U.S. Department of Labor

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

RELEASE - PART 3-0700 Post-Award Administration, FEDERAL (EEOICPA) PROCEDURE MANUAL

EEOICPA TRANSMITTAL NO. 09-09 September, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part E Procedure Manual (PM) E-1000 State Workers' Compensation. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

- This material provides instructions to Claims Examiners (CEs) for use in Part E cases that have been approved for benefits.

- This material describes the actions taken by the National Office (NO) to ensure that payment of medical benefits to covered Part E employees is fully coordinated with any state workers' compensation benefits received by those employees or their survivors.

Rachel P. Leiton

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Director, Division of
Energy Employees Occupational Illness Compensation

FILING INSTRUCTIONS:

File this transmittal behind Part 2 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

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

TABLE OF CONTENTS

1. Purpose and Scope. This chapter outlines the actions Claims Examiners (CE) take on Part E cases after a claim has been approved for benefits. This chapter also describes the procedures used by the National Office (NO) to ensure that payment of medical benefits to covered Part E employees is fully coordinated with any state workers' compensation benefits received by those employees or their survivors.

2. Authority. Section 7385s-11(a) requires that compensation to an individual under Part E be coordinated with state workers' compensation benefits, other than medical benefits and benefits for vocational rehabilitation, that the individual has received for the same covered illness. The Director of DEEOIC has been delegated the authority to request information from state workers' compensation authorities concerning state workers' compensation benefits that covered Part E employees receive.

3. Claims Examiner Responsibilities. The CE sends a Form EE-12 letter, accompanied by Form EN-12 enclosure (Exhibit 1), to each covered Part E employee who receives medical benefits under Part E for a covered illness. These forms are sent on the one-year anniversary of the latest award of any type of Part E benefits, and every year thereafter in which the employee continues to receive medical benefits. The employee must complete and return the EN-12 questionnaire within 30 days.

If the employee has not responded after 30 days, the CE attempts to verify the employee's contact information in the case file and send another Form EE/EN-12 and provide the employee with an additional 30 days to in which to respond.

Upon receipt of a completed Form EN-12 from an employee, the CE reviews the employee's responses and takes the appropriate action as noted below.

a. Change of Address. If the employee lists a new address or telephone number, the CE notes the new information in the case file. The CE also ensures that the new contact information is reflected in the ECMS.

b. Treatment Concerns. If the employee identifies concerns about the treatment that he or she is receiving for a covered illness, the CE acknowledges these concerns by letter and advises that they are being referred to the appropriate person for further action.

3. Claims Examiner Responsibilities. (Continued)

c. Additional Impairment or Wage Loss. If the employee indicates that he or she wishes to claim additional Part E compensation due to increased permanent impairment as a result of an accepted covered illness, or additional compensation for another calendar year of qualifying wage-loss, the CE follows established procedures for facilitating these claims.

d. State Workers' Compensation. If the employee indicates that he or she has filed for or received state workers' compensation benefits after the receipt of an award of Part E benefits, the CE ensures that all of the information requested concerning the state workers' compensation benefits filed for or received has been provided.

e. Tort Awards or Settlements. If the employee indicates that, since receiving an award of benefits under Part E, he or she has received a tort award or settlement (other than for a claim for workers' compensation) in connection with a lawsuit alleging exposure to a toxic substance for which the Part E award was received, the CE ensures that all of the information requested concerning the tort award or settlement has been provided.

4. National Office Responsibilities. At the beginning of each fiscal year, the NO Fiscal Officer sends a Form EN-13 information request (Exhibit 2) to each state's workers' compensation authority advising of the requirement under EEOICPA that any state workers' compensation benefits received by a covered Part E employee for an accepted covered illness must be coordinated with Part E benefits received for that same illness, and requesting information about workers' compensation benefits paid to employees who have been awarded Part E benefits.

