U.S. Department of Labor

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

RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-1300, Impairment Ratings.

EEOICPA TRANSMITTAL NO. 17-01 November 2016

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the EEOICPA Procedure Manual (PM) Chapter 2-1300, Impairment Ratings to include:

- Removed pagination from the Chapter and the Page number column from the Table of Contents.
- Removed the footer on all pages subsequent to the Table of Contents.
- Removed outdated ICD-9 Codes.
- Clarified under section 4d(4)(c) that if the employee contracted more than one covered illness that affects the same organ or body function, the physician does not need to provide separate ratings for each covered illness.
- Explained under section 4e that there must be a triggering impairment that is clearly due to a covered illness before any consideration can be given to any additional impairment to the same organ system.
- Section 5, titled Developing an Impairment claim was divided into three new sections, including section 5 titled How a Claimant Files an Impairment Claim, section 6 titled Impairment Ratings by the Employee's Choice Physician, section 7 titled Impairment Ratings by a CMC.

- Section 5 took out the requirement for an initial phone call to the employee to solicit an impairment claim. This is accomplish by sending the employee the impairment letter and response form (Form EE-11A/EN-11A).

- Section 5b(3) clarified that a signed EN-11A or Form EN-10 must be submitted before development of impairment claim. The impairment form must be signed by the employee, the authorized representative or the employee's Power of Attorney.

- Section 6a provided an URL link to the medical bill pay agent enrollment forms.

- Section 6b shortened the time to schedule an appointment for an impairment rating from six months to three months.

- Added a new section 11 titled Impairment Award to provide guidance on calculating impairment award and explained maximum aggregate compensation and how it affects the impairment award.

- Provided additional guidance under section 12 on calculating impairment award subject to tort offset/state workers' compensation coordination.

- Added new section 13 entitled How to Calculate Increased Impairment Award with Tort Offset/SWC Coordination.

- Expanded section 16 to include more examples where the two-year waiting period for an increased impairment claim is waived.

- Removed Form EE-11A/EN-11A from the Exhibit section.

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1. Purpose and Scope. This chapter provides procedures for evaluating a claim for permanent impairment. It explains the responsibilities of the Claims Examiner (CE) in awarding a covered Part E employee impairment attributable to a covered illness. The chapter provides guidance on how to evaluate medical evidence relating to impairment and the evidence necessary to establish a ratable permanent impairment. The chapter includes a discussion on calculating an impairment award if the impairment award is subject to tort offset and/or state workers' compensation coordination.

2. Policy. Division of Energy Employees Occupational Illness Compensation (DEEOIC) staff is responsible for processing impairment claims and ensuring that benefits are appropriately paid. In impairment decisions, DEEOIC staff explains the general requirements for impairment and provides a clear explanation of the calculations used to compute the impairment award. The assigned CE is responsible for bronzing into the OWCP imaging system (OIS) all case-related correspondence or other documentation generated or received during the development of an impairment rating.

3. Definition of Impairment.

a. Impairment. The American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*), 5th Edition, defines impairment as "a loss, loss of use or derangement of any body part, organ system or organ function." Furthermore, "Impairment percentages or ratings developed by medical specialists are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common **Activities of Daily Living (ADL)**, *excluding work.*" (Emphasis in original) The AMA's Guides organize ratable organ or body function by chapter e.g., respiratory, cardiovascular, nervous, endocrine etc.

4. General Requirements for Impairment Ratings.

a. Covered Employees. The employee is a covered Department of Energy (DOE) contractor or subcontractor employee, or Radiation Exposure Compensation Act (RECA) section 5 employee found to have contracted a covered illness through exposure to a toxic substance at a DOE facility or RECA section 5 facility.

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b. Claiming Impairment. The employee has to claim impairment in writing.

c. Maximum Medical Improvement (MMI). An impairment rating is to encompass each covered illness that has reached MMI according to the rating physician. MMI means the condition is unlikely to improve substantially with or without medical treatment. A CE may consider conditions that are progressive in nature and worsen over time, such as chronic beryllium disease (CBD), to have reached MMI when the condition is not likely to improve.

(1) Terminal Employees. An exception to the MMI requirement exists for terminal employees undergoing treatment for an illness that has not reached MMI. In these situations, the terminal employee could die before the end of treatment and eligibility for an impairment award would be extinguished. Therefore, if the CE finds probative medical evidence that the employee is terminal, the CE includes the covered illness in the impairment rating even if the covered illness has not reached MMI.

(2) MMI Has Not Been Reached. If the rating physician or the treating physician states that a condition is not at MMI, and the employee is not terminal, the CE cannot make an impairment determination.

(a) If the CE does not make an impairment determination due to the employee not being at MMI, the CE sends a letter informing the employee that an impairment determination is not possible because the employee's condition has not reached MMI and that the impairment claim is closed administratively. The letter includes a statement instructing the employee to contact the district office once he or she receives medical evidence that describes the condition is at MMI. (See Exhibit 1).

(b) Once the CE receives notice from the employee and medical evidence indicating that the employee is at MMI, the CE resumes development.

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(3) Multiple Covered Illnesses. In a case of multiple covered illnesses, where one condition is at MMI and another is not, the CE proceeds with a determination regarding impairment for the condition at MMI. If different covered illnesses affect the same organ or body function, and one condition is not at MMI, the CE cannot proceed with an impairment rating until all conditions in that organ or body function have reached MMI.

d. Impairment Rating. An impairment evaluation performed by a qualified physician is the basis for the CE's determination of impairment benefit entitlement. Therefore, the physician's impairment rating report is to include narrative text that clearly communicates the physician's opinion, and that provides a convincingly descriptive rationale in support of the stated impairment rating.

(1) Evaluation. An impairment evaluation of the employee must be based upon the 5th Edition of the AMA's *Guides*.

(2) Rating Physician Qualification. A physician who performs an impairment evaluation must satisfy certain criteria. In order for a CE to accept an impairment rating, the rating physician must hold a valid medical license and Board certification/eligibility in his/her field of expertise (e.g., toxicology, pulmonary, neurology, occupational medicine, etc.). In addition, the physician must meet at least one of the following criteria: certified by the American Board of Independent Medical Examiners (ABIME); certified by the American Academy of Disability Evaluating Physicians (AADEP); possess knowledge and experience in using the AMA's *Guides*; or possess the requisite professional background and work experience to conduct such ratings.

(a) A CE may determine the qualifications of the physician upon receipt of a letter or a resume demonstrating that the physician has a medical license and meets the requisite program requirements. There is no need to submit copies of his/her medical license or other certification.

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(b) If a physician does not possess ABIME or AADEP certification, the physician must submit a statement certifying and explaining his/her familiarity and years of experience in using the AMA's *Guides*.

(3) Rating Percentage. The impairment rating is a percentage that represents the extent of a whole person impairment of the employee, based on the organ or body function affected by a covered illness or illnesses. A qualifying impairment rating must account for all Part E accepted covered illnesses claimed by the employee and must include all pre-existing conditions present in the claimed organ or body function at the time of the impairment evaluation.

