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 - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1600 RECOMMENDED DECISIONS.

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EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Procedure Manual (PM) Chapter 2-1600, Recommended Decisions.

Incorporates changes that have arisen since last publication of PM Chapter 2-1600, Recommended Decisions; including the following:

- This material clarifies the administrative closure procedures.
- This material has been revised to clarify the handling of claims involving non-filing survivors and non-responsive claimants
- Provides additional guidance on the issuance of multiple claimant Recommended Decisions
- Updates instructions regarding the content and format of a Recommended Decision; eliminating the "Findings of Fact" section and replacing it with "Explanation of Findings"
- Gives additional instruction on issuance of Letter Decisions
- Provides guidance in certain special circumstances; such as issuing Recommended Decisions:
    - When aggregate lump-sum compensation has been attained

- o When an employee dies prior to claim adjudication
- o Addressing prior overpayments

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FILING INSTRUCTIONS:

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

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

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1. Purpose and Scope. The District Office (DO) issues Recommended Decisions for claims filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). A Recommended Decision is a written decision made by the Claims Examiner (CE) regarding the eligibility of a claimant to receive compensation benefits available under the EEOICPA. As a recommendation, it does not represent the final program determination on claim compensability. It is a preliminary determination made by the program that is subject to challenge by any claimant party to the decision, and ultimately must undergo independent action by the Final Adjudication Branch (FAB). This chapter describes the procedures for issuing a Recommended Decision.

2. Authority. 20 C.F.R. § 30.300 grants the DO authority to make determinations with regard to compensability and issue Recommended Decisions with respect to EEOICPA claims. Under this section, the DO is authorized to recommend the acceptance or denial of a claim for benefits under the EEOICPA. All Recommended Decisions are forwarded to the FAB for review.

3. When a Recommended Decision is Required. A Recommended Decision is required in situations where a claimant seeks an entitlement benefit provided for under either Part B or E of the EEOICPA. Entitlement benefits include medical benefits under Part B and/or E; lump-sum compensation under Part B; impairment or wage-loss awards under Part E; and lump-sum survivor compensation under Part E. In certain situations, as explained later, exceptions to this guidance apply to decisions involving new cancer claims after a prior finding of Probability of Causation (PoC) of 50% or greater, consequential illnesses, or approval or denial for medical procedures, equipment or other medically indicated necessities.

Claims made under Part B or E of the EEOICPA can involve multifaceted elements, filed at varying points in time, involving a multitude of medical conditions, or periodic claims for monetary lump-sum benefits, i.e. recurring wage-loss and impairment. The question of when a case element is in posture to be decided and a Recommended Decision issued is dependent on several factors that the CE must consider. First, the CE must identify the parties seeking

benefits, i.e., employee vs. survivor claims. This includes individuals who have filed claims or potential claimants who have not filed, but may be eligible. Secondly, the actual claimed entitlement benefit for which a decision is required must be identified. In some instances, there may be multiple benefits being sought under Part B and/or E, especially if more than one illness is being claimed.

Based on examination of the evidence of record, development must then be completed to overcome any defect in the case evidence that does not satisfy the eligibility criteria for a claimed benefit. Once development has occurred, the CE then performs an examination of the case evidence to determine if it is sufficient to accept or deny a claim for benefit entitlement.

a. When a Claim is Submitted. Documents containing words of claim are acceptable to begin the adjudication process and set the effective date for the date of filing; however, the CE is to obtain the applicable claim form before issuing a Recommended Decision. The CE notifies the claimant of the need to submit the required form. A period of 30 days is to be allotted for the claimant to submit the required documentation. If the appropriate form is not forthcoming, the CE administratively closes the claim. Notice should be provided to the claimant that no further action will be taken on their claim until such time as the proper claim form is submitted.

(1) The CE has the discretion to conclude that a new claim actually has been previously addressed in a prior determination under the EEOICPA. For example, a claim for "lung disease" is filed and denied lacking any diagnosed condition. Subsequent filing is made for "lung problems." While the exact wording of the claimed condition is dissimilar, the nature of the claim is the same and, in this situation, would not require new adjudication, unless the claimant provides evidence of a more specific diagnosis.

Additionally, no Recommended Decision is needed if a newly claimed condition has been previously

addressed by a Final Decision. In such instances, the claimant should be notified that the condition has previously been decided and no further action will be taken without a request from the claimant to reopen the claim.

b. On the Initiative of the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC). Upon the issuance of a Director's Order, the DO may be instructed to issue a new Recommended Decision to address new evidence.

c. At the Request of a Claimant. The claimant may request a Recommended Decision be issued either after or in lieu of a letter decision. This may occur in any of the situations discussed later in this chapter where a letter decision is permitted.

d. Administrative Closures. Several situations exist that require administrative closure of a claim without the issuance of a Recommended Decision. For example, situations where an administrative closure is necessary include the death of a claimant, failure to complete the OCAS-1, withdrawal of claim prior to the issuance of a Final Decision, and lack of response to a request for information regarding State Workers' Compensation or Tort payments. When the circumstances of the case lead to an administrative closure, a Recommended Decision is not required for the affected claimant. Instead, when appropriate, the DO issues a letter to the claimant and/or his or her representative advising of the administrative closure, and the steps required to reactivate the claim.

(1) When multiple claimants have filed for benefits and an administrative closure is required for one or more individual claim(s), the CE proceeds with the adjudication of the remaining active claims. The decision will describe the basis for any administrative closure, and the persons whose claims were closed will not be a party to the Recommended Decision. If at a later date, the administrative closure ends and development resumes, any Final Decision that deferred action on an administratively

closed claim will need to be vacated to allow for a new decision to all individuals named in the case record.

4. Who Receives a Recommended Decision. Each individual who files a claim under a case, and has not had their claim administratively closed, is required to be a party to a Recommended Decision that decides a benefit entitlement.

