



RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL
VERSION 3.0:

EEOICPA TRANSMITTAL NO. 19-01

April 5, 2019

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this transmittal to notify staff of the publication of Version 3.0 of the Federal (EEOICPA) Procedure Manual (PM). Version 3.0 (v3.0) replaces Version 2.3 (v2.3), effective the date of publication of this transmittal.

Following are the content edits that make up Federal (EEOICPA) PM v3.0:

- Chapter 2, The EEOICPA:
 - Ch. 2.4b(1) has been modified to remove reference to the Medical Bill Processing Unit. The language included in v2.3 read:
 - (1) *Policy Branch. Personnel in the Policy Branch consist of the Policy, Regulations and Procedures Unit (PRPU), Medical Bill Processing Unit, and the Medical, Health & Science Unit (MHSU).*

It has been revised in v3.0 to:

- (1) *Policy Branch. Personnel in the Policy Branch consist of the Policy, Regulations and Procedures Units (PRPU) and the Medical, Health & Science Unit (MHSU).*
 - (a) *The PRPU is responsible for working with the Office of the Director and the SOL in the research, determination and writing of all program policies, regulations and procedures, as well as providing consultative services regarding those policies, regulations and procedures to various DEEOIC staff.*
 - (b) *The MHSU conducts and oversees scientific and nursing-related consultative services for DEEOIC staff. This can include industrial hygiene, health physicist, toxicological and nursing-related advice and consulting services. Additionally, these staff provide specific medical and scientific research, reporting and advice in the development of policies, regulations and procedures that involve scientific and/or medical issues.*

- Ch.2.4b(1)(b) has been deleted and its content moved to Ch. 2.4c(1).
- Ch. 2.4b(1)(c) has also been deleted. Accordingly, what was Ch. 2.4b(1)(d) has been renumbered to Ch. 2.4b(1)(b).
- Ch. 2.4b(5) has been added to include language regarding the responsibilities of the Branch of Medical Benefits Adjudication and Bill Processing (BMBABP), and states:

(5) *Branch of Medical Benefits Adjudication and Bill Processing (BMBABP). Personnel in this branch are responsible for medical bill processing, adjudication of certain medical benefits that require pre-approval (like home health care related activities) for claimants who have accepted conditions, and program integrity.*

(a) *The Medical Bill Processing Unit (MBPU) oversees the medical bill processing systems, transactions and coding necessary to assure prompt and accurate payment for approved medical benefits, and works with OWCP and the Central Bill Processing contractor to develop and implement appropriate bill payment codes, procedures and resolutions to issues which arise.*

(b) *The Program Integrity Team provides analysis, investigations, audit and reporting regarding whether payments made to claimants or providers were accurate and appropriate, and align with necessary treatments for approved conditions. When potential billing inaccuracies or discrepancies are identified, they will work to provide training and/or implement bill adjustments, as appropriate and necessary.*

(c) *The Medical Benefits Adjudication Unit (MBAU) provides medical benefits adjudication and decisions regarding requests for medical care or equipment that requires preauthorization.*

- Ch.2.4c(1) has been added and includes the following language which was previously Ch. 2.4b(1)(b):

(1) *A separation must exist between the DOs and FAB to maintain impartiality in case adjudication functions. The designated CE assigned to a case handles all necessary development on outstanding claim elements not related to the RD currently in front of the FAB for review, and may issue a RD whenever the case record contains enough evidence on file to support a RD on any of the outstanding claim elements. While the CE may concurrently work on a case assigned to FAB, the CE may not engage in any case adjudication activity relating to a claim under evaluation by FAB. Moreover, FAB may not seek CE assistance with regard to its evaluation or development of a claim under consideration for finalization.*

- Chapter 5, Program Directives:

- Ch. 5.4 has been edited to clarify the proper PM citation method, including version number. The language included in v2.3 read:

4. Maintenance and Revision. *EEOICPA Transmittals update the EEOICPA PM and are to be cited in the following manner:*

- a. *Citations to the PM. The EEOICPA PM has thirty-six chapters, which in turn are divided into paragraphs, subparagraphs, and sometimes sub-subparagraphs. The PM should be cited as follows:*