(4) Whole Person Impairment. The physician must specify the percentage points of whole person impairment resulting from all covered illnesses. This includes accepted consequential conditions.

(a) In some instances, there are diseases or life style choices (e.g., smoking), in addition to the covered illness, that affect organ or body function. The DEEOIC does not apportion damage within the same organ or body function, thus the impairment rating should assess the functionality of the whole organ or body function regardless of other non-occupational factors that might cause impairment.

(b) If an employee's covered illness affects more than one organ or body function, the physician must specify the percentage points of impairment for each organ or body function affected by the employee's covered illness. The physician references a combined value chart in the AMA's *Guides* to calculate the aggregation of multiple organ or body function impairments into whole person impairment.

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(c) If the employee contracted more than one covered illness that affects the same organ or body function, the physician does not need to provide separate ratings for each covered illness since DEEOIC does not apportion damage within the same organ or body function.

(d) An impairment that is the result of any accepted covered illness that cannot be assigned a numerical impairment percentage using the 5th Edition of the AMA's *Guides* will not be included in the employee's impairment rating, and the physician performing the impairment evaluation must explain why a numerical impairment percentage cannot be assigned.

e. Triggering Impairment. There first must be impairment to an organ or body function that is clearly due to a covered illness before the CE can give any consideration for additional impairment to that organ or body function resulting from any unaccepted illness or condition. For example, if the employee has an accepted Part E claim for COPD only, and the rating physician opined that the employee's respiratory system has 0% impairment due to COPD, but 9% due to asthma (which has not been accepted), the CE is to deny the employee's impairment claim for COPD.

5. How a Claimant Files an Impairment Claim. After the Final Adjudication Branch (FAB) issues a Part E final decision to an employee with a positive causation determination, the CE sends Form EE-11A/EN-11A to solicit impairment claims from employees who are potentially eligible for impairment benefits. See Section 16 for developing a claim for increased impairment two years after the initial impairment final decision.

a. Impairment Letter and Response Form (Form EE-11A/EN-11A). Form EE-11A contains information explaining impairment benefits and that the employee may be eligible for an award based on permanent impairment.

b. Words of Claim. If the employee submits written words of claim for impairment, the CE must follow up with the employee to obtain a signed Form EN-11A or Form EN-10. The impairment forms must be signed by the employee, the

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authorized representative, or the employee's Power of Attorney.

(1) Request for Impairment Claim. Form EE-11A provides information that the employee must advise the DEEOIC in writing as to whether or not he/she wishes to claim impairment for a covered illness or illnesses. Form EN-11A is a response form on which the employee claims impairment.

(2) Physician Choice. Form EE-11A includes instruction that the employee may choose to have his/her own qualified physician or a Contract Medical Consultant (CMC) perform an impairment evaluation. CMCs are DEEOIC contracted physicians qualified to perform impairment evaluations. The employee indicates this choice on Form EN-11A. If the employee requests his/her own physician to perform the impairment rating, the employee must provide the physician's name, address and phone number. Form EN-11A contains a space for this information.

(3) Timeframe. The CE allots 60 days for the employee to respond to Form EE-11A/EN-11A, with a follow up request sent to the employee at the first 30-day interval. The CE uses Form EE-11A/EN-11A for the follow up request, but the form must be marked "Second Request." The CE does not develop the impairment issue until he or she receives a completed Form EN-11A.

(a) If the employee does not respond to Form EE-11A/EN-11A within 60 days, the CE sends a final Form EE-11A/EN-11A marked as a "Final Request" to the employee. After the CE sends the final request Form EE-11A/EN-11A, the CE updates the Energy Compensation System (ECS) to indicate the employee is not claiming impairment. If at any time, the employee informs the CE that he/she does not want to pursue a claim for impairment, the CE sends a letter to the employee advising that the DEEOIC will not undertake further development of the claim for impairment. The CE also notifies the employee of his/her right to claim impairment in the future (See Exhibit 2).

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(b) If the employee responds by Form EN-11A claiming impairment, the CE updates ECS appropriately. The impairment claim date is the postmark date of the form, if available, or the date the district office, FAB, Central Mail Room (CMR), or Resource Center receives the form, whichever is the earliest determinable date.

(c) If the employee does not indicate on the EN-11A form who he or she would like to perform the impairment evaluation, the CE calls the employee for this information. The CE advises the employee to document his or her choice in a written statement submitted to the DEEOIC Central Mail address.

6. Impairment Ratings by the Employee's Choice Physician. If the employee elects to have the physician of his/her choice perform the impairment rating, the CE must obtain evidence necessary to document that the physician is qualified as explained in Section 4.

a. Letter to Selected Physician. The CE sends a letter (Exhibit 3) to the physician selected by the employee. In the letter, the CE notifies the physician of the employee's eligibility, and the covered illness or illnesses with respective ICD-9/10 code(s). The CE also explains in the letter that for the DEEOIC to pay for an impairment evaluation, the physician must perform the evaluation within one year of the report's receipt by the DEEOIC. The letter includes reference to the requirement that the impairment evaluation is to be performed in accordance with the 5th Edition of the AMA's *Guides*, and that the rating physician must cite the appropriate page numbers and tables applied from the AMA's *Guides*. The letter explains that the physician must submit supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) with the impairment report. The letter includes instructions for the physician to contact the district office if they need medical evidence from the case file. Lastly, the CE provides URL links to the medical bill pay agent enrollment forms, which is to include: an OWCP-1500, Health Insurance Claim Form, OWCP-1168, the EEOICP Provider Enrollment Form, and a SF Form 3381. The OWCP-1168 contains a written explanation of how a physician enrolls with the medical bill pay agent.

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If a physician has previously enrolled with the DEEOIC, there is no need to enroll again. If the employee opts to select his/her physician to perform the impairment rating but does not know of one, the CE may direct the employee to the appropriate Resource Center (RC) or the DEEOIC bill pay agent website for a list of physicians who are enrolled in the program.

b. Scheduling an Appointment with the Selected Physician. Upon receipt of the employee's written choice of physician, the CE sends a letter explaining that the employee is to schedule the impairment appointment within 30 days and the appointment is to occur within three months. The CE advises that the employee may request that the district office provide the rating physician with medical evidence in the case file to perform the impairment evaluation. The CE also explains that any appointment scheduled to occur later than three months may lead to denial of the impairment claim, unless there is a valid reason for the delay (for example, the earliest appointment available for a specialist was over three months).

If after 30 days, the CE finds no evidence of an impairment evaluation or that the employee scheduled an appointment, the CE makes a phone call to determine the status of the appointment (whether it has been made or is in the process of being made, etc.). The CE advises the employee verbally of the need to schedule the appointment within the next 30 days and to provide written evidence of such to the CE. The CE also explains that if the appointment is not scheduled or the claimant has scheduled it to occur later than the three months period without a valid reason, a recommended decision to deny the impairment claim may be issued. The CE records this discussion in the phone calls section of ECS. After this phone call, the CE sends a written summary of the call to the employee.