Given the variant benefit filings that may exist in a single case, the CE may divide benefit entitlement claims to be addressed by separate Recommended Decisions. This will occur when one or more entitlement benefit claims can be decided based on the evidence of record, while concurrent development is required on outstanding claimed components. For example, separate decisions may be issued awarding medical benefits for a cancer under Part E, and a subsequent decision issued for any impairment linked to that cancer.

a. Multiple Claimant Recommended Decisions. All claimants who have filed a claim under Parts B and/or E, and have not had their claim administratively closed, are to be parties to any Recommended Decision deciding a benefit entitlement. This is necessary to ensure that any decision comprehensively addresses the entitlement for all claimants with an interest in the claim. Each claimant is provided with the information necessary to understand the outcome for all claims. Moreover, it grants all claimants equal opportunity to present objections, should they disagree with any particular aspect of the decision. A CE should not issue a Recommended Decision determining any single individual claimant's eligibility to receive benefits in a multiple person claim, except in the circumstance of a newly filing ineligible survivor.

(1) Once a Final Decision is issued, should a new individual subsequently file a claim seeking benefits, the CE will undertake normal development to determine the claimant's eligibility to benefits. Should the new claimant be deemed ineligible, a recommended denial of benefits that addresses his or her individual claim may be issued without reopening the

previously decided claims. However, if the circumstances of the case develop to the point where a newly filing claimant may be eligible for benefits, it will be necessary to reopen all previously decided claims to allow for a new combined Recommended Decision.

b. Discretionary Authority in the Decision Process. The CE employs appropriate discretion to decide the most effective course to bring timely resolution to all entitlement claims. Particular attention should be directed at benefit entitlement determinations that will result in a positive outcome. In these situations, the CE is not to delay the issuance of a Recommended Decision, even if other benefit entitlements may exist that require development. For example, two survivors of an employee file for lump sum compensation under Parts B and E. Development is undertaken and both are found to be eligible to a Part B benefit of $150,000 because the employee had lung cancer related to covered employment. However, under Part E, only one of the survivors has submitted evidence to establish that he or she was under the age of 18 at the time of the employee's death. The other survivor indicates he or she is having problems obtaining school transcripts to show full-time student status. In this situation, the CE proceeds to issue a decision on the benefit entitlement of both claimants under Part B, but would defer any decision on the Part E claim.

c. Non-Filing Survivors. The situation may arise where a potentially eligible survivor has been identified through development, but whose whereabouts are unknown or who does not wish to seek benefits. This includes situations where a survivor specifically notifies the CE that he or she does not wish to pursue benefits or states that he or she is clearly ineligible and will not file a claim. Under these circumstances, it is not possible for the CE to include them as party to a Recommended Decision. The CE may proceed with the issuance of the Recommended Decision to the remaining claimants; however, the decision must reference the fact that there is a

potentially eligible survivor who has not filed a claim.

(1) In the situation where the non-filing survivor's eligibility to benefits cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-filing survivor is eligible. The potential survivor's share of compensation is held in abeyance until a claim is filed, evidence is received establishing the survivor's status as ineligible, or notice of his or her death is received. Should the CE obtain evidence establishing that the non-filing survivor is clearly ineligible or deceased, any payable compensation being held in abeyance can be allocated among the remaining survivor(s).

(2) When non-filing survivors have been advised of the requirement for establishing eligibility and have communicated to the CE that they will not file as they consider themselves ineligible, the CE attempts to obtain a signed, written statement confirming the survivors' ineligible status. If written confirmation can not be obtained, the CE must be clearly document that the survivor intends not to file. Under this circumstance, unless the CE has reason to doubt the accuracy of the survivor's ineligibility; the fact that there is a non-filing, ineligible, survivor is to be noted in the decision. However, the non-filing survivor is not to be named, but addressed as a non-filing survivor. The non-filing survivor is not a party to the decision and no money is held in abeyance.

(3) Development involving a non-filing survivor should not extend past a reasonable period, as to significantly delay the issuance of a Recommended Decision to other claiming survivors. The CE should make a reasonable effort to obtain either a claim form or written confirmation of the non-filing survivor's status. In most situations, the CE should allow 30 days to provide requested documentation. When there is no response to a

request for information within an allowable time frame, the CE may proceed with the adjudication of the claim based on the evidence present in the case record and the procedural guidance provided on handling non-filing. However, the non-filing survivor will be excluded as a party to the case. The administrative closure of the claim is to be noted in the decision, and the non-filing claimant is to be presumed eligible. As such, compensation is held in abeyance until such time as the CE obtains the properly completed claim form.

(4) Once a Recommended Decision has been issued that involves a non-filing survivor, if the survivor later decides to file a claim form, it will be necessary to issue a new Recommended Decision. Should development result in the claimant being found ineligible, a Recommended Decision is permitted to be issued solely to the new claimant denying his or her claim. Under this circumstance, a reopening of any prior claims is unnecessary, because the denial has no effect on the previously decided claims. Alternatively, if the claimant is eligible to a benefit, a reopening of all previously decided claims is required to enable the issuance of a new Recommended Decision to all individuals who are party to the claim.

d. Non-Responsive Claimants. In situations in which a claim is filed and the claimant subsequently becomes unresponsive, reasonable steps should be taken to obtain confirmation of the non-responsive claimant's status. However, development should not extend past a reasonable period. In most situations, the CE should allow 30 days to provide the requested documentation. When there is no response within an allowable time frame, the CE may proceed with adjudication of the claim and issuance of a Recommended Decision based on the evidence present in the case record.

