



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

EEOICPA TRANSMITTAL NO. 14-02

August 2014

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace Procedure Manual Chapter 2-1600, Recommended Decisions. This version incorporates changes that have arisen since last publication of Chapter 2-1600, to include:

- Expands guidance regarding appropriate content within the Explanation of Findings section of a Recommended Decision.
- Removes requirement that the Conclusions of Law section contain a legal/statutory citation and provides additional guidance on the proper content of a Conclusion of Law.
- Provides additional information on the issuance of letter decisions, and expands on the latitude of a CE to issue a Recommended Decision in lieu of a letter decision without such being requested by a claimant.
- Includes guidance pertaining to the handling of claims and the issuance of decisions in cases involving forfeiture due to fraud.
- Provides additional Recommended Decision sample as Exhibit 3.

A handwritten signature in cursive script that reads "Rachel P. Leiton".

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

FILING INSTRUCTIONS:

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

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

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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 CE that is subject to challenge by any claimant party to the decision. The Final Adjudication Branch (FAB) independently assesses each recommended decision for finalization. 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 to recommend the acceptance or denial of a claim for benefits under the EEOICPA. The DO forwards all Recommended Decisions 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 in this chapter, 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 CE is to identify the actual claimed entitlement benefit for which a decision is required. In some instances, a claimant may be seeking multiple benefits under Part B and/or E, especially if the claimant is claiming more than one illness.

Based on examination of the evidence of record, development occurs to overcome any defect in the case evidence that does not satisfy the eligibility criteria for a claimed benefit. Once development is completed, 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 an EE-1/2, as applicable, before issuing a Recommended Decision. The CE notifies the claimant of the need to submit the required form. A period of 30 days is allotted for the claimant to submit the required documentation. If the appropriate form is not forthcoming, the CE administratively closes the claim. The CE is to provide notice to the claimant(s) that no further action will be taken on their claim until the proper claim form is submitted.

(1) The CE has the discretion to conclude that a new claim has been adjudicated 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 Final Decision has previously addressed a newly claimed condition. In such instances, the claimant is notified that the condition has previously been decided and no further action will be taken without a request from the claimant to reopen the prior final decision.

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 Director may instruct the DO to issue a new Recommended Decision to address new evidence.

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

4. 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 (but are not limited to) the death of a claimant, failure to complete the OCAS-1, withdrawal of claim prior to the issuance of a Recommended 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 CE 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.

a. When multiple claimants have filed for benefits and an administrative closure is required for one or more individual claims, 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 are closed will not be a party to the Recommended Decision. If at a later date, the administrative closure ends and development resumes, the CE

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determines what affect the resumption of development may have on the case, including a potential need to vacate a prior Final Decision to permit a new benefit entitlement decision involving all parties to the claim.

5. 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 the CE is able to decide one or more entitlement benefits based on the evidence of record, while concurrent development occurs on outstanding claimed components. For example, the CE may issue separate decisions awarding medical benefits for a cancer under Part E, and a subsequent decision 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

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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, or a denial would affect the benefits available to other parties to the claim, it will be necessary to reopen all claims and issue a new Recommended Decision addressing the eligibility of all claimants under the case record.

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. The CE should pay particular attention to 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 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 issues a decision on the benefit entitlement of both claimants under Part B, but defers any decision on the Part E claim.

c. Non-Filing Survivors. The situation may arise where the CE identifies a potentially eligible survivor 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 CE's



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decision is to reference the fact 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 then be allocated among the remaining survivor(s).

(2) When non-filing survivors have been advised of the requirements 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. Development involving a non-filing survivor should not extend past a reasonable period, as to delay significantly 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. If written confirmation cannot be obtained, the CE must 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 CE may proceed with the issuance of a Recommended Decision regarding the eligibility of the remaining claimants. The fact that there is a non-filing, ineligible, survivor is to be noted in the decision. However, the non-filing survivor is not a party to the decision, is not to be named, and instead addressed as a

non-filing survivor. In such a situation, the CE does not hold payable lump-sum compensation in abeyance.

(3) 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 found to be eligible to a benefit, a reopening of all previously decided claims is required to allow for 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 the allotted time, 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 is to be a party to the Recommended Decision. Should the CE obtain evidence establishing that the non-

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responsive survivor is clearly ineligible or deceased, any payable compensation can then be allocated among the remaining survivor(s).