If at the end of this total 60-day period no evidence exists to show progress in obtaining the necessary impairment evidence and the employee has not provided a valid reason for the delay (e.g. he/she was sick), the CE may issue a recommended decision to deny the impairment claim.

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7. Impairment Ratings by a CMC. If the employee chooses the CMC option, the CE reviews the medical evidence in the case file to determine if the evidence is sufficient for a CMC to perform the impairment evaluation.

a. Required Medical Evidence. Since the CMC will not conduct a physical examination, the employee's Activities of Daily Living (ADL) or equivalent information is required. The CMC or the employee's physician can collect ADL information from a variety of sources, including the use of ADL worksheet (See Exhibit 4 for an example), patient interview, or other techniques. The ADL or equivalent information should be completed within the last 12 months before the impairment evaluation. The CE also checks Xerox's Stored Image Retrieval (SIR) system to provide the most current medical record to the CMC. If the employee is under nursing care, the CE provides all nursing notes from the past 30 days to the CMC for review. In addition to the ADL or its equivalent, some conditions require specific medical evidence before a CMC can complete the impairment evaluation, as outlined in Exhibit 5. If Exhibit 5 does not identify the condition to be rated, the CE is to consult with a CMC to determine what medical information is required as outlined in the AMA's *Guides*.

After receipt of the notice that the employee has chosen the CMC option, the CE sends a letter to the employee attaching a sample blank ADL or an ADL for breast cancer or skin cancer(Exhibit 4). The CE also includes the information regarding the required medical evidence (Exhibit 5) for the covered illness(es). If the CE determines that additional evidence and/or diagnostic test(s) is required to conduct an impairment evaluation, the CE explains the requirement in this letter. The letter includes instruction for the employee to return the required evidence within 30 days. If after 30 days, the claimant does not submit the required evidence, the CE makes a phone call to determine the status of the evidence. The CE advises the employee verbally of the need to obtain this evidence. The CE explains that if the employee does not return the required evidence within 30 days, a recommended decision to deny the impairment claim may be issued. The CE records this discussion in the phone calls section of ECS. After this phone call, the CE sends a second letter to the employee and includes a written summary of the phone call, blank ADL and information

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regarding the required medical evidence needed to conduct an impairment evaluation.

If at the end of this total 60-day period no evidence exists to show progress in obtaining the necessary impairment evidence and the employee has not provided a valid reason for the delay, the CE may issue a recommended decision to deny the impairment claim.

b. Insufficient Evidence. If the CE determines that the submitted medical evidence is insufficient, the CE sends a follow-up development letter to the employee explaining the deficiency and the additional evidence and/or diagnostic test(s) required to conduct an impairment evaluation.

c. Unavailability of Records. If the employee is unable to provide the necessary medical records, the CMC must decide if an impairment evaluation is possible in accordance with AMA's *Guides* given the available evidence. The CE may proceed with a CMC referral to determine if the available records are sufficient to perform a rating. If the CMC is able to perform a rating based on the available medical evidence but states that additional testing could potentially increase the rating, the CE notifies the employee that additional testing may result in a higher rating and that the DEEOIC will pay for the additional testing. The CE sends the employee a letter and gives the employee the option of obtaining the necessary testing paid by DEEOIC, or notifying the CE in writing that a decision may proceed based on the available medical evidence. If the employee does not respond, the CE proceeds with the impairment evaluation based on the available medical evidence.

d. Outdated Evidence. If the CE has provided the employee the opportunity to obtain current medical evidence but the claimant has not responded adequately, the CE may use medical evidence in the file that is older than 12 months to obtain an impairment rating from a CMC. In some instances, the CMC may not be able to render an opinion with older or missing medical records.

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8. Impairment Ratings for Certain Conditions:

a. Mental Disorders.

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

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

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

b. Breast Cancer.

(1) Upon receipt of a claim for impairment for the breast in either a male or female, the CE submits a request to the physician undertaking the evaluation, explaining all the criteria that are to be considered and referenced in the impairment report (See Exhibit 5). For the purposes of considering impairment due to breast cancer in a female, childbearing age will not be a determining factor when issuing an impairment rating, as the AMA's *Guides* do not define "child-bearing age."

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(2) When the physician returns a completed impairment evaluation, the CE is to review it to ensure that the physician has comprehensively addressed each of the factors necessary for an acceptable rating. The impairment evaluation is to contain written information to show that the physician has considered:

(a) The presence or absence of the breast(s);

(b) The loss of function of the upper extremity (or extremities if there is absence of both breasts due to cancer), including range of motion, neurological abnormalities and pain, lymphedema, etc.;

(c) Skin disfigurement (may include notes older than a year and/or photos) and

(d) Other physical impairments resulting from the breast cancer. The total percentage of permanent impairment of the whole person must be supported by medical rationale and references to the appropriate sections and tables (with page numbers) of the AMA's *Guides*.

(3) If the CE determines that the physician has not provided a complete rating for a claimed impairment of the breast, the CE sends a follow-up letter to the physician. The CE explains in the letter the noted deficiency in the assessment, and explains that a complete response ensures that the employee receives the maximum allowable rating provided by the AMA's *Guides*.

c. Pleural Plaques/Beryllium Sensitivity.

(1) The CE may accept an impairment claim for pleural plaques/beryllium sensitivity if the rating physician provides medical rationale and references to the appropriate sections and tables (with page numbers) of the AMA's Guides to justify the impairment rating.

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d. Metastatic Bone Cancer.

(1) In situations where the CE accepts a case under the Special Exposure Cohort (SEC) provision based on metastatic (secondary) cancer, i.e. metastatic bone or metastatic renal cancer, often the primary source of the metastatic cancer will prove to be the prostate. If the CE does not accept the prostate cancer due to a lack of a causative link and because prostate cancer is not an SEC-specified cancer, it is important that the CE ensure that a physician does not apply the non-covered prostate cancer in an impairment rating. A physician or CMC may only consider the accepted condition of SEC metastatic cancer for the impairment rating.

9. Receipt of the Impairment Evaluation. Upon completion of the impairment evaluation by a physician, the CE reviews the report to assure that it contains all the information necessary to meet DEEOIC's criteria for a valid impairment. The CE reviews the impairment evaluation to determine the following: whether the opining physician possesses the requisite skills and requirements to provide a rating as set out in paragraph 4d(2); whether the evaluation was conducted within one year of receipt by the DEEOIC; whether the report addresses the covered illness or illnesses; whether the whole person percentage of impairment is explained with a clearly rationalized medical opinion as to its relationship to the covered illness or illnesses, and whether the medical opinion is supported by medical evidence in the case file.

a. Incomplete Ratings. If the impairment rating report is unclear or lacks rationalized medical analysis in support of the offered conclusion, additional clarification is required. In such instances, the CE returns the impairment rating evaluation to the rating physician with a request for clarification, explaining what areas are in need of remedy. If the employee's choice physician submitted the insufficient report and no response is received, or it is returned without sufficient clarification, the CE notifies the physician and the employee of the need for additional justification. If a response is not forthcoming, the CE may issue a recommended decision to deny the impairment claim for an

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insufficient impairment report. If the CMC submits an incomplete report, the CE notifies the CMC of the deficiency and requests a more comprehensive report.