Citation to a chapter: Federal (EEOICPA) PM Chapter 1

Citation to a paragraph: Federal (EEOICPA) PM Chapter 1.1

Citation to a subparagraph: Federal (EEOICPA) PM Chapter 1.1a

Citation to a sub-subparagraph: Federal (EEOICPA) PM Chapter 1.1a(1)

It has been revised in v3.0 to:

4. Maintenance and Revision. *EEOICPA Transmittals update the EEOICPA PM.*

- a. *Citations to the PM. The EEOICPA PM has thirty-six chapters, which in turn are divided into paragraphs, subparagraphs, and sometimes sub-subparagraphs. The PM should be cited as follows:*

Citation to a chapter: Federal (EEOICPA) PM Chapter 1 (Version X.X)

Citation to a paragraph: Federal (EEOICPA) PM Chapter 1.1(Version X.X)

Citation to a subparagraph: Federal (EEOICPA) PM Chapter 1.1a (Version X.X)

Citation to a sub-subparagraph: Federal (EEOICPA) PM Chapter 1.1a(1) (Version X.X)

- Chapter 12, Representative Services:

- Ch. 12.7 has been edited to clarify representative conflict of interest guidance. The language included in v2.3 read:

7. Representative Conflict of Interest Guidance. *The DEEOIC prohibits an AR of a claimant from having private, non-representational financial interests relating to a claim, other than the fee for serving as a representative. This ensures that ARs serve the interests of his or her client in a fair and unbiased manner. The DEEOIC will consider an AR to have a "conflict of interest" if the AR could directly benefit financially from an EEOICPA claim due to something other than the statutorily set fee for representing a client in connection with his or her EEOICPA claim. For example, an AR will be considered to have a conflict of interest*

if, in addition to being the client's AR, she or he is also being paid by DEEOIC, directly or indirectly, as a provider of authorized medical services to the client.

It has been revised in v3.0 to:

7. Representative Conflict of Interest Guidance. Conflicts of interest can arise when a duly appointed AR has direct financial interests arising out of the acceptance of a claim, even if those interests are only potential in nature, aside from the representational fees permitted under EEOICPA. This is because those other financial interests may be more lucrative to an AR, and therefore may be more important, than the potential amount of the fee for representing a client with a claim before DEEOIC. These sorts of divided interests on the part of ARs might motivate representatives to act in a manner contrary to a claimant's best interests and are not allowed under this policy.

- Exhibit 12-3, Notification to Representative, has been edited to include revised language regarding conflict of interest. The language included in v2.3 read:

Conflict of Interest Policy. As an authorized representative of a claimant under the EEOICPA, you are prohibited from having private, non-representational direct financial interests, other than your fee for serving as a representative, in regard to your client's claim with DEEOIC. Because the "role" of an authorized representative is so important, DEEOIC will consider you to have a conflict of interest if you could directly benefit financially from your client's EEOICPA claim due to something **other than** your statutorily limited fee for representing your client in connection with his or her EEOICPA claim. For example, you will be considered to have a conflict of interest if, in addition to being your client's authorized representative, you are also being paid by DEEOIC, directly or indirectly, as a provider of authorized medical services to your client. Because there is an obvious conflict of interest that will arise in this sort of situation, DEEOIC will not recognize you as an authorized representative should this occur, and will inform the claimant of the need to designate another person as his or her authorized representative who does not have such a conflict. If you are in a position to directly benefit financially from your client's EEOICPA claim, you are required to notify DEEOIC and withdraw as representative.

It has been revised in v3.0 to:

Conflict of Interest Policy. Since an authorized representative is expected to act in a way that promotes the best interests of his or her client, DEEOIC will consider you to have a prohibited "conflict of interest" if you could benefit financially from the acceptance of your client's claim, either directly as a provider of services or supplies, or indirectly as an employee or contractor of such a provider, regardless of whether those services or supplies have already been provided, or may be provided after the claim has been accepted. If this situation occurs, DEEOIC will not recognize you as an authorized representative and will inform the claimant of the need to designate another person as his or her authorized representative who does not have such a conflict, if he or she still wishes to have a representative.