6. 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 recommends acceptance or denial of entitlement benefits in accordance with the legal criteria set out under the EEOICPA. The CE is to defer on any outstanding claims.

The CE ensures that any decision issued is well written, uses appropriate language to clearly communicate information, and addresses all facets of the evidence that led to the conclusion, including evidence the claimant submitted. The CE is to provide a robust, descriptive explanation of how the evidence satisfied or failed to satisfy the eligibility requirements of the EEOICPA, including 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 that is used in the text.

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

c. 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 being deferred pending further development, but there is no need to discuss it in detail. Extensive case history, which is inconsequential to the issue being decided, does not need to be discussed.

d. 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 being decided in the introduction, 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 also recommends denial of claimed conditions in survivor claims that have previously reached the maximum allowable benefit entitlement and no further compensation is payable.

e. Mailing Addresses. The decision is to be addressed to each claimant who has filed a claim, and/or 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 any claimant disagree with any aspect of the conclusions.

7. 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; and lists the benefits being awarded, if any. 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. 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 is issued using the opinion of a Contract Medical Consultant (CMC), the cover letter must advise the claimant that the CMC 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

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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. Exhibits 2 and 3 below provide samples of Recommended Decisions.

(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.

(2) Statement of the Case. The Statement of the Case is a clear, chronological, and concise narrative of the relevant 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 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 relevant history of the case leading up to the present decision and includes basic information such as the relevant evidence submitted, development actions taken, and any other relevant information that correlates to the discussion and analysis in the Explanation of Findings. Basic information that may be covered in the Statement of the Case, when relevant, includes:

(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 the pertinent 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 important for inclusion are the results of any searches conducted or documentation generated from the Site Exposure Matrices (SEM), Occupational History Questionnaires (OHQ), records from the Former Worker Program, and Document Acquisition Request (DAR) records. The evidence and development actions discussed in the Statement of the Case should correlate with the discussion and analysis, which follows in the Explanation of Findings.

In a recommended denial, the CE discusses what evidence he or she sought, how the CE 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 is critical that the CE writing the decision include a compelling, robust justification of his or her decision to accept or deny a claim. CE findings made without any explanatory

justification, or communicated in vague or overly broad language is not appropriate. A poorly written recommended decision increases the likelihood that a claimant will not understand the outcome of the claim and the probability of objection. Moreover, it serves to increase the potential objection by the claimant, or remand by the FAB.

In writing the content of the Explanation of Findings, the CE follows a logical and sequential presentation of findings and explains the relevant legal, regulatory or procedural guidelines of DEEOIC claims adjudication, the relevant evidence, and how the evidence does or does not satisfy the referenced criteria. In this manner, the CE communicates to the claimant his or her interpretive analysis of available evidence in satisfying the legal requirement for claim acceptance or denial. Moreover, it provides the narrative content, which allows the FAB to properly conduct its role of independently assessing the sufficiency of the CE's recommendation.

Given the various types of benefit entitlements that may be involved, the content of this section will vary depending on the context of the matter under review. However, the CE is to communicate information pertinent to the issue for 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 is 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 benefit entitlement. This is particularly important in situations involving toxic chemical exposure analysis under Part E, conflicting medical opinion, or other complex procedural applications. 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.

In instances where the claim is being denied, the discussion should focus on the first logical element that failed to meet the eligibility criteria. However, in multi-claimant cases, the reason for denial may differ for each claimant. In such instances, the CE should explain the basis of denial for each individual party to the claim.

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 have 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 differences, 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 describe completely 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 fully explains 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 workdays for SEC classes, latency periods for diseases, and offsets for State Worker's Compensation or tort settlements.

For example, when accepting a claim for wage-loss, the CE is expected to provide a narrative explanation of how he or she arrived at the various components of the decision. Specifically, how the first date of wage-loss was determined, the evidence of wages used to calculate average annual wage, how the average annual wage was compared to future calendar years of wage-loss, and any explanation of how the wage-loss benefit is calculated to arrive at the amount being awarded.