(1) In the situation where the non-responsive claimant is a party to a multiple survivor claim, and the non-responsive survivor's eligibility

cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-responsive survivor is eligible; and his or her share of compensation is held in abeyance until such a time evidence is received establishing the survivor's eligibility. In such cases, the non-responsive claimant must be a party to the Recommended Decision. Should the CE obtain evidence establishing that the non-responsive survivor is clearly ineligible or deceased, any payable compensation being held in abeyance can then be allocated among the remaining survivor(s).

5. Writing a Recommended Decision. When the CE has completed development to allow for a decision involving an entitlement benefit, the CE issues a Recommended Decision. The decision either recommends acceptance or denial of entitlement benefits in accordance with the legal criteria set out under the EEOICPA. Any outstanding, unadjudicated claims are deferred.

Any decision issued must be well-written, use appropriate language to clearly communicate information, and address all the facets of the evidence that led to the conclusion, including evidence the claimant submitted. Particular attention should be directed at any denial of benefits. With a denial, the CE is to provide a robust, descriptive explanation of the specific reason(s) why the evidence fails to satisfy the eligibility requirements of the EEOICPA and any interpretive analysis the CE relied upon to justify the decision. Moreover, the discussion should address the actions taken to assist with the development of the case.

a. Use Simple Words and Short Sentences. Avoid technical terms and bureaucratic "jargon", and explain the first time any abbreviation is used in the text.

b. Use the Active Rather than the Passive Voice. For example, the decision is to read "We received the medical report" rather than "The medical report was received."

c. Divide Lengthy Discussions into Short Paragraphs. The progression of the text is to follow a logical and chronological pattern.

d. Confine the Discussion to Relevant Issues. These are the issues before the CE that need to be resolved. It may be necessary to state an issue is pending, but there is no need to discuss it in detail.

e. Address All Matters Raised by the Claimant. This includes any issue or medical condition relevant to the decision, whether raised in the initial report of the claim or during adjudication. Make certain to address all claimed conditions (accepted, denied or deferred) in the discussion and conclusion. If the CE recommends acceptance of a covered condition, and the claimant has also claimed other conditions that are not covered, the non-covered conditions are to be denied. The CE will also recommend denial of claimed conditions in survivor claims that have previously reached the maximum allowable benefit entitlement and no further compensation is payable.

f. Mailing Addresses. The decision must be addressed to each claimant who has filed a claim, and his or her authorized representative. This ensures that each person who has filed a claim receives official notification of the decision and is granted the opportunity to object, should he or she disagree with any aspect of the conclusions.

6. Content and Format. A Recommended Decision is comprised of a cover letter, a written decision, a waiver, and an information sheet provided to a claimant explaining his or her right to challenge the recommendation. The CE is responsible for preparing the Recommended Decision and all its component parts. The format and content of a Recommended Decision is as follows:

a. Cover Letter. A cover letter summarizes the recommendation(s) of the DO to accept, deny or defer claimed benefit entitlement(s) under Part B, Part E or both. It advises that the accompanying decision is a recommendation and that the case file has been forwarded to the FAB for review and the issuance of a

Final Decision; listing the address of the FAB office where the case file is to be forwarded. Further, the cover letter advises the claimant of his or her right to waive any objection or to file objections within 60 days of the date of the Recommended Decision. Finally, if the decision was made using the opinion of a District Medical Consultant (DMC), the cover letter must advise the claimant that the DMC report is available for review upon request.

A separate cover letter is addressed to each individual party to the claim. In some instances, it may be necessary to tailor or individualize each cover letter to the specific circumstances affecting the claimant addressed. Exhibit 1 provides a sample cover letter.

b. Written Decision. The written decision is comprised of an Introduction, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 2 provides a sample Recommended Decision which includes each component discussed below.

(1) Introduction. This portion of a Recommended Decision succinctly summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E. An example of introductory language is provided in the sample cover letter as part of Exhibit 2.

(2) Statement of the Case. The Statement of the Case is a clear, chronological, and concise narrative of the factual evidence leading up to the Recommended Decision. It describes the steps taken by the CE to develop evidence, the outcome of any development, and any other relevant factual information derived from examination of the case records. The Statement of the Case should not be overly technical covering every minute detail of the case evidence, nor should it include interpretation of the evidence; as this is to be covered in the "Explanation of Findings" outlined below. Essentially, the Statement of the Case tells the story of the case leading up to

the present decision and includes basic information such as:

(a) Name of the claimant or survivor, name of employee, and when the claim was filed;

(b) Benefit(s) the claimant is seeking. In the case of a survivor claim, the relationship of the claimant to the employee and documentation submitted in support of the relationship, if any;

(c) Claimed employment and evidence submitted to establish covered employment, if any;

(d) Claimed medical condition and medical evidence submitted to establish a diagnosed illness;

(e) In a recommended acceptance, pertinent issues may include specific medical documents received from the claimant or other sources which confirm the diagnosis of the claimed condition, and evidence establishing the claimed employment and exposure. Also, searches conducted in the Site Exposure Matrices (SEM), Occupational History Questionnaires (OHQ), records from the Former Worker Program, and Document Acquisition Request (DAR) records are important.

In a recommended denial, the CE discusses, particularly in relation to the denied element, what evidence was needed, how the DO advised the claimant of the deficiencies, any assistance provided to overcome a defect, and the claimant's response.

(3) Explanation of Findings. This section of the Recommended Decision explains the CE's analysis of the case evidence used to arrive at the various factual findings necessary to substantiate a conclusion on benefit entitlement.

It should be labeled as "Explanation of Findings."

The CE follows a logical and sequential presentation of findings and explains how the evidence does or does not meet the legal, regulatory or procedural guidelines of DEEOIC claim adjudication. In this manner, the CE communicates to the claimant the reason(s) for claim acceptance or denial; and upon which FAB will independently assess appropriateness. A Recommended Decision lacking a comprehensive and rationalized explanation of findings increases the likelihood that a claimant will not understand the outcome of the claim adjudication and increases the potential for a remand by FAB.