- Chapter 14, Establishing Special Exposure Cohort Status:
 - Exhibit 14-1, List of SEC Designated Classes, updated to include Ames Laboratory from January 1, 1971 through December 31, 1989 (Circular 18-03); and Sandia National Laboratories from January 1, 1995 through December 31, 1996 (Circular 19-01).
- Chapter 15, Establishing Toxic Substance Exposure and Causation:
 - Ch. 15.3c(1) has been added to include language regarding evaluating an opinion of a treating physician.
 - (1) *In instances where a physician submits an opinion that a toxic substance exposure was a contributory or aggravating factor in the development of a claimed illness specific to the individual, his or her opinion must be determined to be well rationalized, as that phrase is defined later in this chapter, before the Part E claim can be accepted. In particular, the physician must offer an interpretation of epidemiological or medical health science data that reasonably supports the opinion presented. Moreover, the CE must corroborate the factual presentation of information used in the formulation of the opinion (e.g. medical history, verified periods of covered employment, and toxic substance exposure characterization) with evidence available in the case file or obtained through the application of program resources, such as the SEM or referral to a medical health science expert.*
 - Ch. 15.12a has been revised for clarity. The language included in v2.3 read:
 - a. *Cancerous conditions. The application of a radiation dose in deciding a Part E cancer claim may require the application of the Part B dose reconstruction analysis.*

It has been revised in v3.0 to:

- a. *Cancerous conditions. The effect of radiation in establishing a diagnosed cancer, as a covered Part E illness, requires the application of the PoC calculation derived from a NIOSH dose reconstruction.*
- Ch. 15.12b has been revised for clarity. The language included in v2.3 read:
 - b. *Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH but will need the review by the NO HP.*

It has been revised in v3.0 to:

- b. *Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH, but will need a review by the NO HP if there is*

a medical or scientifically-based link between the condition and radiation exposure.

- Ch.15.13b (1) has been added to include language regarding a CE's responsibility when a causation opinion of an employee's physician is found to be insufficient, and states:
 - (1) *In these situations, the CE is to provide the physician with any employment or scientific evidence that DEEOIC has obtained to establish an accurate factual presentation of exposure; including exposure analysis worksheets, affirmative SEM search outputs, epidemiological data, or IH assessments.*
- Exhibit 15-4, Section 3b, discussing asbestos exposure after 1986 through 1995, has been deleted.
- Exhibit 15-4, Section 7b(1) has been edited for clarity. The language included in v2.3 read:
 - (1) *The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to 1986.*

It has been revised in v3.0 to:

- (1) *The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1986.*
- Exhibit 15-4, Section 8 has been edited to clarify the process by which a finding can be made that a job is the equivalent of a listed job, and to communicate ways in which an IH and SEM can be used to assist in adjudication of claims. The language included in v2.3 read:

8. **Hearing Loss:** *In order to satisfy the standard for Part E causation for hearing loss, the following conditions must be met:*

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

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

- *Boilermaker*
- *Chemical Operator*
- *Chemist*

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

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

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

d. For hearing loss claims in which the employee provides evidence asserting a causative link between covered employment and exposure to OTHER solvents not listed in this Exhibit, the CE forwards such evidence to the NO for specialist review.

e. Challenges to the DEEOIC Conditions of Acceptance. This policy guidance represents the sole evidentiary basis a CE is to use in making a decision

concerning whether it is “at least as likely as not” that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateral sensorineural hearing loss. Claims filed for hearing loss that do not satisfy the conditions for acceptance outlined in this procedure cannot be accepted, because these standards represent the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance. The CE is to undertake routine development (i.e., SEM, SEM mailbox, IH referral, etc.) on any hearing loss claim that does not meet the criteria described in this procedure, including communicating to the claimant the evidence necessary for a compensable hearing loss claim. As part of that development, the CE is to notify the claimant of his or her ability to challenge the scientific underpinnings of the DEEOIC hearing loss policy.

The claimant has the burden of establishing, through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data. If a claimant seeks to argue that the standard by which DEEOIC evaluates claims is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. Any claimant submission of scientific documentation, including journals, periodicals, or other literature (including citations to literature) has to relate to the topic of the correlation between hearing loss and toxic substance exposure. Scientific evidence that does not relate to or reference hearing loss is insufficient. With the receipt of compelling scientific data relating to a challenge to the DEEOIC conditions of acceptance for hearing loss, the CE is to prepare a referral of the documentation to the Policy Branch for examination by a Health Scientist who will respond to whether the evidence warrants a change to program policy regarding hearing loss.

