove the requirement that letter decisions contain signatures of both the CE and another management official. The language in v6.0 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. 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.

It has been updated in v7.0 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. 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.

- Exhibit 23-2, Sample Letter Decision, has been updated to better exemplify the basic formatting requirements for decisions issued by the DEEOIC.

- **Chapter 24 – Recommended Decisions**

  - Ch. 24.7a has been edited to introduce a new Exhibit 24-1: Uniform Formatting Guidelines for Decision Writing, which provides guidance on applying formatting standards for decisions issued by the DEEOIC. The language in v6.0 previously read:

    a. Written Decision. The written decision is comprised of an introductory statement, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.

  It has been updated in v7.0 to:

    a. Written Decision. The written decision is comprised of an introductory statement, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 provides uniform formatting guidelines for decision writing. Exhibit 24-2 provides a sample RD format.

  - Ch. 24.7a(5) has been edited to ensure format consistency of recommended decisions. The language in v6.0 previously read:

    (5) Signatory Line. The signature line must include the name and title of the person who prepared the recommendation and the name and title of the person who reviewed and certified the decision, when applicable. When a decision is certified by a SCE or CES, this means that the reviewer has assessed the overall accuracy and readability of the decision to ensure quality.

It has been updated in v7.0 to:

> *(5) Signature Block. The signature block must include the name, job title, and the location and office of the person who prepared the recommendation.*

- Exhibit 24-2, Sample Recommended Decision Format, has been incorporated to reflect the basic formatting requirements for decisions issued by the DEEOIC.

- Exhibit 24-3, Sample Recommended Decision, Deny, (v6.0) has been removed.

- Based on the changes to the exhibits listed above, the remaining exhibits of Chapter 24 have been renumbered accordingly.

- **Chapter 26 – FAB Decisions**

  - Ch. 26.2 has been edited to ensure format consistency of FAB Decisions. The language in v6.0 previously read:

    > *2. <u>FDs</u>. The FAB HR reviews all evidence of record and the RD. Based upon that review, the FAB HR issues an independent written decision addressing the appropriateness of the RD outcome. A FD 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 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 FD, the FAB HR makes findings of fact and conclusions of law that support his or her position.*

  It has been updated in v7.0 to:

  > *2. <u>FDs</u>. The FAB HR reviews all evidence of record and the RD. Based upon that review, the FAB HR issues an independent written decision addressing the appropriateness of the RD outcome. FAB follows the same uniform formatting guidelines as the RD (which are outlined in Exhibit 24-1). A FD 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 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 FD, the FAB HR makes findings of fact and conclusions of law that support his or her position.*

  - Ch. 26.3a has been edited to incorporate language regarding new exhibits to Chapter 26. Specifically, Exhibit 26-1, Sample Final Decision Cover Letter; Exhibit 26-2, Sample

Final Decision Format; and Exhibit 26-3: Sample Certificate of Service. The language in v6.0 previously read:

a. Three Components. The FAB representative must prepare three components before issuing a FD (a sample of a complete FD is shown as Exhibit 26-1):

(1) A cover letter explaining that a FD has been reached. The cover letter must clearly identify what is being accepted, denied and/or deferred, 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 Notice of Final Decision (Introduction), Statement of the Case, Findings of Fact and Conclusions of Law.

(3) Certificates of Service certify that each listed claimant and his or her AR 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 AR 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 26-2); and/or (2) two Acceptance of Payment forms (EN-20), which is required before payment can be issued.

It has been updated in v7.0 to:

a. Three Components. The FAB representative must prepare three components before issuing a FD.

(1) A cover letter explaining that a FD has been reached. The cover letter must clearly identify what is being accepted, denied and/or deferred, and under what Part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant. Exhibit 26-1 provides a sample FD cover letter.

(2) The FD. The FD contains a Notice of Final Decision (Introduction), Statement of the Case, Findings of Fact and Conclusions of Law. Exhibit 26-2 provides a sample FD format.

(3) Certificates of Service certify that each listed claimant and his or her AR 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 AR may appear on the same certificate of service. Exhibit 26-3 provides a sample 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 26-4); and/or (2) two Acceptance of Payment forms (EN-20), which is required before payment can be issued.

- Exhibit 26-1, Sample Final Decision Cover Letter, has been updated to include language regarding the EN-20 electronic submission process.

- Exhibit 26-2, Sample Final Decision Format, has been updated to better exemplify the basic formatting requirements for decisions issued by the DEEOIC.

- Exhibit 26-3, Sample Certificate of Service, has been added.

- Based on the incorporation of the exhibits listed above, the remaining exhibits of Chapter 26 have been renumbered accordingly.

- **Chapter 29 – Ancillary Medical Benefits**

  - Ch. 29.5 has been added to include language regarding DEEOIC's marijuana reimbursement policy. This language previously existed at Ch. 29.20 (v5.0) and was inadvertently removed. It has been placed at Ch. 29.5n, and reads:

    n. Marijuana Reimbursement Policy. All products that contain any amount of tetrahydrocannabinol (THC), an active ingredient of marijuana, are considered schedule I controlled substances by the U.S. Drug Enforcement Administration (DEA) and are therefore not eligible for payment/reimbursement. State laws authorizing the use of Schedule I drugs, such as marijuana, even when characterized as medicine, are contrary to Federal Law. The Controlled Substances Act (Title 21 United States Code 801 et al.) designates Schedule I drugs as having no currently accepted medical use and there are criminal penalties associated with production, distribution, and possession of these drugs.