Given the various types of benefit entitlements for which a claim may be made, the content of this section will vary depending on the context of the matter under review. However, the CE must communicate information pertinent to the issue under determination in a logical, comprehensive manner. For example, the logical presentation of findings for a new Part E claim for causation will follow this general order - diagnosis, employment, relation to employee (in survivor claims), exposure, and causation. However, a different presentation of findings may be needed depending on the circumstances of the claim; such as with impairment, where the presentation of findings would follow a different order - accepted condition, evaluation for impairment, and outcome of evaluation with award or denial of impairment benefit.

Given the disparate types of evidence that may exist in a claim record, there may be instances where the discussion is based exclusively on the presentation of undisputed evidence that clearly affirms findings leading to a conclusion. In other instances there will be a need to use inference or extrapolation to support a finding. In either situation, the CE is to provide a compelling argument as to how the evidence is

interpreted to support the various findings leading to acceptance or denial of a benefit entitlement. The assessment will rest on various factors; such as the probative value of documentation, relevance to the issue under contention, weight of medical opinion, or the reliability of testimony, affidavits, or other circumstantial evidence. It is within the discretion of the CE to decide the appropriate level of narrative required to justify a particular position.

Within the context of decision analysis, the CE is to maintain a claimant-oriented perspective. This can be defined as decisions made within the scope of the law that has the effect or potential to produce a positive benefit to the claimant(s).

(a) Contested Factual Items and Other Claim Disputes. Written analysis is particularly important when reaching judgment on a claim issue that differs from the position of the claimant or has negative consequences to the claim. The CE is to identify the difference, clearly note the decision made, and the evidence or argument that supports such a decision. This is frequently the case where there is disagreement over medical diagnosis, dates or location of employment, health effects of toxic exposure, interpretation of program procedure, or medical opinion on causation. In any instance where a dispute involves a decision based on the weight of medical evidence, the CE is to completely describe the weighing methodology in support of the chosen medical opinion.

(b) Complex subject matter and other complicated evidentiary situations. Evidence presented in support of DEEOIC claims can often be open to a variety of interpretations, especially in situations involving complicated subject matter or in situations where evidence is vague.

Whenever a CE is presented with a situation involving a complex set of issues for which a finding is necessary; e.g. establishing intermittent covered employment at multiple facilities, it is essential that the CE provide sufficient explanation as to how he or she chose to apply the evidence in arriving at a finding. Simply making a factual statement in these situations without providing the underlying rationale for making such a finding will not suffice.

(c) Mathematical Calculations. In any decision involving a mathematical calculation, the CE must fully explain the figures used to arrive at the finding listed. Situations where calculations need to be described include: impairment or wage-loss, division of benefits between multiple claimants or Part B vs. Part E claims, aggregated work days for SEC classes, latency periods for diseases, and offsets for State Worker's Compensation or tort settlements.

(d) Application of Written Program Policy, Regulations, Procedure or case precedent. A CE may have to explain the use of policy guidance from various program resources in support of a decision being made in a claim. In these situations, the CE must clearly reference the resource being used, and if necessary, make a specific citation or reference. The program policy must pertain to the issue at hand and the CE must explain how it provides guidance in resolving a particular claim issue.

(1) Case precedent. A CE is permitted to use only those case decisions that are specifically authorized and recognized as setting precedent. These can be found on the DEEOIC main web page and are updated periodically. It is not appropriate for a CE to

generalize information or findings from a non-precedent setting case to address a separate case under review.

(4) Conclusions of Law. A conclusion of law is a determination as to how the law is applied to the accepted facts in a case to arrive at a determination of eligibility. The CE's conclusion either accepts or rejects the claim in its entirety, or it may address a portion of the claim presented. In a section headed "Conclusions of Law," the CE lists the critical conclusions rendered to determine whether the claimant is legally entitled to benefits under the EEOICPA.

(a) The CE cites the relevant sections of the EEOICPA or its governing regulations that support the offered conclusion. The citations must be accurate and specific to the issues addressed. The CE must employ appropriate discretion to limit citations to that which is most pertinent to the situation at hand and avoid repetitious or redundant legal references.

(b) When the conclusion is to accept a claim, the CE must include a reference to the legal provisions permitting a positive determination. This may include provisions pertaining to the qualification of the claimant to receive benefits (employee or survivor), covered or occupational illness, qualifying employment, establishment of causation by SEC membership, PoC, or linkage to toxic substance exposure, and the amount of payable lump-sum compensation or award of medical benefits.

(c) In a conclusion that results in a denial of benefits, the CE is to identify the claimed condition, benefit being denied and the specific legal criteria that the evidence of record does not satisfy. In any

denial of benefits, the CE is not to state the lump-sum amount to be denied.

(6) Signatory Line. The signature line must include the name, title, and signature of the person who prepared the recommendation and the name, title, and signature of the person who reviewed and certified the decision, when applicable.

(7) Notice of Recommended Decision and Claimant's Rights. Provides information about the claimant's right to file specific objections to the Recommended Decision and to request either a review of the written record or an oral hearing before the FAB. A sample Notice of Recommended Decision and Claimant's Rights is included as part of Exhibit 2.

(8) Waiver of Rights. A waiver form is sent with each Recommended Decision and is to include the last four digits of the file number, name of the employee, name of the claimant, and the date of the decision in the upper right hand corner. The claimant may waive his or her right to a hearing or review of the written record and request that the FAB issue a Final Decision. In this instance, the claimant is required to sign a waiver and return it to the FAB. Exhibit 3 contains a sample Waiver.