(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. This portion of the Recommended Decision summarizes the determination of eligibility reached based on the discussion and analysis contained in the Explanation of Findings. The CE's conclusion either accepts or rejects the claim in its entirety, or it may address a portion of the claim presented. The conclusions should be limited to a simple

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recommendation of acceptance or denial of the claim(s) under consideration under Part B and/or Part E.

As a Recommended Decision does not represent the final program determination regarding eligibility under the EEOICPA, it is not necessary to cite sections of the EEOICPA or its governing regulations in support of the conclusions reached.

(a) When the conclusion is to accept a claim, the CE must include the amount of payable lump-sum compensation or award of medical benefits effective the date of filing, and under what Part of the Act the benefit is being awarded.

(b) In a conclusion that results in a denial of benefits, the CE is to identify the denied claimed condition. 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 4.

(8) Waiver of Rights. A waiver form is sent with each Recommended Decision and is to include the case ID 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 5 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 6 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 that led to the denial. Option 2 allows the claimant to waive the rights to object to all findings and conclusions.

8. 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 is in posture for acceptance 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 narrative included in the decision should be sufficient to justify each element of the decision process that factored into the acceptance.

b. Denial. If after development, criteria for a compensable claim have not been met, the CE issues a Recommended Decision to deny the claim as a whole. The narrative justification for the recommended denial should communicate the singular basis serving as the first logical element that does not meet the necessary EEOICPA criteria. However, the CE may also relay other critical information in his or her decision that will serve to assist the claimant in understanding other components of the case file that, while not directly tied to basis of claim denial, describe other potential shortcomings in the case evidence. For example, a claimant submits a claim for asthma, but provides no medical evidence of the diagnosis. The CE prepares a denial on the singular basis of insufficient medical evidence to support the claimed medical condition, but may also communicate that the claimed employment does not correspond to the information received from the employer, which would also need to be overcome in order for eventual claim acceptance.

(1) Addressing all claimed elements. Once development has occurred, the CE is to proceed with the issuance of a Recommended Decision that addresses as many claimed elements as can be addressed in the Recommended Decision. Each specific claimed element that does not satisfy the requirements of the EEOICPA are to be consolidated into one Recommended Decision and reasons supporting the recommendation to deny each element clearly explained. Elements that the CE cannot address are to be deferred for later action.

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.

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, 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 outline the relevant Part B CBD criteria; 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 Introduction 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 the 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.

9. 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.

(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 established address of record, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative is considered notification to both parties.

(1) A signed and dated copy of the Recommended Decision is imaged into the electronic case file.

(2) The decision issuance is to be appropriately recorded in the Energy Compensation System (ECS).

(3) The CE then forwards the case record to the appropriate FAB office.

10. Letter Decisions. In certain situations, an entitlement determination is addressed in a simple letter to the claimant. If a CE makes a decision in this format, the CE communicates the nature of the claim that was made, evaluates 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. In some situations, including contentious or otherwise complicated issues for which the claimant is likely to contest a decisional outcome, the CE may exercise his or her judgment in deciding to issue a recommended decision in lieu of a letter decision without specific request for such by the claimant. 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)

11. 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 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 denied as no additional compensation is payable. For guidance concerning 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

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condition that may have contributed to the death of the employee.

c. Forfeiture Due to Fraud. When a claimant pleads guilty to, or is found guilty of fraud, in connection with an application for or receipt of federal or state workers' compensation, that claimant forfeits any entitlement to further benefits under the EEOICPA. In cases where there are other eligible claimants, the CE is to reallocate the forfeited amount to the remaining eligible claimants without holding the forfeited amount in abeyance.

d. 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.

e. 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 transferred to the Unit for Policies, Regulations and Procedures 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. After the National Office sends the Final Decision on the overpayment to

the claimant(s), it will return the case to the DO for issuance of the Recommended Decision. The National Office will provide instruction on how to address the overpayment in the Recommended Decision.