10. Pre-Recommended Decision Challenges: Upon request, the CE may provide the employee with a copy of the impairment rating report. The employee may submit written challenges to the impairment rating report and/or additional medical evidence of impairment. However, any additional impairment evaluations must meet the criteria discussed above in Section 9 before the CE can consider it when making impairment determinations. The DEEOIC will only pay for one impairment evaluation unless the DEEOIC directs the employee to undergo additional evaluations. The employee is responsible for the payment of any subsequent evaluations not directed by the DEEOIC. If the additional evaluation differs from the existing rating, the CE must review and weigh (See guidance provided in Procedure Manual Chapter 2-0800, Developing and Weighing Medical Evidence) the two reports to determine which report has more probative value. If the reports appear to be of equal value and the impairment ratings are within 10% of each other, the CE accepts the higher rating impairment.

a. Determining Probative Value. If the impairment reports appear to be of equal value and the ratings are not within 10% of each other, the CE must obtain an evaluation from a second opinion physician.

11. Impairment Award. To calculate the impairment award, the CE multiplies the percentage points of the impairment rating of the employee's covered illness or illnesses by $2,500.00. For example, if a physician assigns an impairment rating of 40% or 40 points, the CE multiplies 40 by $2,500.00, to equal a $100,000.00 impairment award.

a. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000.00. The CE considers any previous compensation awarded under Part E for impairment and/or wage-loss to determine if a subsequent award needs to be reduced to ensure that it does not exceed the $250,000.00 maximum aggregate compensation. In determining the aggregate compensation, the CE does not take into consideration the reduction of compensation based on state workers' compensation coordination or tort offset. For

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example, if the employee was previously awarded benefits for impairment in the amount of $100,000.00 but his compensation was reduced because of tort offset to $60,000.00, the amount of compensation used to determine the maximum aggregate compensation is $100,000.00 not $60.000.00.

12. Impairment and Tort Offset/State Workers' Compensation (SWC) Coordination. If there are impairment benefits due to multiple covered illnesses, and at least one of those illnesses is subject to a tort offset or coordination of SWC award, the CE must determine the impairment award by following the steps in this section. Since DEEOIC does not apportion impairment within the same organ or body function, if there are several covered illnesses affecting the same organ or body function and one illness from the same organ or body function is subject to coordination or offset, the entire rating for that affected organ or body function is subject to coordination or offset.

a. Determine that coordination and/or offset is required.

(1) SWC Coordination - In an impairment case with multiple covered illnesses, the CE confirms that at least one covered illness from the impairment award is the *same illness* that serves as the basis for SWC payment.

(2) Tort Offset - In an impairment case based upon multiple covered illnesses, the CE confirms that at least one covered illness from the impairment award is associated with the *same exposure* to a toxic substance that a tort settlement references as causing illness.

b. Identify the combined impairment rating and calculate the dollar amount. For example, John Doe has a 20% impairment due to his asbestosis and 7% impairment due to his skin cancer. The combined impairment rating according to the Combined Values Chart is 26%, and the potential impairment award is $65,000.00 (26% X $2,500.00 = $65,000.00).

c. Determine the percentage of the combined impairment rating that each separate impairment represents (apportionment) using these steps:

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(1) Determine the sum of the individual impairment rating. In the John Doe example case, the individual ratings are 20% due to his asbestosis (lung) and 7% due to his skin cancer, so the sum of his individual impairment ratings is 27% (20% + 7% = 27%)

(2) Calculate the relative percentage of impairment for each organ or body function:

For asbestosis - Divide 20% by 27% to determine that 74.07% of the sum of the individual rating is attributable to asbestosis.

For skin cancer - Divide 7% by 27% to determine that 25.93% of the sum of the individual impairment rating is attributable to skin cancer.

d. Calculate the dollar amount attributable for each organ or body function. In the John Doe example case, the calculation is as follows:

For asbestosis - Multiply 74.07% (the percentage attributable to asbestosis) by the dollar amount of the combined impairment award of $65,000.00 to determine that $48,145.50 is the dollar amount attributable to asbestosis.

For skin cancer - Multiply 25.93% (the percentage of impairment rating attributable to skin cancer) by $65,000.00 to determine that $16,854.50 is the dollar amount attributable to skin cancer.

e. Subtract Offset/Coordination amount from the dollar amount attributable to the organ or body function subject to offset and/or coordination.

Example 1: If the dollar amount attributable to John Doe's lung impairment has to be reduced by $10,000.00 due to coordination (the eligible amount paid from a state workers' compensation claim), $10,000.00 is subtracted from $48,145.50 (the dollar amount attributable to asbestosis), which leaves $38,145.50 payable due to asbestosis after coordination of SWC benefits.

Example 2: If the dollar amount attributable to John Doe's lung impairment has to be reduced by $50,000.00 due to coordination, $50,000.00 must be subtracted from $48,145.50

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(the dollar amount attributable to asbestosis), which leaves $1,854.50 as a surplus after coordination of SWC benefits. His surplus due to asbestosis will not affect his entitlement to benefits for skin cancer.

f. Calculate the Payable Impairment Award. Add the dollar amounts for each organ or body function(after coordination and/or offset) to determine the amount of the impairment award.

Example 1: Add $38,145.50 for asbestosis (after subtracting the coordination amount of $10,000.00) to $16,854.50 for skin cancer for a total impairment award of $55,000.00.

Example 2: If the coordination amount to asbestosis is $50,000.00, the amount of the total impairment award is $16,854.50 from the skin portion of the combined impairment award if skin cancer is not subject to offset or coordination. The surplus of $1,854.50 after coordination of SWC benefits for asbestosis is NOT subtracted from the skin cancer award. The CE absorbs this surplus from medical benefits for asbestosis and future compensation benefits for asbestosis.

13. How to Calculate Increased Impairment Award with Tort Offset/SWC Coordination. For increased impairment claim involving tort offset and/or SWC coordination, the calculation must be based on the current impairment rating/award and not on the net increased impairment award.

For example, John Doe had previously been awarded impairment for asbestosis and skin cancer for 26%. The current combined impairment rating is 40%, which comprised of 33% due to asbestosis and 10% due to skin cancer. Using the current impairment rating, follow the calculation in Section 12c to determine the relative percentage of impairment for each organ or body function and Section 12d to determine the dollar amount attributable for each organ or body function. The dollar amount attributable to each organ or body function must be based on the current impairment award of 40% or $100,000.00 and not on the net increase of 14% (40% - 26% = 14%) or $35,000.00. As such, the increased impairment calculation is as follows:

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For asbestosis - Multiply 76.74% (the percentage attributable to asbestosis based on the current impairment rating) by the current impairment award of $100,000.00 to determine that $76,740.00 is the dollar amount attributable to asbestosis.