(a) Bifurcated Waivers. In many instances, the DO accepts one element of a claim and denies another, all within one Recommended Decision. It is therefore possible for a claimant to waive the right to object to the acceptance portion of the decision and file an objection regarding the denied portion of the same decision. A claimant has 60 days from the date the Recommended Decision is issued to file an objection, and may waive this right at any time.

Exhibit 4 provides a sample Bifurcated Waiver of Rights for a partial

acceptance/partial denial. Option 1 allows the claimant to waive the right to object to the benefits awarded but reserve the right to object to the findings of fact or conclusions of law. Option 2 allows the claimant to waive the rights to object to all findings and conclusions.

7. Types of Recommended Decisions. Due to the wide variety of possible benefit entitlements available under Part B and Part E, various claim elements may be in different stages of development and adjudication at any given time. Following are examples of several types of Recommended Decisions that may be necessary:

a. Acceptance. Where the entire case can be accepted and no outstanding claim elements [e.g., wage-loss, impairment, additional claimed illness, or a cancer claim pending dose reconstruction at the National Institute for Occupational Safety and Health (NIOSH)] need further development, the CE issues a Recommended Decision to accept in full. The acceptance addresses all the elements that have been claimed.

b. Denial. If after all development is complete and all elements are in posture for denial, the CE issues a Recommended Decision recommending denial on a claim as a whole. The CE waits until every element of a claim has been developed, if possible, before issuing a denial.

(1) Addressing all claimed elements. The CE must be alert to the various adjudicatory issues in the case and clearly identify each element being denied.

(2) Where no objection is pending at the FAB, the CE develops all claim elements in posture for denial and, whenever possible, issues one comprehensive decision denying all possible claims for benefits under the EEOICPA as a whole. If other portions require further development, a partial denial/partial develop decision may also be necessary.

c. Partial Accept/Partial Deny. If the CE determines that no further development is necessary on a case file and concludes that some claim elements should be recommended for acceptance and some for denial, the CE issues a Recommended Decision that clearly sets forth those recommendations. The claimant is provided with a notice of his or her rights and a bifurcated wavier; which provides the claimant the opportunity to contest only the portion of his or her claim which was recommended for denial, or waive his or her right to object to the decision as a whole (see Exhibit 4).

For instance, if an illness that can be covered under both Part B and Part E of the EEOICPA (cancer, beryllium illness, chronic silicosis) is claimed and meets the evidentiary requirements only under Part E but not under Part B, (or vice versa) the CE states that the Part E benefits are being accepted and the Part B benefits are being denied.

(1) Example. A claimant files a claim for chronic beryllium disease (CBD) and submits medical evidence that contains a medical diagnosis of CBD that is sufficient to meet the Part E causation burden, but not the statutory criteria under Part B; the CE issues a Recommended Decision awarding benefits under Part E and denying benefits under Part B. In the denial under Part B, the CE should clearly explain what evidence was lacking and why the case is being denied. The CE clearly delineates the benefits being awarded and denied under Part B and Part E.

d. Partial Accept/Partial Develop. When a claim element is fully developed and ready for acceptance, but other elements remain for further development (e.g., wage-loss, impairment, another claimed illness, or a cancer pending dose reconstruction at NIOSH), the CE issues a Recommended Decision accepting the claimed illness and specifies all associated benefits awarded under the EEOICPA as a whole. With regard to other claim elements requiring further development, in the Recommended Decision the CE advises that these

elements are deferred until they are fully developed and adjudication is possible. Partial adjudication of a claim should be avoided whenever possible. In any instance where a part of a claim is deferred, it is the CE's responsibility to ensure that action is ultimately taken to address the outstanding claim by way of a Recommended Decision or administrative closure, when appropriate. Development for a deferred claim may be required by the assigned CE2 unit while other components of the claim are addressed by FAB.

e. Partial Accept/Partial Deny/Partial Develop. If one portion of the claim is in posture for acceptance and another portion is in posture for denial, while yet a third portion requires additional development, the CE addresses all claim elements in one comprehensive Recommended Decision. Where one or more claim elements are accepted and other elements are either denied or deferred for additional development, the CE must clearly outline the status of each element that is accepted, denied and deferred. The claimant is provided with a notice of his or her rights and a bifurcated waiver.

8. Decision Issuance. After preparing a Recommended Decision, the CE routes the decision and case file to the appropriate signatory for review, signature, date, and release.

a. Clearing the Recommended Decisions for Release. The appropriate signatory reviews all Recommended Decisions. Requests for medical treatment, equipment/supplies, and surgery requests are reviewed by the CE. Medical bill processing is discussed further in Chapter 3-0200.

(1) Deficiency Identified. If the appropriate signatory discovers a deficiency or other problem, the Recommended Decision is returned to the CE with a detailed explanation of why the decision is not in posture for release. When the appropriate signatory has provided comments or has extensively edited the Recommended Decision, the CE is to revise the decision accordingly.

(2) Decision Approved. If the signatory agrees with the decision, he or she signs and dates the Recommended Decision. The date shown on the Recommended Decision must be the actual date on which the decision is mailed.

b. Mailing the Recommended Decision. The signed and dated Recommended Decision is mailed to the claimant's last known address, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative will be considered notification to both parties.

(1) A copy of the Recommended Decision is filed in the case record.

(2) See Chapters 2-2000 and 2-2100 for coding instructions.

c. Forwarding the Case. Within the appropriate timeframe, the CE sends the case record to the appropriate FAB office.