SUPERSEDED

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Sample Cover Letter

Dear [NAME]:

Enclosed is the Notice of Recommended Decision of the district office concerning your claim for compensation 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. As such, it is recommended that you be awarded \$150,000.00 under Part B, as well as medical benefits under Parts B and E of the Act. **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 CMC report)** In arriving at this decision, the district office received the opinion of a Contract Medical Consultant (CMC) who reviewed all the medical records contained in your file and provided an opinion on your case. If you would like to review the CMC's report, you may send your request to:

**U.S. Department of Labor, FAB  
P.O. Box 8306  
London, KY 40742-8306**

The request should indicate that you are requesting the "CMC Report"; include your full name, file number, signature, and address to which you want us to send the records.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

**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

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Sample Recommended Decision, Accept

**EMPLOYEE:** [NAME]  
**CLAIMANT:** [NAME]  
**CASE NUMBER:** XXXXXXXX

**NOTICE OF RECOMMENDED DECISION**

This is a Recommended Decision of the 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, and recommends that you be awarded lump sum compensation under Part B of \$150,000.00, as well as medical benefits under Parts B and E of the Act.

**STATEMENT OF THE CASE**

The evidence of record shows that on June 24, 2006, you filed a claim for benefits under both Parts B and E of the EEOICPA, claiming that you had developed skin cancer as a result of your employment at a Department of Energy (DOE) facility. A pathology report of November 27, 2001 provided confirmation of diagnosis with basal cell carcinoma (BCC) of the left arm.

You claimed 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 DOE was able to verify 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.

In development of your Part B claim, the district office forwarded relevant claim documentation to the National Institute for Occupational Safety and Health (NIOSH) for a radiation dose reconstruction. NIOSH used this information to estimate your exposure to occupational radiation and complete a dose reconstruction report. With the return of the completed dose reconstruction, the district office then applied the dose estimate in a calculation to determine the probability that your cancer was related to exposure to radiation during your employment at the SRS. In this case, the probability was calculated to be 57.6%, which exceeds the 50% requirement for compensability.

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### EXPLANATION OF FINDINGS

The issue for determination in this case is whether you are eligible to receive benefits under Part B and Part E for the claimed conditions of skin cancer.

As outlined above, the district office verified your employment with E.I Dupont and Westinghouse, both known DOE contractors at the SRS. Additionally, medical evidence submitted in support of your claim established your diagnosis with skin cancer. Accordingly, you meet the employment and diagnostic criteria of the EEOICPA.

In order for your Part B claim to be compensable, it must be established that the claimed skin cancer was "at least as likely as not" (a 50% or greater probability) related to occupational exposure to radiation. In your case, the district office used the results of a dose reconstruction to calculate a probability of causation (PoC) of 57.6. This exceeds the 50% threshold for compensability. Accordingly, the district office recommends acceptance of your Part B claim.

With regard to your Part E claim, the evidence shows that you worked as a contractor employee at the SRS site, a requirement for a compensable Part E claim. In addition, with the finding of a compensable Part B occupational illness, the same illness is accepted as work-related under Part E. As you have qualifying contractor employment, and the evidence of record establishes that you have a qualifying occupational illness, the district office also recommends acceptance of that your Part E claim.

Finally, in accordance with EEOICPA regulations, you have submitted Form EN-16, declaring that you have neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which you are eligible to receive compensation under the Act. You also declared that you have neither filed for nor received any state workers' compensation benefits on account of the claimed illness. Lastly, you have declared that you have neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

### CONCLUSIONS OF LAW

Based on the above, the district office recommends acceptance of your claim for benefits for the condition of skin cancer be accepted under both Part B and Part E of the Act. It is recommended that you be awarded lump-sum compensation of

of \$150,000.00 under Part B of the EEOICPA, as well as medical benefits for this illness under Parts B and Part E, commencing the date of claim filing.

Prepared by:

\_\_\_\_\_  
(Name of Appropriate Signatory)  
(Title)  
(District Office)

\_\_\_\_\_  
Date

SUPERSEDED



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Sample Recommended Decision, Deny

**EMPLOYEE:** [NAME]  
**CLAIMANT:** [NAME]  
**CASE NUMBER:** XXXXXXXX

**NOTICE OF RECOMMENDED DECISION**

This is a Recommended Decision concerning your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). The district office recommends a denial of your Part E claim for liver disease.