For skin cancer - Multiply 23.26% (the percentage of current impairment rating attributable to skin cancer) by $100,000.00 to determine that $23,260.00 is the dollar amount attributable to skin cancer.

Since the CE calculates the increased impairment award based on the current impairment rating and not on the net increase, any previous award(s) of impairment and any SWC coordination/tort offset for that organ or body function must be subtracted from the current impairment award.

Example: In the previous impairment decision issued to John Doe, the CE concluded that a surplus of $1,854.50 remained for asbestosis after coordination of SWC benefits for asbestosis in the amount of $50,000.00. The total impairment award was $16,854.50 from the skin portion of the combined impairment award. Since the previous impairment decision, the CE concluded that John Doe received an additional SWC coordination for asbestosis in the amount of $10,000.00 for a total coordination amount of $60,000.00.

To calculate the new impairment award, subtract the total coordination amount of $60,000.00 for asbestosis from the new dollar amount attributable to asbestosis ($76,740.00) which equals to $16,740.00 payable for asbestosis. From the new dollar amount attributable to skin cancer of $23,260.00, subtract the previous award of $16,854.50, which equals to $6,405.50. The CE adds the dollar amounts for each organ or body function to determine that the increased impairment award is $23,145.50($16,740.00 + $6,405.50 = $23,145.50) with no outstanding surplus.

In any unique or challenging circumstance involving how best to apply SWC coordination or tort offset to a payable impairment, the CE consults with the National Office Policy Branch.

SUPERSEDED

14. Issuance of a Recommended Decision. The recommended decision for impairment must contain a CE's discussion of the relevant impairment evidence submitted in deciding the claim. Moreover, the CE must explain the sufficiency (or insufficiency) of the evidence justifying the decision outcome. For example, the CE discusses the qualification of the physician to perform an impairment rating. In addition, the CE includes a description of the medical evidence that satisfy the necessary procedural requirements for a valid impairment including MMI, use of AMA's *Guides*, calculation of rating, citation of AMA tables, etc. For any lump-sum award, the CE explains clearly the calculation of the award, including subtractions due to prior lump sum impairment payments. If coordination and/or offset is required, the CE explains the steps and calculations performed to derive at the award.

If a decision recommends denial of an impairment claim based upon an insufficient evaluation, or if the CE relies on one evaluation over another evaluation(s) in the file, the CE provides a detailed discussion regarding the probative value of the evaluation(s). In the case of competing medical opinions, the CE discusses the weight of medical evidence as to why one report is insufficient, and/or why one report offers more probative value. In other words, the CE has to explain how he or she selected one physician's opinion over another. This is necessary in the event that the employee submits additional impairment evidence to FAB, as any additional impairment evidence submitted has to overcome the weight of medical evidence as assigned by the CE.

15. FAB Development. Once the CE issues recommended decision on impairment and the CE forwards it to FAB, the employee may submit new medical evidence and/or additional impairment evaluations to challenge the impairment determination discussed in the recommended decision.

a. Reviewing Ratings. The employee bears the burden of providing additional impairment evidence that shows an error of procedural application or that provides a probative medical argument to overcome the CE's assignment of weight of medical evidence as discussed in the recommended decision. However, if the evidence is not from a qualified physician who meets the requirements of paragraph 4d(2) of this chapter, the FAB Hearing Representative (HR) or FAB CE will not consider it probative.

SUPERSEDED

b. FAB Review. The FAB CE or HR reviewing the case is to take into consideration the list of factors in section 9 when weighing impairment evaluations for probative value. In addition to the impairment rating(s), the FAB reviews all the relevant evidence of impairment in the case record and determines which evidence is most probative. If the employee's file contains multiple impairment evaluations, the FAB CE or HR reviews each report to determine which provides the most probative value given the totality of the evidence. Any analysis by a FAB CE or HR relating to a contested impairment rating must include a careful consideration of the weight of medical evidence. The mere presentation of new medical evidence does not serve as a singular basis to invalidate the weight of medical evidence as assigned in a recommended decision. The FAB may not remand impairment solely on the basis of receipt of new evidence.

c. Development. When evaluating objection or new evidence in response to a recommendation relating to impairment, the FAB CE or HR must undertake any reasonable development to resolve disputes. This includes submitting medical evidence received after the issuance of a recommended decision to a CMC to determine the effect, if any, it has on an assigned impairment rating.

d. Final Decision. The final decision must contain sufficient narrative to describe whether the FAB CE or HR feels that the recommended findings comply with the procedural requirements of the DEEOIC for a valid impairment award and that the findings derive reasonably from the medical evidence of record. The FAB CE or HR must independently validate any calculations of impairment, including any applicable SWC coordination or tort offsets.

16. Additional Filings for Increased Impairment Benefits. An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. For such a claim, the claimant must file using Form EN-10. When a claim for increased impairment is developed but the medical evidence establishes lower whole person impairment than previously determined, the CE denies the claim for increased impairment. The CE takes no action to reopen a prior impairment determination in these circumstances because a claim filed for increased impairment after the two-year waiting period is a new claim.

SUPERSEDED

a. Timeframe. The employee may not submit a Form EN-10 for an increased impairment rating earlier than two years from the date of the last final decision on impairment, except for the following reasons.

(1) New Covered Illness. The CE waives the two-year time period requirement if the CE adjudicates an additional impairment claim based upon new covered illness not included in the previous award. A new covered illness must involve a different disease, organ, body function, illness, or injury that was not the basis of the original impairment rating.

(2) New Consequential Illness. The CE waives the two-year time period requirement if the consequential condition affects an organ or body function that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. The FAB issued a final decision one year ago to award a 50% impairment due to whole person impairment rating to the respiratory system. A consequential illness is accepted for stomach ulcers because of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the consequential illness affects an organ or body function (digestive) that was not included in the prior impairment assessment.

However, if the consequential illness involves an organ or body function previously included in an impairment assessment, the two-year time period requirement is not waived.

(3) Terminal Employees. If medical evidence or other information clearly establishes that the employee is terminal, the CE has the discretion to waive the two-year period requirement.

(4) 0% Rating. If FAB issues a 0% impairment rating final decision and subsequently it or the district office obtains a new impairment rating greater than 0%, the two-year wait period does not apply. The new evidence for increased impairment is to be reviewed and either a District Director with authority to do so or the Director should consider reopening the final decision with the 0% impairment. However, if the two-

SUPERSEDED

year wait period has elapsed between the 0% rating and a request for increased impairment, a reopening is not required since a CE can treat the request as a new claim.

The two-year wait period still applies if the employee is denied an impairment award because there is no increase in the impairment rating. For example, the final decision denied the impairment claim because the rating of 15% did not increase from the previous final decision. In this situation, the employee must comply with the two-year wait period from the last final decision that denied the impairment claim because of no increase in rating.