Upon receipt from the states, the NO Fiscal Officer sends copies of the information gained to each District Office Fiscal Officer for comparison against the information contained in the claims files for listed individuals.

a. Initial Requests. Form EE-13 lists employees who worked at DOE facilities in the state in question whose claims for compensation under Part E were accepted during

4. National Office Responsibilities. (Continued)

the 12 months preceding issuance of the Form EE-13. For each employee, the list contains the following information:

(1) Name(s) of the claimant(s);

(2) Whether the claimant is the employee or the employee's survivor;

(3) Social Security number of the employee;

(4) Employee's accepted medical condition; and

(5) Date the claimant's eligibility for Part E benefits began.

For each employee listed, the state agency is asked to provide information about state workers' compensation claim(s) that have been filed on behalf of the same worker, including the name(s) of the claimant(s), whether the claim was accepted, and if so, the medical condition accepted and the effective date of the award.

b. Subsequent Requests. Form EE-13 also contains a second list of employees for whom information has already been requested by a prior Form EE-13. For each employee on the second list, the state agency will be asked to indicate whether any information provided in response to the initial request has changed.

FORM EE-12 LETTER ENCLOSING EN-12 QUESTIONNAIRE

Dear Claimant Name:

The information requested in the attached enclosure is required in connection with your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. § 7384 *et seq*. This information will be used to ensure that we have current contact information for you, and to verify that you are eligible to continue receiving medical or other benefits for your accepted conditions as shown above. The form also provides you with an opportunity to provide us with any concerns regarding your current medical treatment for your accepted conditions, and in some cases, to initiate review of potential additional impairment or wage-loss benefits.

Please completely answer all questions and return the enclosure within 30 days of the date of this letter. Pub. L. 100-503 provides that the statements on the enclosure and other information in your claim file may be verified through computer matches. OWCP may also request that you submit additional factual evidence to support your statements, if needed.

READ ALL INSTRUCTIONS CAREFULLY BEFORE FILLING OUT THE ENCLOSURE. YOU MUST ANSWER ALL OF THE QUESTIONS. IF THE QUESTION DOES NOT APPLY TO YOUR CLAIM, STATE “NOT APPLICABLE (N/A)” OR “NONE.”

If you need more space to fully answer any of the questions, use another sheet of paper with your name and claim number at the top. Sign and date each extra sheet.

When you have completed the enclosure, **sign it and return it to the address shown at the top of this letter**. Your signature certifies that you have supplied all information requested by the enclosure. If you have any questions about completing the enclosure, call me at (111) 222-3333 or write to me at the above address.

Sincerely,

Claims Examiner

Enclosure: EN-12
OMB No. 1215-0197 EE-12 Page 1
Expiration Date: February 2008

NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, OWCP, Room S3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to complete this form unless it displays a currently valid OMB number.

File Number: Claimant:

SECTION A – CURRENT CONTACT INFORMATION

If you have moved or have a different mailing address from the one shown at the top of the first page of the accompanying letter, provide the current information in the space provided below. (Do not complete if the information is correct). Also, please provide a current telephone number.

Name:_____
Address:_____
City and State:_____
Zip Code:_____
Telephone Number:_____

SECTION B – CURRENT MEDICAL CONDITION

Do you have any concerns regarding treatment for your accepted medical conditions as shown on the letter that accompanied this form?
Yes or No: _____

If yes, please describe your concerns:
_____
_____
_____
_____

Do you wish to claim additional compensation for impairment due to your accepted condition? Yes or No: _____

Do you wish to claim additional compensation for wage-loss? (Wage-loss benefits are payable only if the wages were lost prior to your regular Social Security retirement age.) Yes or No: _____

Would you like for your claims examiner to contact you by telephone regarding your concerns? Yes or No: _____

File Number: Claimant:

SECTION C – STATE WORKERS' COMPENSATION

1. Have you filed for and/or received any state workers' compensation for your accepted condition(s) since you were awarded EEOICPA benefits? Yes or No: _____

2. If you answered "Yes," please tell us the following information:

Date of filing:_____
State in which you filed:_____
Name of employer, insurer or state that paid:_____
Amount of monetary benefits received: $_____
Type of benefits (disability, impairment, etc.):_____

List the same information for any other state workers' compensation received after being awarded EEOICPA benefits on an extra sheet.