**STATEMENT OF THE CASE**

The history of your claim shows that you have filed for and received several final decisions regarding medical conditions you claimed as being related to occupational exposure to toxic substances. As part of the development of those prior claims, the district office has accepted that you worked for a Department of Energy (DOE) contractor at the Lawrence Livermore National Laboratory (LLNL). Specifically, you were an administrative assistant between July 18, 1989 and September 1, 1994.

Recently, you filed a claim for the condition of liver disease. Along with your claim, you submitted a narrative report from your treating physician confirming your diagnosis with sarcoidosis of the liver. Additionally, you submitted a printout of toxic substances known to be present at LLNL, noting that both trichloroethylene and vinyl chloride were present at LLNL and claiming both contributed to the onset of liver disease.

The DEEOIC evaluated all information available with regard to known links between chemical or biological agents and the development of liver sarcoidosis. This included reviewing employment, occupational and medical evidence in your case. Moreover, claims staff searched the Site Exposure Matrix (SEM) for any information on sarcoidosis. The SEM is an electronic repository of known toxic materials at covered DOE facilities, along with information on the known health effects of those exposures. None of the research conducted produced any compelling evidence to document that you were potentially exposed to any toxic

substance, including trichloroethylene and vinyl chloride, during your employment, that are linked to sarcoidosis.

To provide you additional opportunity to support your claim, the DEEOIC asked you to supply any evidence that might assist with the analysis of your claim. In particular, the district office requested you submit evidence to show that, during your employment at LLNL, you were exposed to any toxic substance linked to liver disease. No response from you was forthcoming.

### EXPLANATION OF FINDINGS

As outlined above, the district office finds that you worked at the LLNL as an administrative assistant between July 18, 1989 and September 1, 1994.

Medical evidence submitted in support of your latest claim is sufficient to allow the district office to find that you have sarcoidosis of the liver, which a physician diagnosed in 2010. Accordingly, you meet the employment and diagnostic criteria under Part E of the Act.

The issue for determination in this case is whether there exists sufficient evidence that occupational exposure to a toxic substance was "at least as likely as not" a significant factor that caused, contributed to, or aggravated your diagnosed condition of sarcoidosis. A toxic substance is defined under the Act as any biological, chemical or radioactive material that has the potential to cause illness or death.

Research of case evidence and all other available resources did not reveal any known scientific link between any biological or chemical exposure and the onset of sarcoidosis. Further, case records contained no reference or other information linking your liver disease to a specific toxin to which you, as an administrative assistant, would have been exposed while working at LLNL.

With regard to your assertions that trichloroethylene and vinyl chloride are linked to liver disease, our research has found no such scientific consensus. As mentioned, you were asked to submit probative evidence to support such a link; however, you did not provide any further evidence for the district office evaluate. Moreover, research of records obtained from the DOE, including medical or employment records, revealed no evidence of your exposure to either trichloroethylene or vinyl chloride or any other hazard that is known to induce liver disease. The Site Exposure Matrix (SEM), which provides scientifically scrutinized information on the health effects of various toxins encountered at

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LLNL, also provided no data to show that an administrative assistant at LLNL had the potential to encounter any toxic substance in performance of their duties that is linked to sarcoidosis.

Given the lack of information we were able to obtain regarding your claim, you were notified of the need for evidence, specifically evidence linking your illness to a toxin you encountered at LLNL. These requests also explained that you ultimately bore responsibility for providing the evidence necessary to establish your claim. Unfortunately, you provided no response.

After reviewing all available evidence, there is presently no basis to conclude that occupational exposure was "at least as likely as not" a significant factor in aggravating, contributing to or causing your diagnosed disease of sarcoidosis. As such, the district office has to recommend that your Part E claim for liver disease be denied.

#### CONCLUSIONS OF LAW

Based on the above, the district office recommends a denial of your claim for liver disease under Part E of the Act.

Prepared by:

\_\_\_\_\_  
(Name of Appropriate Signatory)  
(Title)  
(District Office)

\_\_\_\_\_  
Date

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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  
P.O. Box 8306  
London, KY 40742-8306**

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.