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

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

17. Issues Involving Survivor Election. If a covered Part E employee dies after submitting a Part E impairment claim, but before that claim is paid, and death is caused solely by a non-covered illness or illnesses, the survivor may elect to receive the compensation that would have been payable to the employee (known as election of benefits), including impairment (refer to PM Chapter 2-1200 Establishing Survivorship). The survivor must file a written confirmation that he or she is seeking an election of benefits. The claim filing date of the election of

SUPERSEDED

benefits for impairment is the postmark date of the written confirmation, if available, or the date the district office, FAB, Central Mail Room (CMR), or Resource Center receives the written confirmation, whichever is the earliest determinable date.

a. Instances Where Impairment is Not Available to a Survivor. In some cases, an impairment rating is not possible in accordance with the *AMA's Guides* because the necessary diagnostic or medical evidence is unavailable. If new information cannot be collected following the death of the employee, the CE advises the survivor of the deficiency in a letter. The CE should also advise the survivor that he/she may be eligible to receive compensation for wage-loss. If the CE is uncertain as to whether there is sufficient medical evidence to perform an impairment rating following the death of the employee, the CE can refer the case to a CMC for consideration. The CE notifies the claimant of any deficiency that prevents the CMC from opining on the employee's impairment and allow for the submission of supportive evidence. If an impairment rating cannot be performed due to lack of sufficient medical evidence, the CE denies the impairment claim.

SUPERSEDED

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Date
Case ID Number:
Employee:

Name
Address
Address

Dear Mr./Mrs. Last Name:

I am writing to inform you that we are unable to make a determination on your claim for impairment benefits under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

In order to determine whether you have sustained a permanent impairment, the physician must conclude that your accepted condition is well stabilized and unlikely to improve substantially with or without medical treatment; this is called maximum medical improvement or MMI. The medical evidence shows your condition has not reached this state; therefore, we cannot determine your impairment rating at this time.

Your impairment claim will be administratively closed until your condition has reached MMI. At that time, please submit your physician's opinion and we will reopen your impairment claim and resume development.

If at any time you would like to discuss this issue further, please do not hesitate to contact our office, toll-free, at ( ) . If it is more convenient, you may visit one of our local resource centers for additional help.

Sincerely,

Printed Name
Claims Examiner

SUPERSEDED

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date
Case ID Number:
Employee Name:

Name
Address
Address

Dear Mr./Ms. Last Name:

This is regarding your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). On Date of Letter or Phone Call you advised us that you do not want to pursue a claim for impairment.

I would like to thank you for taking the time to consider our request to file for an award. Please note that your decision at this time does not relinquish your right to file a claim for impairment in the future. Therefore, we will not undertake further development for impairment at this time. Should you wish to pursue a claim in the future, please notify us in writing at the address above.

If you have any questions about your claim or other benefits available under this program, do not hesitate to call me, toll-free, at ( ) . If it is more convenient, you may visit one of our local resource centers for additional help.

Sincerely,

Printed Name
Claims Examiner

SUPERSEDED

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date

CASE ID NUMBER:

EMPLOYEE:

Medical Provider
Street Adress
City, State, Zip Code

Dear Medical Provider;

Our office has determined that the above employee is eligible for an impairment evaluation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) in relation to the following accepted illness Insert name AND ICD-9/10 of covered illness.

Employee name has identified you as his/her choice to perform an impairment evaluation in relation to his/her covered illness. The Division of Energy Employees Occupational Illness Compensation (DEEOIC) will cover the cost of the impairment evaluation as long as the condition has reached a point where further improvement is not expected (Maximum Medical Improvement/MMI), or the employee is considered to be in the terminal stages of the illness. The evaluation must also be performed within one year of the date DEEOIC receives the completed impairment report, and not performed prior to Filing date (the date he/she filed for benefits under the EEOICPA). The evaluation must be performed in accordance with the 5th Edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment (*AMA's *Guides)*, with specific page and table references included in your report.

Physicians who perform impairment evaluations for the DEEOIC must hold a valid medical license and Board certification/eligibility in their field of expertise (e.g., toxicology, pulmonary, neurology, occupational medicine, etc.). The physician must also meet at least one of the following criteria:

- is certified by the American Board of Independent Medical Examiners (ABIME)
- is certified by the American Academy of Disability Evaluating Physicians (AADEP)
- possesses knowledge and experience in using the AMA's *Guides*
- possesses the requisite professional background and work experience to conduct such ratings

When your impairment evaluation has been completed, please submit a letter to establish that you meet the criteria listed above. If you do not possess either the ABIME or AADEP certification, please submit a statement certifying and explaining your familiarity and years of experience in using the AMA's *Guides*.

Physicians may bill impairment evaluation using CPT Code 99455 or 99456 with ICD-9 code V70.9. Diagnostic services related to impairment evaluations must be billed with the appropriate CPT codes. Supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) must be submitted with the completed Office of Workers' Compensation Program (OWCP) Health Insurance 1500 Form (OWCP 1500). If you need a copy of the medical record in our case file to perform the impairment evaluation, please contact me. Reimbursement for these services will be in accordance with the OWCP fee schedule.

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Electronic versions of OWCP-1500 and the Provider Enrollment Package are available on-line at:

OWCP-1500 – http://www.dol.gov/owcp/dfec/regs/compliance/OWCP-1500.pdf

Provider Enrollment Package - http://www.dol.gov/owcp/dfec/regs/compliance/OWCP-1168.pdf

If you have any questions regarding this letter or impairment ratings in general, please contact me directly at (XXX) XXX-XXX.

Thank you for your assistance.

Sincerely,

Examiner name
Claims Examiner

Enclosures:
Required Medical Evidence for Determining Impairment Rating By Specific ICD-9/10 Codes
Examiner note: print appropriate section from Impairment Documentation for ICD9 template

SUPERSEDED

Impairment Rating Requirements

If you elect to file an impairment claim, you will be required to provide **Activities of Daily Living (ADL)**, along with the required medical records dated *preferably* within the last 12 months.

The ADLs must be provided by your Specialist Physician, Family Practitioner or Primary Physician in a letter or should be noted in your medical records (for example, History and Physical Examination) in order for the impairment rating to be performed. **For your convenience, please take the attached sample ADL Questionnaire to your treating physician for his/her completion.** Please remember your medical records and diagnostic examinations must include your current treatments and prescribed medications. **This information *should* be dated within the last 12 months. However, if you have no additional medical records to provide, please inform our office in writing, so that we can proceed with your impairment claim.**

Since you will not be physically examined by a Contract Medical Consultant (CMC), obtaining your current medical records and ADLs or equivalent record from your physician is important in determining your rating. The lack of medical information, could potentially affect your impairment rating. Below is an example of the ADL information needed from your physician, as referenced in the AMA's *Guides*, Table 1-2.