It has been revised in v3.0 to:

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

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

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

- Boilermaker*
- Chemical Operator*
- Chemist*

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

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

- (1) *Referral to the SEM mailbox. The SEM team has access to site documentation that can assist in making determinations of equivalency, or*
- (2) *Submission of an IH referral. After a review of the evidence submitted and through the use of their expert knowledge of industrial processes, an IH can opine whether jobs are equivalents.*

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

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

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

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

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

If the claimant wants to challenge one or more of the criteria of the standard, the claimant has the burden of establishing, through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data. If a claimant seeks to argue that the standard is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. At a

minimum, the claimant must produce epidemiological evidence (medical health science journals, articles, periodicals or other peer-reviewed publications) that specifically identifies or references a toxic substance, as defined by DEEOIC's regulations, which the evidence describes as having a health effect of bilateral sensorineural hearing loss. If the entire published article(s) are not provided, then the citation(s) must include: Journal Name, Author Last Name, Year Article Published, Title of Article, Volume (#) and Pages (#-#). Upon receipt of such evidence, the CE may refer the matter to the National Office Medical Health Science Unit for evaluation. The CE does not need to refer to the National Office cases where claim submissions do not present evidence that satisfies the minimal standard for consideration.

- Exhibit 15-4, Section 15b has been edited for clarity. The language included in v2.3 read:

b. Exposure: The employee had 250 days or more of significant exposure to asbestos through 1986. This can be determined by an IH assessment or by working in one of the identified labor categories provided in Exhibit 15-4, Item 3, paragraph "a(1)".

It has been revised in v3.0 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Chapter 18, Eligibility Criteria for Non-Cancerous Conditions:

- Ch. 18.5c has been revised. The language included in v2.3 read:

c. False Negative Results. If the claimant has a history of steroid use, a false negative result on the BeLPT/BeLTT or the beryllium patch test can occur. If there is evidence that this has occurred, then the CE requests that the employee undergo a repeat BeLPT/BeLTT or beryllium patch test. If the claimant is deceased, the CE should try to obtain as much information as possible on past LPT results and possible steroid use. If exhaustive efforts produce little or no results and the evidence of record contains the normal/borderline LPT result along with a biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim.

It has been revised in v3.0 to:

c. False Negative Results. If a claimant has a history of steroid use, a false negative result on a BeLPT/BeLTT or the beryllium patch test can occur. DEEOIC will accept that a false negative test qualifies as an abnormal BeLPT/BeLTT only when a physician provides a well-rationalized opinion supporting the contention that a normal BeLPT/BeLTT represents a false-negative result. The opinion of

the physician must align with the objective medical evidence of record including that the patient used steroid medication at the time of BeLPT/BeLTT testing.

- Ch. 18.6 has been revised for clarity. The language included in v2.3 read:

6. *Established CBD Before 1993, Part B.* *The evidence required to establish a claim for established CBD under Part B of the Act is described under 42 U.S.C. § 7384l(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested for, diagnosed with, and/or treated for a chronic respiratory disorder.*

If the earliest dated document showing that the employee was either tested for, treated for, or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria should be used. Evidence of a chronic respiratory disorder includes records communicating existence of a long term, prolonged pulmonary disease process. References to acute pulmonary conditions, such as short-term pulmonary distress associated with temporary viral or bacterial infection do not qualify as a chronic respiratory disorder. Pulmonary testing performed in occupational or medical settings, which identify abnormalities, are not appropriate to document a chronic respiratory disorder, unless interpreted as such by a physician. In situations where it is critical that the question of whether historical documentation communicates the existence of a chronic respiratory disorder, the CE is to undertake development to allow for a physician chosen by the claimant to provide clarification, or when the claimant is unable to provide such evidence, seek the input of a CMC.