  - Ch. 29.7b(2) has been edited to expressly note that Medical Benefits Examiners (MBEs) writing recommended decisions are to follow guidance about the drafting and format of recommended decisions provided in Chapter 24 – Recommended Decisions (with the exception of specifying whether the benefit is being awarded under Part B or Part E of the Act). The language in v6.0 previously read:

    (2) RDs. If the claimant submits a written request for a RD in response to the denial of a requested AMB, the MBE completes the RD process in accordance with existing DEEOIC procedures, making sure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.

It has been updated in v7.0 to:

> *(2) RDs. If the claimant submits a written request for a RD in response to the denial of a requested AMB, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (with the exception of the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The author is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.*

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

  - Ch. 30.9 has been edited to expressly note that Medical Benefits Examiners (MBEs) writing recommended decisions are to follow guidance about the drafting and format of recommended decisions provided in Chapter 24 – Recommended Decisions. The language in v6.0 previously read:

    > *9. Issuing Recommended Decisions to Deny or Reduce Authorized HRHC. A recommended denial of authorization occurs when the MBE identifies a deficiency in the medical evidence and after the MBE has taken appropriate development steps, as described in this chapter. A RD to deny is only appropriate under certain circumstances:*
    >
    > *a. Denial of a claim for initial HRHC in its entirety. Where the medical evidence for an initial claim does not support an authorization for any of the claimed HRHC, the MBE issues a RD to deny authorization.*
    >
    > *b. A reduction of previously authorized HRHC. For either an ongoing, or renewing authorization for HRHC, should the evidence support an authorization at a level, frequency, or duration of care that is less than previously authorized by the MBE, a RD is necessary. Under this circumstance, the MBE issues a recommendation explaining the evidence that warrants a reduction in the level, frequency, or duration of HRHC previously authorized. Within the recommendation, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the FAB determines whether to finalize the RD.*

  It has been updated in v7.0 to:

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

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

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

When issuing a RD in these circumstances, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (with the exception of the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The author is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.

- **Chapter 31 – Tort Action and Election of Remedies**

  - Ch. 31.3e has been updated to clarify that a Form EN-16 response is applicable for six months unless there is a new exposure or illness (including consequential) being accepted. The language in v6.0 previously read:

    e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the lawsuit/SWC/fraud statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant had submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

  It has been updated in v7.0 to:

    e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regard to the lawsuit/SWC/fraud statement. As such, it is not necessary to request this information more often than once in a six-month period, unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant

had submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

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

  - Ch. 32.6e has been updated to clarify that a Form EN-16 response is applicable for six months unless there is a new exposure or illness (including consequential) being accepted. The language in v6.0 previously read:

    e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the lawsuit/SWC/fraud statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant had submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

  It has been updated in v7.0 to:

    e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regard to the lawsuit/SWC/fraud statement. As such, it is not necessary to request this information more often than once in a six-month period, unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant had submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

- **Chapter 36 – Debt Liquidation**

  - Ch. 36.10 has been modified to provide new guidance regarding the recovery of a debt from a deceased claimant's estate. The language in v6.0 previously read:

    10. Recovery From Deceased Claimant's Estate. If the claimant dies before the debt is recovered, the PA reviews the case file to obtain information about the estate. Prompt action is essential because creditors who have not properly asserted a claim before the estate is closed may be precluded from any recovery. The PA follows the procedures outlines in Chapter 35 – Overpayment Process to recover the debt from the estate. The PA takes action to recover both established and newly discovered debts from an estate. However, once the estate is closed and the proceeds distributed, the PA must terminate collection efforts, as no other recourse exists to collect the debt. The PA prepares a

memorandum to the file describing the situation and the outstanding debt is noted as unrecoverable. The PA terminates the debt in the overpayment database.

It has been updated in v7.0 to:

10. Debt Recovery After Claimant Death. If the claimant dies before an established debt is fully recovered, the CE responsible for the case will prepare a memorandum to the Policy Branch explaining that an outstanding debt exists for which the claimant is responsible for repayment. The CE will then refer the memo to the Policy Branch requesting a review of the matter for a determination of possible debt recovery. Upon receipt, the case will be assigned to a PA who is to determine if there is any information supporting the existence of an estate established to manage the assets and liabilities of the deceased claimant.

In the absence of any credible information identifying an open estate or evidence that the claimant's estate has been settled previously, the PA prepares a memorandum to the file for signature by the Policy Branch Chief, or designee, documenting that the claimant has no estate and that there is no legal mechanism for debt recovery. The PA will then administratively close any debt collection activity and upload the completed memorandum to the OIS case file. Where evidence of an active estate exists, the PA will consult with SOL to determine if there is a legal basis for attempting recovery of an outstanding debt. Depending on the outcome of such consultation, the PA will then proceed with attempted recovery of the debt or prepare a memorandum to file, for the signature of the Policy Branch Chief or designee, explaining the lack of justification for an attempt to recover the outstanding debt.

RACHEL POND Digitally signed by RACHEL POND
Date: 2022.10.20 14:15:34 -04'00'

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