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales

Activity	**Example**
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

SUPERSEDED

Activities of Daily Living Questionnaire	**Name:**
	Case ID #:

Accepted Conditions	ICD-9/10 Code	Condition @ MMI[1]
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
☐ See attached if more than 3 conditions		

Rating Scale
(Each criteria is graded in level of dependence)

1 – Performs independently without reminder or assistance
2 – Performs with assistance or reminders
3 – Unable to perform on own, even if assisted

Is the claimant terminal? ☐ YES ☐ NO If YES, estimated timeframe: _____

Since the employee will not be physically evaluated for **impairment** by a Department of Labor physician, the following information regarding the employee's Activities of Daily Living (ADL) or equivalent information is required. Rate the activity based **only** on limitations caused or contributed to by the **accepted condition(s)**. Address all items using the above rating scale to determine the person's ability to perform the activity.

	Self-Care / Personal Hygiene	**Rating**		**Additional comments concerning these activities**
	Dressing/undressing oneself			
	Eating			
	Meal preparation			
	Taking or managing medicine			
	Toileting – getting to and on/off toilet			
	Toileting – keeping self-clean and dry			
	Toileting – arranging clothes			
	Bladder/Bowel control			
	Brushing teeth			
	Combing/brushing hair			
	Bathing			
	Light housekeeping			

	Communication	**Rating**		**Additional comments concerning these activities**
	Writing			
	Typing			
	Seeing			
	Hearing			
	Speaking			

	Physical Activity	**Rating**		**Additional comments concerning these activities**
	Standing			
	Sitting			
	Reclining			
	Walking			
	Climbing Stairs			

[1] Condition has reached maximum medical improvement (MMI) i.e. well-stabilized and unlikely to improve with medical treatment or not required if an illness is in a terminal stage.

SUPERSEDED

Sensory Function	Rating	Additional comments concerning these activities
Hearing		
Seeing		
Tactile Feeling		
Tasting		
Smelling		

Other: Non-specialized hand activities	Rating	Additional comments concerning these activities
Grasping		
Lifting		
Pulling/Pushing		
Reaching up, down, out		
Tactile Discrimination		

Travel	Rating	Additional comments concerning these activities
Riding		
Driving		
Flying		
Arranging travel for self		

Transferring In and Out of:	Rating	Additional comments concerning these activities
Bed		
Tub/Shower		
Chair/Sofa		
Vehicles		

Sexual Function	Yes	No	Additional comments concerning these activities
Orgasm			
Ejaculation			
Lubrication			
Erection			

Sleep	Yes	No	Additional comments concerning these activities
Restful			
Nocturnal Sleep Pattern			

Provide any additional comments to explain what this person can or cannot do in their daily life (if additional space is needed, please provide a typed narrative report and attach it to this questionnaire):

The information listed above is complete and accurate to the best of my knowledge:

_____

Physician's Printed Name

_____ _____

Physician's Signature ***Date***

Exhibit 4

SUPERSEDED

Activities of Daily Living **Supplementary ADL Specific to: Breast Cancer**	**Name:** **Case ID#:**

Is the patient at MMI for breast cancer and if so what date? MMI ☐ Yes ☐ No Date: _____

1. Was removal of part or all of one or both breast required? If so, describe.

2. Is there resulting lymphedema in the affected arms? If so, describe severity. Is it partially or completely controlled with stockings?

3. Is there a resulting decrease of motion in affected extremities? If so, detail range of motion for those joints.

4. Is there any decrease in strength in the upper extremities? If so, describe on a scale of 0-5 with mention of involved motor nerves.

5. Is there decreased sensation in the affected extremities? If so, describe with mention of which sensory nerves.

6. Is there any intermittent or continuous pain of the chest wall? If so, describe.

7. Has there been metastasis? If so, describe.
Additional Comments:

SUPERSEDED

Activities of Daily Living **Supplementary ADL Specific to: Skin Cancer**	**Name:** **Case ID#:**

Is the patient at MMI for skin cancer and if so what date? MMI ☐ Yes ☐ No Date: _____

1. Is the claimant limited to sun exposure? If so, describe.

2. Does the claimant have a significant deformity from the skin cancer affecting interpersonal relationships? If so, please describe.

3. Does the claimant have a deformity or scarring that limits range of motion of any joints? If so, please state joint and indicate range of motion.

4. Does the claimant require use of a prescriptive drug for the treatment of skin cancer, either intermittently or continuously? If so, please describe.

5. Does the claimant's skin cancer limit any ADL other than sun exposure? If so, please describe.

6. Has there been metastasis? If so, please describe.

Additional Comments:

SUPERSEDED

Required Medical Evidence for Specific Conditions

- Disorder of the Thyroid gland must have the following reported *within the past year* before impairment rating can take place:
  - Note from Physician with the following information:
    - Current symptoms
    - Physical exam findings of the area(s) affected
    - Any Biopsy information
    - Surgical history of site

- Anemia must have the following reported *within the past twelve months* before impairment rating can take place:
  - Note from Physician with the following information:
    - Current symptoms
    - Need for transfusion and the intervals involved
    - Current treatment(s) including prescriptions
  - Complete Blood Count with differential (CBC with Diff)

- Tremor must have the following reported *within the past twelve months* before impairment rating can take place:
  - Note from Physician with the following information:
    - Current symptoms
    - Physical exam findings of the area(s) affected:
      - Motor strength
      - Coordination
      - Dexterity
    - Functional Activity pertaining to Activity of Daily Living (ADL):
      - Buttoning shirt
      - Lacing shoes
      - Performing peg tasks
    - Current treatment(s)

- Peripheral Neuropathy, Polyneuropathy must have the following reported *within the past twelve months* before impairment rating can take place:
  - Note from Physician with the following information:
    - Current symptoms
    - Physical exam findings of the Upper Extremities
      - Motor strength
      - Coordination
      - Dexterity
    - Functional Activity pertaining to Activity of Daily Living (ADL):
      - Buttoning shirt
      - Lacing shoes
      - Performing peg tasks
    - Physical exam findings of the Lower Extremity
      - Motor strength
      - Coordination
    - Functional Activity pertaining to Activity of Daily Living (ADL): (Upper extremities)
      - Standing (with/without mechanical support and/or assistive device)
      - Walking
        - With/without assistance
        - Ability to start and stop walking
        - Limited to level surface
        - Difficulty with elevation/stairs

SUPERSEDED

- Loss of stature
- Romberg Sign
- Current treatment(s)

- Electromyography (EMG)

► Cataracts must have the following reported *within the past year* before impairment rating can take place:
Note from Physician with the following information:

- Current symptoms
  - Physical exam findings
  - Current treatment(s)
  - Surgical procedure(s)
- Visual Acuity testing, corrected
- Visual Field testing

► Hearing loss must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
- Tympanometry
- Speech Discrimination test
- Pure Tone Audiogram of both ears

► Chronic Sinusitis must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms including: headaches, balance problems
  - Physical exam findings of the area(s) affected
  - Current treatment(s) including prescriptions
- Sinus CT

► Allergic Rhinitis must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms including headaches, balance problems
  - Physical exam findings of the area(s) affected
  - Current treatment(s) including prescriptions

► Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Bronchitis, Asbestosis, Chronic Respiratory condition must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Current treatment(s) including prescriptions
- Pulmonary Function Test (PFT) with DL_{CO} with pre/post bronchodilator

► Liver Disease must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history of site
  - Nutritional Status and/or restrictions

SUPERSEDED

- Current treatment(s) including prescriptions

- Liver Function Test (LFTs)

► Upper Genitourinary Disease must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history
  - Current treatment(s) including prescriptions
  - Need for Dialysis and its schedule
  - Nutritional Status and/or restrictions
- Kidney Function Test (Creatinine Clearance Test)
- Serum Creatinine
- Urine Analysis

► Bladder Disease must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current signs/symptoms (frequency, nocturia, loss of control, urgency, dribbling)
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history
  - Current treatment(s) including prescriptions

► Dermatitis, Skin Rash must have the following reported *within the past twelve months* before impairment rating can take place:

- Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area in question
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Patch testing information when available

SUPERSEDED

Cancers
(in alphabetical order)

All information has to be dated in the past 12 months including the diagnostic tests.