It has been revised in v3.0 to:

6. *Established CBD Before 1993, Part B.* *The evidence required to establish a claim for established CBD under Part B of the Act is described under 42 U.S.C. § 7384l(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested for, diagnosed with, and/or treated for a chronic respiratory disorder.*

If the earliest dated document showing that the employee was either tested for, treated for, or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria should be used. Evidence of a chronic respiratory disorder includes records communicating existence of a long term, prolonged pulmonary disease process. Generally, the term “chronic” identifies a disease process, including symptoms or medication usage that is documented by a physician to have existed for more than three months. References to acute pulmonary conditions, such as short-term pulmonary distress associated with temporary viral or bacterial infection do not qualify as a chronic respiratory disorder. Pulmonary testing performed in occupational or medical settings, which identifies abnormalities, is not appropriate to document a chronic respiratory disorder, unless interpreted as such by a physician. In situations where it is critical that the question of whether historical documentation communicates the existence of a chronic respiratory disorder, the CE is to undertake development to

allow for a physician chosen by the claimant to provide clarification, or when the claimant is unable to provide such evidence, seek the input of a CMC.

○ Ch. 18.7a(2) has been revised. The language included in v2.3 read:

(2) *In claims that contain a normal or borderline LPT, and the lung tissue biopsy confirms the presence of granulomas consistent with CBD, the CE may accept the claim for CBD. The lung biopsy is considered the “gold standard.” However, the following steps must be followed before accepting a claim in this manner.*

(a) *If the claimant is living, the CE should contact the treating physician and obtain a detailed narrative report detailing the history of the claimant’s LPT results (if possible). Specifically, the physician should address whether the claimant has a history of positive LPTs with recent normal or borderline LPT results. The CE should note that if the claimant has a history of steroid use, this may cause a false negative on the LPT result.*

(b) *If the claimant is deceased, the CE should try to obtain as much information as possible on past LPT results and possible steroid use. If exhaustive efforts produce little or no results and the claim contains the normal/borderline LPT results along with a biopsy of the lung tissue showing the presence of granulomas, the CE may accept the claim.*

(c) *If there is no LPT and the lung tissue biopsy confirms the presence of granulomas consistent with CBD, the CE may accept the claim.*

It has been revised in v3.0 to:

(2) *In claims where a normal or borderline BeLPT/BeLTT has been interpreted by a physician as false-negative result due to steroid use, and a lung tissue biopsy has been performed, the CE is to obtain a medical opinion from the employee’s physician explaining whether the biopsy results is interpreted as “consistent with CBD.” The physician must provide his or her opinion that explains what aspects of the biopsy objectively support that the results reasonably represent a disease process consistent with CBD. In the absence of a rationalized opinion from the employee’s physician, the CE is to refer the medical evidence to a CMC for analysis and opinion. Once a normal BeLPT/BeLTT has been interpreted by a physician as false-negative result and a rationalized opinion from a qualified physician establishing that the results of a lung biopsy is consistent with CBD has been received, the CE may accept the claim.*

● Exhibit 21-2, Not Claiming Impairment Letter, has been updated to include Electronic Document Portal link.

● Exhibit 21-4, Impairment Rating Requirements, has been updated pertaining to the certification of Activities of Daily Living (ADL). The language included in v2.3 read:

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.

It has been revised in v3.0 to:

Reported ADLs must be described in sufficient detail to allow a physician to apply the information to the assessment of whole person impairment in accordance with the AMA's Guides to the Evaluation of Permanent Impairment 5th Edition. 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.

- Exhibit 21-5, Evidence to Support Impairment Rating for Certain Conditions, Chronic Obstructive Pulmonary Disease (COPD) section has been updated to include Emphysema and Chronic Bronchitis, Asbestosis, and other chronic respiratory conditions.
- Exhibit 22-2, Not Claiming Wage-Loss Letter, has been updated to include Electronic Document Portal link.
- Chapter 24, Recommended Decisions:
 - Ch. 24.7a has been revised to remove the requirement that the amount of benefits being awarded be included in a cover letter. The language included in v2.3 read:
 - 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 FD. 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 RD. Finally, if the DO issued a recommendation based on written input received from a DEEOIC medical health scientist (toxicologist/industrial hygienist or health physicist) or Contract Medical Consultant, the CE must attach the document(s) for reference.*

It has been revised in v3.0 to:

a. *Cover Letter. A cover letter summarizes the recommendation(s) of the DO to accept, deny or defer claimed benefit entitlement(s) under Part B, Part E, or both. It advises that the accompanying is a recommendation, is not a final decision, and that the case file has been forwarded to the FAB for review and the issuance of a FD. 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 RD. Finally, if the DO issued a recommendation to deny based on written input received from a DEEOIC medical health scientist (TOX/IH or HP) or CMC, the CE must attach the document(s) for reference.*

o Ch. 24.7b(6) has been revised for clarity. The language included in v2.3 read:

(6) *Signatory Line. The signature line must include the name and 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.*

It has been revised in v3.0 to:

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

o Ch. 24.10g has been added to include language allowing the use of letter decisions to accept additional claims for skin cancers of the same type under Part E, and states:

g. *For any primary skin cancer that is accepted under Part E for toxic substance exposure other than radiation (e.g. chemical or biological exposure), DEEOIC may accept by letter decision any subsequent claim of the same type of primary skin cancer diagnosed at a different anatomical location.*

• Chapter 26, FAB Decisions:

o Ch. 26.2b has been edited to remove reference to CE2. The language included in PM v2.3 read:

b. *Denials. When FAB receives a RD in which the DO denies the claim in full or in part, FAB reviews the RD and independently reviews the case to ensure that appropriate development has occurred, the case has been adjudicated consistent with the law, regulations, policies and procedures and that the assessment of evidence has been interpreted reasonably to allow for a negative outcome. Provided no technical or procedural errors exist, FAB issues a FD to deny the claim.*

If the RD denies one claim element and defers another claim element pending further development, the designated CE2 continues to develop the claim element that is not before the FAB.

It has been revised in v3.0 to:

- b. *Denials. When FAB receives a RD in which the DO denies the claim in full or in part, FAB reviews the RD and independently reviews the case to ensure that appropriate development has occurred, the case has been adjudicated consistent with the law, regulations, policies and procedures and that the assessment of evidence has been interpreted reasonably to allow for a negative outcome. Provided no technical or procedural errors exist, FAB issues a FD to deny the claim.*

If the RD denies one claim element and defers another claim element pending further development, the assigned DO CE continues to develop the claim element that is not before the FAB.

- o Ch. 26.3a has been edited to clarify information that is required in a cover letter, and to include the “Notice of Final Decision” (Introduction) section as a part of a FD. The language included in v2.3 read:
 - (1) *A cover letter explaining that a FD has been reached. The cover letter must clearly identify what is being accepted or denied and under what Part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant.*
 - (2) *The FD. The FD contains a Statement of the Case, Findings of Fact and Conclusions of Law.*

It has been revised in v3.0 to:

- (1) *A cover letter explaining that a FD has been reached. The cover letter must clearly identify what is being accepted, denied and/or deferred, and under what Part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant.*
- (2) *The FD. The FD contains a Notice of Final Decision (Introduction), Statement of the Case, Findings of Fact and Conclusions of Law.*
- o Ch. 26.3b has been edited to add a subparagraph regarding the “Notice of Final Decision” (Introduction) section of a FD, as follows:
 - (1) *Notice of Final Decision (Introduction). This portion of a FD succinctly summarizes what benefit entitlement is being accepted, denied or deferred. Distinction is made between benefits addressed under Part B vs. Part E.*

- Based on the addition of a new Ch. 26b(1) as outlined above, the remaining sections of Ch. 26.3b have been renumbered accordingly.
- Ch. 26.4c has been edited to remove reference to the Secondary Claims Unit (CE2). The language included in v2.3 read:
 - c. *Receipt of New Medical Evidence or a New Claim for a Previously Unclaimed Illness. If while the case is at FAB, new medical evidence or a new claim for a new illness is received that is material to the recommended denial, FAB may remand or reverse to accept the claim, as applicable.*

For example, if the RD denies a claim for CBD on the basis of a lack of medical evidence and the claimant later submits medical evidence establishing CBD, the FAB may remand the claim or reverse the RD if all elements of the adjudicatory process are complete.

If a claim for a new illness is received, the case will be remanded for development of the newly claimed illness if it will affect the outcome of the issue before the FAB. If filing of the new claim will not affect the issue before the FAB, the FAB can issue a FD and return the new claim to the DO for further development. If the FAB is not immediately ready to issue the FD, then the CE2 should create the new claim and begin development while the case is at FAB.