9. Letter Decisions. In certain situations, an entitlement determination can be addressed in a simple letter to the claimant. If a CE makes a decision in this format, the CE merely needs to communicate the nature of the claim that was made, evaluate the evidence supporting the outcome and the conclusion. A formal Recommended Decision is not necessary, unless the claimant submits a written request for one or objects to a letter decision. Circumstances where a letter decision is permitted include:

a. Approval of additional claims for medical benefits for cancer:

(1) Once a PoC value has been calculated at 50% or greater and a Final Decision accepting the cancer has been issued, any subsequent new claim for cancer related to the same organ system will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

(2) Once a Final Decision accepting a specified cancer under an SEC class has been issued, any subsequent new claim for a specified cancer will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

b. Consequential illness acceptance.

c. Acceptance or denial of medical care or treatment, including home health care.

d. Acceptance or denial of durable medical equipment or housing/vehicle modification.

e. Alternative filing determination (see survivorship Chapter 2-1200 for further guidance)

10. Special Circumstances. As noted previously, there are disparate issues that confront the CE during the process of making a Recommended Decision. This section provides guidance in certain unique situations that the CE may encounter.

a. Cases Where the Maximum Aggregate Lump Sum Compensation Has Been Attained. The maximum lump sum compensation payable under Part B is $150,000 and $250,000 under Part E. Once the maximum aggregate compensation has been awarded, claims for any new medical condition(s) are to be addressed for medical benefit coverage only. Under Part E, once the maximum lump sum figure has been reached, any new claim for impairment or wage-loss benefit is to be denied.

(1) If the employee dies after receiving the maximum lump sum compensation available to him or her, any subsequent claim by a survivor is to be denied as no additional compensation is payable. For guidance for Part E claims in which an employee dies subsequent to receiving a lump sum payment less than the maximum aggregate allowable, refer to Chapter 2-1200.

b. Death of Employee Prior to Claim Adjudication. In a scenario involving an employee who files for

benefits, but dies prior to claim adjudication, the CE administratively closes the claim and no Recommended Decision is issued. If a survivor claim is later presented, the CE is to proceed with claim adjudication based on the condition(s) claimed only by the survivor. In this scenario, the CE is not to resume development for conditions previously claimed by the employee. Instead, the CE is to contact the survivor to discuss any potential benefit that may be derived from filing a claim for a condition previously filed by the employee, but for which the survivor has not claimed, e.g., such as a potentially compensable condition that may have contributed to the death of the employee.

c. Issuing a Recommended Decision After the Maximum Aggregate Compensation Has Been Paid in a Part B or E Survivor Claim. Once the maximum available compensation has been awarded in a survivor claim, i.e., $150,000 under Part B or $175,000 under Part E, and a new survivor presents a valid claim, the CE is to develop the claim to determine the new survivor's eligibility. Should the survivor be deemed eligible, it will be necessary to vacate any prior decision to other survivors to allow for a new decision to all claimants. In the decision, the CE explains the circumstances of the new claim, the eligibility of the new survivor to receive benefits, and the reallocated award based on the number of qualifying survivors. The new survivor is awarded his or her share of payable compensation, regardless of the fact that the maximum payable compensation was previously paid. Once a Final Decision has been issued with regard to this matter, the CE takes action to assess any survivor in the case who has a potential overpayment.

d. Issuing a Recommended Decision When There is a Prior Overpayment. When there is an overpayment in a case, and the CE needs to issue a new Recommended Decision, the case file is to be transferred to the Policy & Procedures Unit at National Office **before** the Recommended Decision is issued. The National Office will send the claimant(s) an initial overpayment notice advising them of the overpayment. The claimant then has thirty (30) days to dispute the overpayment or request a

waiver. When a Final Decision on the overpayment is sent to the claimant(s), the case file will be returned to the DO for issuance of the Recommended Decision. The DO will be instructed on how to address the overpayment in the Recommended Decision.

Sample Cover Letter

Dear Claimant Name:

Enclosed is the Notice of Recommended Decision of the Jacksonville District Office concerning your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The district office recommends acceptance of your claim for skin cancer under both Part B and Part E of the EEOICPA, and recommends that you be awarded medical benefits, in addition to lump sum compensation in the amount of $150,000.00. The district office recommends that your Part B and Part E claims for fibromyalgia be denied. Finally, your claim for chronic obstructive pulmonary disease (COPD) is being deferred pending further development. **Please note that this is only a RECOMMENDATION; this is not a Final Decision**. We caution against making financial commitments based on the anticipated receipt of an award. The Recommended Decision has been forwarded to the Final Adjudication Branch (FAB) for their review and issuance of the Final Decision.

Please read the Notice of Recommended Decision and Claimant Rights carefully, as it recommends an acceptance of some benefits and denial of others. You have several choices. Consider your options carefully as your choice will affect your ability to raise objections, as well as the steps the FAB takes in issuing a Final Decision.

(**Insert this paragraph when the decision was made using a DMC report)** In arriving at this decision, the district office received the opinion of a District Medical Consultant (DMC) who reviewed all the medical records contained in your file and provided an opinion on your case. If you would like to review the DMC's report, please send a letter to the FAB at the address listed above asking for a copy. Your request should include your full name, file number, date of request, signature, that you are requesting the "DMC Report," and the address to which you want us to send the records

State Workers' Compensation: If you receive or have received any benefit (with the exception of medical benefits or vocational rehabilitation) from a state workers' compensation program for any of the same

conditions being recommended for acceptance in this decision under Part E, you must notify the FAB immediately. This includes any benefits received after the issuance of this Recommended Decision (***remove this paragraph if the decision is a denial or Part B decision)***.

Tort Actions: If anyone receives or has received any form of benefit (money, medical benefits, etc.) based on a lawsuit claiming that the employee was harmed from the same type of exposure (e.g. asbestos, radiation, beryllium, or any other toxic substance) upon which the EEOICPA claim is being recommended for acceptance in this decision, the FAB must be notified immediately. This includes any benefits received after the issuance of this Recommended Decision (***remove this paragraph if the decision is a denial)***.