Bladder Cancer

Note from Physician with the following information:

- Current symptoms to include urinary frequency/nocturia, reflex activity of the bladder
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs)
- Current treatment(s)

Breast Cancer

Note from Physician with the following information:

- Current symptoms
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs)
- Current treatment(s)

Colon Cancer

Note from Physician with the following information:

- Current symptoms including weight loss and percentage
- Presence of any stomas
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s)

Esophageal Cancer

Note from Physician with the following information:

- Current symptoms including weight loss and percentage
- Presence of any stomas
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s)

Gallbladder Cancer

Note from Physician with the following information:

- Current symptoms including weight loss and percentage, and jaundice
- Presence of any stomas
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs) to include any limitation on diet

SUPERSEDED

- Current treatment(s)

- Liver Function Tests (LFTs)

Hodgkin's Lymphoma

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Complete Blood Count (CBC) with differential
- Pathology report *if available*

Hypo-pharyngeal Cancer

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Presence of any stomas
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Laryngeal Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Presence of any stomas
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Leukemias *(includes Acute/Chronic Lymphocytic Leukemia (ALL/CLL) and Acute/Chronic Myelocytic Leukemia (AML/CML))*

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any liver or spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Complete Blood Count (CBC) with differential
- Liver Function Tests (LFTs)

SUPERSEDED

Liver Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage, presence of jaundice
  - Physical exam findings of the area(s) affected including presence of ascites
  - Surgical history to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
- Liver Function Tests (LFTs)

Lung Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
- Pulmonary Function Test (PFT)

Multiple Myeloma

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Complete Blood Count (CBC) with differential

Myelodysplastic Syndrome

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Complete Blood Count (CBC) with differential

Nasal Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Presence of any stomas
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

SUPERSEDED

Nasopharyngeal

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Presence of any stomas
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Kidney Cancer

See Renal Cancer

Pancreatic Cancer

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage, and jaundice
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
- Liver and Pancreatic Function Tests

Pharyngeal Cancer

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Presence of any stomas
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Polycythemia Vera

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Complete Blood Count (CBC) with differential

SUPERSEDED

Prostate Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage along with urinary control and sexual function after surgery *if prostatectomy was performed*
  - Physical exam findings including pain induced by metastatic lesions
  - Activities of Daily Living (ADLs)
  - Surgical history to the affected area
  - Current treatment(s)

Renal Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Need for dialysis and schedule
  - Kidney transplant
  - Surgical history to the affected area
  - Presence of any stomas
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
- Kidney Function Test (Creatinine Clearance Test)
- Serum Blood Urea Nitrogen (BUN) and Creatinine
- Urine Analysis

Skin Cancer

- Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Physical exam findings of the area in question
  - Activities of Daily Living (ADLs)
  - Current treatment(s)

Small Intestinal Cancer (duodenum, jejunum, ileum)

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Presence of any stomas
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)

Thyroid Cancer

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s) and presence of other illnesses allowing for only partial hormone replacement

SUPERSEDED

Tongue Cancer

- Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Tracheal Cancer

- Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Presence of any stomas
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table below
    *Please complete this task **with and without** use of assistive device for speech*
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

SUPERSEDED

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date

CASE ID#:
EMPLOYEE:

Med Provider
street address
City, State, zip

Dear Medical Provider;

The above-named employee filed a claim for whole body impairment as a result of breast cancer under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) requires impairment determinations to be performed in accordance with the 5th Edition of the American Medical Association's *Guide to the Evaluation of Permanent Impairment* (AMA's *Guides*). Moreover, to ensure that the employee's impairment is fully rated, several factors must be considered and included in the evaluation report. These factors include: (1) the unilateral or bilateral absence of the breast; (2) the loss of function of the upper extremity, including range of motion, neurological abnormalities and pain, etc; (3) skin disfigurement; and (4) other physical impairments affecting activities of daily living.

We would greatly appreciate a detailed narrative report from you, based on your examination that addresses the following:

1. Has maximum medical improvement been reached? If so, what is the approximate date? DEEOIC defines maximum medical improvement as when the claimant's condition is unlikely to improve substantially with or without medical treatment.

2. Is there surgical absence of the breast(s)? Surgical absence of a breast is rated in accordance with AMA's *Guides*, section 10.9, page 239 and is assigned a maximum of 5% of the whole person.

3. A description of the surgical site (if any) and mention of infections, ulcerations, grafts and any other factors that have affected the size and aspect of the scar and the presence of other skin abnormalities. If a rating for skin disfigurement/abnormalities is needed please use Chapter 8 in the AMA's *Guides*.

4. The effects of radiation or other therapies on any organ system represented by clinical findings and/or tests, as well as the ability to perform activities of daily living.

5. Other physical impairments related to the underlying condition including those mentioned under number 4 above. These need to be well documented and ratable under the AMA's *Guides*.

6. Your recommended percentage of impairment including a rationalized opinion as to how you arrived at the total impairment. This includes how you arrived at the impairment figure, referencing applicable tables and sections of the AMA's *Guides*.

Exhibit 6

SUPERSEDED

It is important that you respond to each of these questions to ensure that the patient receives the maximum percentage of impairment allowed by the AMA's *Guides* for his/her work-related condition. The rating should be performed on the patient's current level of impairment. Please note that the DEEOIC allows for periodic re-evaluations for future increases in permanent impairment.

Payment for the impairment evaluation and required diagnostic tests are covered by the DEEOIC. Physicians may bill impairment evaluation using CPT Code 99455 or 99456 with ICD-9 code V70.9. Diagnostic services related to impairment evaluations must be billed with the appropriate CPT codes. Supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) must be submitted with the completed Office of Workers' Compensation Program (OWCP) Health Insurance 1500 Form (OWCP 1500). Reimbursement for these services will be in accordance with the OWCP fee schedule.

If you have any questions or concerns regarding this letter or impairment ratings in general, please contact me directly at (XXX) XXX-XXXX.

Thank you for your assistance.

Sincerely,

Examiner name
Claims Examiner

SUPERSEDED