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**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 waive your right to object on the accompanying waiver form and forward 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

Case Number:  
Employee:  
Claimant:  
Date of Decision:

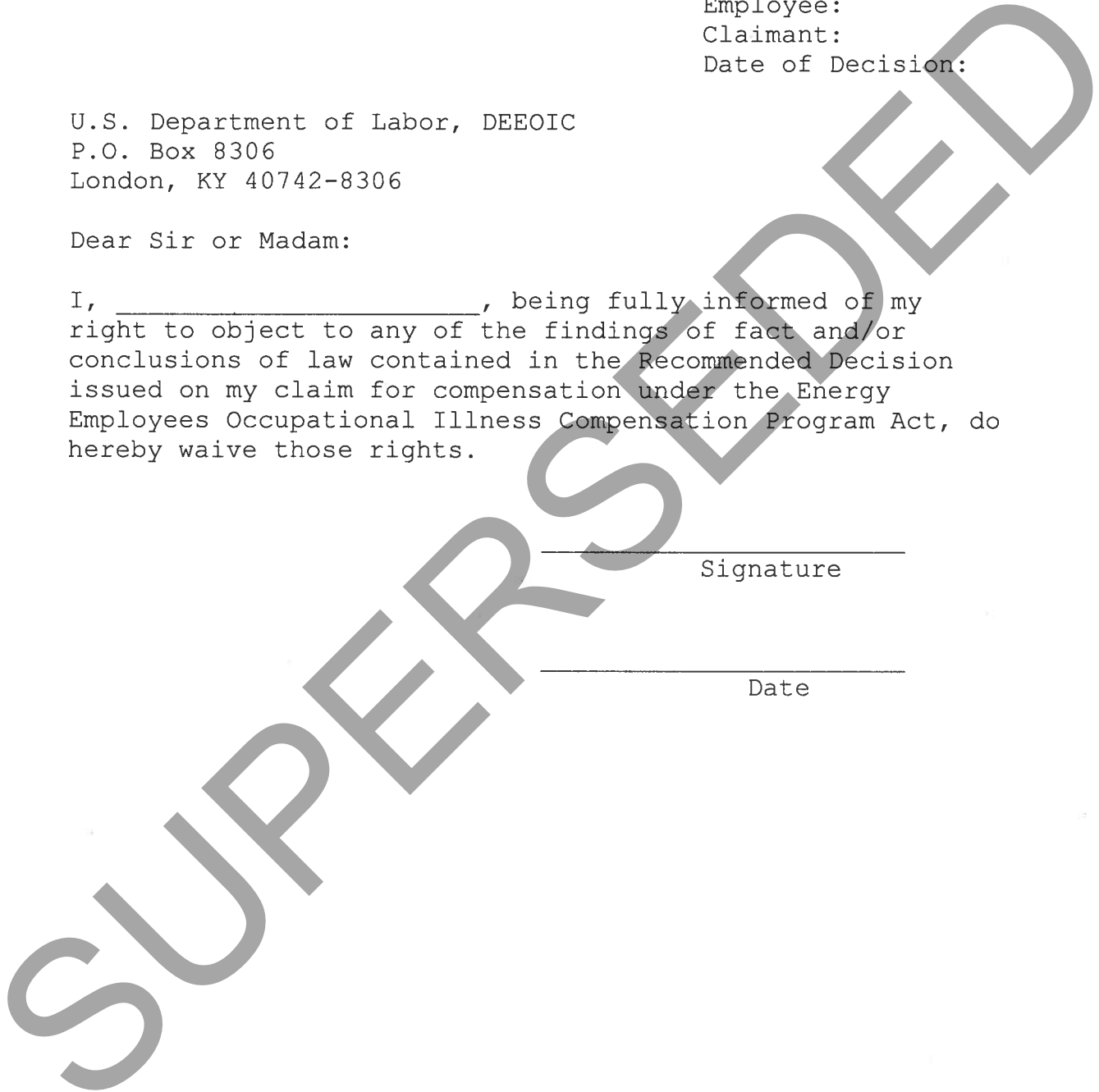
U.S. Department of Labor, DEEOIC  
P.O. Box 8306  
London, KY 40742-8306

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

Case Number:  
Employee:  
Claimant:  
Date of Decision:

U.S. Department of Labor, DEEOIC  
Attn: Final Adjudication Branch  
P.O. Box 8306  
London, KY 40742-8306

Dear Sir or Madam:

**(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.)

SUPERSEDED