Should you have any questions concerning the recommendation, you may call the FAB, toll free, at: (FAB Office telephone number)

Sincerely,

Claims Examiner

Sample Recommended Decision

EMPLOYEE: **Steven C. Smith**

CLAIMANT: **Steven C. Smith**

FILE NUMBER: **XXX-XX-1234**

NOTICE OF RECOMMENDED DECISION

This is a Recommended Decision of the Jacksonville District Office concerning your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). The district office recommends acceptance of your claim for skin cancer under both Part B and Part E of the EEOICPA. The district office further recommends that your claim for fibromyalgia be denied under both Part B and Part E of the Act. Finally, your Part E claim for chronic obstructive pulmonary disease (COPD) is being deferred pending further development.

STATEMENT OF THE CASE

On June 24, 2006, you filed a claim for benefits under Part B and Part E of the EEOICPA, alleging that you had developed skin cancer and fibromyalgia as a result of your employment at a Department of Energy (DOE) facility. On September 21, 2006, you amended your Part E claim to include the condition of COPD.

You stated that you worked as a scientist at the Savannah River Site (SRS) in Aiken, S.C., from September 1, 1974 through April 1, 2004. The Oak Ridge Institute for Science and Education (ORISE) and the DOE were able to confirm your employment at the SRS with E.I. DuPont from September 1, 1974 until June 1, 1989; and with Westinghouse from April 1, 1989 to February 28, 2004. Both E.I. DuPont and Westinghouse are known DOE contractors at the SRS, which is a covered DOE facility.

Additionally, you submitted medical evidence in support of your claims, including a pathology report dated November 27, 2001 which confirmed that you were diagnosed with basal cell carcinoma (BCC) of the left arm. Your diagnosis with fibromyalgia was established by a January 14, 2003 medical narrative signed by Dr. Joseph Stein. A series of chest x-rays and a Pulmonary Function Test performed in 2006 indicate that you have also been diagnosed with COPD.

On November 12, 2006, you participated in an occupational history interview in which you stated that you worked as a scientist at the SRS. You claimed that you were responsible for collecting and processing water and sediment samples, and that during the course of your employment, you collected materials that were contaminated with heavy metals and organic contaminate.

Under Part B, in order for a claim to be adjudicated, it must be forwarded to the National Institute for Occupational Safety and Health (NIOSH) to prepare a radiation dose reconstruction. Your case was forwarded to NIOSH, and on December 18, 2007, the district office received the "NIOSH Report of Dose Reconstruction", which provided the estimate of radiation dose related to your skin cancer. Using the NIOSH Interactive RadioEpidemiological Program (NIOSH-IREP), the district office calculated the probability that your skin cancer was related to exposure to radiation during your employment at the SRS. In this case, the probability of causation was calculated to be greater than 57.6%; which is higher than the 50% requirement for compensability.

With regard to your Part B claim for fibromyalgia, the district office issued a letter dated January 15, 2008 advising you that the condition was not an occupational illness compensable under Part B. It was explained that occupational illnesses under Part B only include chronic beryllium disease (CBD), beryllium sensitivity, chronic silicosis and radiogenic cancer. This letter also requested that you submit evidence to establish a causal link between occupational toxic substance exposure and fibromyalgia. However, no additional evidence was received.

To assist in the development of your fibromyalgia claim under Part E, the district office performed searches of the U. S. Department of Labor Site Exposure Matrices (SEM) to determine the toxic substances that you were potentially exposed to at the SRS. The SEM acts as a repository of information related to toxic substances potentially present at covered DOE sites and has information regarding site investigations and Haz-Map (Occupational Exposure to Hazardous Agents) to assist in evaluating causation. Based on the SEM search and review of all available evidence, the district office was unable to find a link between toxic exposure and fibromyalgia. Accordingly, a second letter dated February 20, 2008 was issued requesting you submit additional evidence to establish that toxic substances you were exposed to at the SRS are associated with the onset of fibromyalgia. To date, no such evidence has been received.

EXPLANATION OF FINDINGS

Based on the employment verification received from the DOE, it is accepted that you were a DOE contractor employee at the SRS with E.I. DuPont from September 1, 1974 until June 1, 1989; and with Westinghouse from April 1, 1989 to February 28, 2004. Medical evidence further establishes that you have been diagnosed with skin cancer, fibromyalgia and COPD.

With regard to the claim for skin cancer, as is explained in EEOICPA PM 2-0900:

> Under Part B, a covered employee seeking compensation for cancer, other than as a member of the SEC seeking compensation for a specified cancer, is eligible for compensation only if DOL determines that the cancer was "at least as likely as not" (that is, a 50% or greater probability) caused by radiation doses incurred in the performance of duty while working at a DOE facility and/or an Atomic Weapons Employer (AWE) facility.

In this case, the dose reconstruction performed by NIOSH was used to calculate a probability of causation finding of 57.6%. Therefore, it is accepted that your diagnosed skin cancer is a compensable Part B occupational illness.

With regard to your claim for skin cancer under Part E, PM 2-0900.19.a.1 provides guidance explaining that medical conditions approved under Part B are given a presumption of causation under Part E. As you were a DOE contractor employee, and your claim for skin cancer is found compensable under Part B, it is also accepted that you qualify for Part E benefits for that condition.

As is delineated under the EEOICPA, Part B coverage only extends to covered beryllium disease, cancer, and silicosis. Fibromyalgia is a systemic pain syndrome disorder and is not a compensable occupational illness under Part B, as it does not fall within one of the compensable disease categories. However, fibromyalgia is a claimable illness under Part E, as that part of the Act provides that any illness may be considered, as long as it results from work-related exposure to a toxic substance.

Regulations at 20 C.F.R. § 30.230 state that in order to meet the eligibility criteria under Part E, it must be established 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 illness.