SECTION D – TORT AWARDS OR SETTLEMENTS

1. Since you were awarded EEOICPA benefits, have you received any settlement or award from a claim or tort suit (other than a claim for workers' compensation) against a third party in connection with an exposure to a toxic substance for which you received EEOICPA benefits? Yes or No: _____

2. If you answered "Yes," please tell us the following information:

Date of award or settlement:_____
Party or parties involved:_____
Type of suit or settlement:_____
Amount of award or settlement: $_____

List any other tort awards or settlements below or on an extra sheet.

SECTION E – CERTIFICATION

I know that anyone who fraudulently conceals or fails to report information that would have an effect on benefits, or who makes a false statement or misrepresentation of a material fact in claiming a payment or benefit under the Energy Employees Occupational Illness Compensation Program Act may be subject to criminal prosecution, from which a fine and/or imprisonment may result.

I understand that I must immediately report to OWCP any state workers' compensation benefits or tort awards/settlements I receive.

I certify that all the statements made in response to questions on this enclosure are true, complete and correct to the best of my knowledge and belief. I have placed "Not Applicable (N/A)" or "None" next to those questions that do not apply to me or my claim.

_____

Signature Date

Date Telephone number

STATE WORKERS' COMPENSATION AGENCY
STREET ADDRESS
CITY, STATE ZIP CODE

The information requested in the attachments is required in connection with claims for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. § 7384 *et seq*. Section § 7385s-11 of the EEOICPA provides for coordination of benefits with respect to state workers' compensation as follows:

> (a) IN GENERAL.—An individual who has been awarded compensation under this part, and who has also received benefits from a State workers' compensation system by reason of the same covered illness, shall receive compensation specified in this part reduced by the amount of any workers' compensation benefits, other than medical benefits and benefits for vocational rehabilitation, that the individual has received under the State workers' compensation system by reason of the covered illness, after deducting the reasonable costs, as determined by the Secretary, of obtaining those benefits under the State workers' compensation system.
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> * * *
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> (c) INFORMATION.—Notwithstanding any other provision of law, each State workers' compensation authority shall, upon request of the Secretary, provide to the Secretary on a quarterly basis information concerning workers' compensation benefits received by any covered DOE contractor employee entitled to compensation or benefits under this part, which shall include the name, Social Security number, and nature and amount of workers' compensation benefits for each such employee for which the request was made.

The first attached list contains the names of employees who worked at facilities in your state on whose behalf a claim under

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Part E of EEOICPA has been accepted during the last year. The second list contains the names of employees for whom we have made a previous inquiry. For each employee, we have listed the name(s) of the claimant(s), whether the claimant is the employee or a survivor, the Social Security Number of the employee, the accepted medical condition, and the date eligibility began. For each entry on the first list, please indicate whether or not a state workers' compensation claim has been filed on behalf of that same worker, the name(s) of the claimant, and whether the claim has been accepted, and if accepted, the accepted medical condition, the effective date of the award, and the amount of the award. For each entry on the second list, please indicate whether there has been any change since the last time information was provided.

If you have questions about this request, please contact XXXXXXX XXXXXXXX at (111) 222-3333.

Thank you for your assistance.

Sincerely,

Director
Director, Division of Energy Employees
Occupational Illness Compensation

Enclosure: EN-13

NOTICE TO RECIPIENT

Public reporting burden for this collection of information is estimated to average 16 hours per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, OWCP, Room S3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to complete this form unless it displays a currently valid OMB number.

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Employee Name Claimant Name E or S Employee SSN Accepted Condition Effective Date

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