Development was undertaken to ascertain whether fibromyalgia was scientifically known to be linked to exposure to a toxic substance. However, evidence reviewed in your case failed to show any established link between occupational exposure to a toxic substance and the onset of fibromyalgia. In addition, you were asked to supply any information in support of your claim; however, we did not receive any evidence to support your claim that this disorder is associated with your employment. Accordingly, there is insufficient probative evidence to establish that occupational exposure to a toxic substance caused, contributed to, or aggravated your diagnosed condition of fibromyalgia. Therefore, you are not eligible to receive benefits under Part E for this condition.

With regard to your claim for COPD, it is noted that development continues with regard to linking the illness to occupational toxic substance exposure. For this reason, no recommendation can be made with regard to the condition at this time and the matter is deferred.

Finally, as required by 20 C.F.R. § 30.505, the district office has confirmed that you have not filed for or received compensation or medical coverage in connection with the condition of skin cancer; have not filed for state workers' compensation benefits in connection with this condition; and that you have never pled guilty or been convicted of any charges in connection with an application for or receipt of federal or state workers' compensation.

CONCLUSIONS OF LAW

The employee is a covered DOE contractor employee with a covered illness under Part E, as those terms are defined in 42 U.S.C. § 7385s(1) and § 7385s(2). With regard to Part B, the employee is a covered DOE contractor with an occupational injury, as defined in 42 U.S.C. § 7384l(15).

It is recommended that your claim for benefits for the condition of skin cancer be accepted under both Part B and Part E of the Act, in accordance with 42 U.S.C. 7384 l (15) and 42 U.S.C. 7385s (2). As such, it is recommended that that you be awarded lump-sum compensation in the amount of $150,000.00 under Part B of the EEOICPA. Additionally, the district office recommends payment of medical benefits for this illness under Part B and Part E, commencing the date of filing, June 24, 2006.

The evidence of file fails to establish that toxic substance exposure "at least as likely as not" caused, contributed to, or aggravated your claimed illness of fibromyalgia, in accordance with 42 U.S.C. 7384 l (15) and 42 U.S.C. 7385s (2). As

such, the district office recommends that your claims for benefits for fibromyalgia be denied under both Part B and Part E of the Act.
Prepared by:

_____ _____

(Name of Appropriate Signatory) Date

Sample Notice of Recommended Decision and Claimant Rights

NOTICE OF RECOMMENDED DECISION AND CLAIMANT RIGHTS

The district office has issued the attached Recommended Decision on your claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This notice explains how to file objections to the Recommended Decision. This notice also explains what to do if you agree with the Recommended Decision and want the Final Adjudication Branch (FAB) to issue a Final Decision before the 60-day period to object has ended. Read the instructions contained in this notice carefully.

IF YOU WISH TO OBJECT TO THE RECOMMENDED DECISION:

If you disagree with all or part of the Recommended Decision, you MUST file your objections within sixty (60) days from the date of the Recommended Decision by writing to the FAB at:

U.S. Department of Labor, DEEOIC
Attn: Final Adjudication Branch
FAB Address
City, State ZIP
Fax #:

If you want an informal oral hearing on your objections, at which time you will be given the opportunity to present both oral testimony and written evidence in support of your claim, you MUST request a hearing when you file your objections. **If you have special needs (e.g., physical handicap, dates unavailable, driving limitations, etc.) relating to the scheduling (time and location) of the hearing, those needs must be identified in your letter to the FAB requesting a hearing.** In the absence of such a special need request, the FAB scheduler will schedule the hearing and you will be notified of the time and place. If you do not include a request for a hearing with your objections, the FAB will consider your objections through a review of the written record, which will also give you the opportunity to present written evidence in support of your claim. If you fail to file any objections to the Recommended Decision within the 60-day period, the

Recommended Decision may be affirmed by the FAB and your right to challenge it will be waived for all purposes.

IF YOU AGREE WITH THE RECOMMENDED DECISION:

If you agree with the Recommended Decision and wish for it to be affirmed in a Final Decision without change, you may submit a written statement waiving your right to object to it to the FAB at the above address. This action will allow the FAB to issue a Final Decision on your claim before the end of the 60-day period for filing objections. If you wish to object to only part of the Recommended Decision and waive any objections to the remaining parts of the decision, you may do so. In that situation, the FAB may issue a Final Decision affirming the parts of the Recommended Decision to which you do not object.

BE SURE TO PRINT YOUR NAME, FILE NUMBER AND DATE OF THE RECOMMENDED DECISION ON ANY CORRESPONDENCE SUBMITTED TO THE FAB.

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

Sample Waiver

File Number:
Employee:
Claimant:
Date of Decision:

Final Adjudication Branch
U.S. Department of Labor - DEEOIC
Attn.: District Manager
FAB Address
City, State ZIP

Dear Sir or Madam:

I, _____, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights.

_____
Signature

_____
Date

Sample Partial Accept/Partial Denial Bifurcated Waiver

File Number:
Employee:
Claimant:
Date of Decision:

Final Adjudication Branch
U.S. Department of Labor, DEEOIC
FAB Street Address
City, State, ZIP

Dear Sir or Madam: File Number:

(Option 1)

I, _____, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights **only** as those rights pertain to the portion of my claim recommended for acceptance. I do, however, reserve my right to object to the findings of fact and/or conclusions of law contained in the Recommended Decision that recommend denial of claimed benefits.

I understand that should I choose to file an objection, I may either attach such objection to this form or submit a separate written objection to the address listed above within 60 days of the date of issuance of the Recommended Decision.

_____ _____
Signature Date

(Option 2)

I, _____, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights.

_____ _____
Signature Date

(**NOTE ON WAIVER:** If you wish to file a waiver of objections, please select and sign **only one** of the above options. Select Option 1 to waive your right to object to the portion of your claim recommended for acceptance but reserve your right to object to the recommended denial of benefits. Select the Option 2 to waive your rights to object to ALL findings and conclusions.)