It has been revised in v3.0 to:

- c. *Receipt of New Medical Evidence or a New Claim for a Previously Unclaimed Illness. If while the case is at FAB, new medical evidence or a new claim for a new illness is received that is material to the recommended denial, FAB may remand or reverse to accept the claim, as applicable.*

For example, if the RD denies a claim for CBD on the basis of a lack of medical evidence and the claimant later submits medical evidence establishing CBD, the FAB may remand the claim or reverse the RD if all elements of the adjudicatory process are complete.

If a claim for a new illness is received, the case will be remanded for development of the newly claimed illness if it will affect the outcome of the issue before the FAB. If filing of the new claim will not affect the issue before the FAB, the FAB can issue a FD and return the new claim to the DO for further development. If the FAB is not immediately ready to issue the FD, then the FAB is to notify the DO that a new claim has been filed so that the assigned DO CE may create the new claim and begin development while the case is at FAB.

- Ch. 26.4g has been edited to remove reference to CE2 unit. The language included in v2.3 read:

g. Where a case is at FAB for review of one claim element and a remand order is issued on another claim element; the designated CE2 addresses the remand order. If there are no outstanding issues before FAB, the remand order and case file is returned to the DO that issued the RD. FAB may also issue remand orders in part, returning one portion of the claim to the DO for further action and issuing a FD on other portions of the claim.

It has been revised in v3.0 to:

g. Where a case is at FAB for review of one claim element and a remand order is issued on another claim element; the designated DO CE addresses the remand order. If there are no outstanding issues before FAB, the remand order and case file is returned to the DO that issued the RD. FAB may also issue remand orders in part, returning one portion of the claim to the DO for further action and issuing a FD on other portions of the claim.

- Chapter 27, Reopening Process:

- Ch. 27.3c(4) has been edited to correct a typographical error regarding the 50% threshold for reopening. The language included in v2.3 read:

(4) PoC. Cases containing a FD based on a PoC of 50% or less are reopened by the DD when new evidence is received that warrants a referral to the NIOSH resulting in a revised PoC that makes the claim compensable. This most commonly occurs with claimant submission of an additional cancer claim. In those instances where a new cancer is evaluated by NIOSH and does not result in a PoC of 50% or greater, a reopening of the prior FD is not necessary. The DD directs his or her staff to proceed with any additional development that may be warranted (Part E analysis for non-radiogenic toxic substances) or proceed with a recommendation to deny the new cancer claim if Part E does not apply.

It has been revised in v3.0 to:

(4) PoC. Cases containing a FD based on a PoC of less than 50% are reopened by the DD when new evidence is received that warrants a referral to the NIOSH resulting in a revised PoC that makes the claim compensable. This most commonly occurs with claimant submission of an additional cancer claim. In those instances where a new cancer is evaluated by NIOSH and does not result in a PoC of 50% or greater, a reopening of the prior FD is not necessary. The DD directs his or her staff to proceed with any additional development that may be warranted (Part E analysis for non-radiogenic toxic substances) or proceed with a recommendation to deny the new cancer claim if Part E does not apply.

- Chapter 29, Ancillary Medical Services and Related Expenses:

- Ch.29.8 has been revised for clarity. The language included in v2.3 read:

8. Hearing Aids. A claimant requesting hearing aid(s) must submit LMN from his or her treating physician. The LMN must contain an explanation for obtaining hearing assistance due to an accepted work-related hearing loss. Services associated with the assessment, provision or fitting of hearing aids must be rendered by a licensed otolaryngologist, otologist, audiologist, or hearing aid specialist. Hearing aids are limited to one per ear every three years. The CE must authorize needed repairs within the three-year period, if the manufacturer's warranty has expired.

It has been revised in v3.0 to:

8. Hearing Aids. A claimant requesting hearing aid(s) must submit a LMN from his or her treating physician. The LMN must contain an explanation for obtaining hearing assistance due to an accepted work-related hearing loss. Services associated with the assessment, provision or fitting of hearing aids must be rendered by a licensed otolaryngologist, otologist, audiologist, or hearing aid specialist. Hearing aids are limited to one per ear every three years. The CE must authorize needed repairs within the three-year period, if the manufacturer's warranty has expired.

When submitting a bill for a hearing device dispensing fee, providers are to indicate the current Healthcare Common Procedure Coding System (HCPCS) procedure code that most appropriately reflects the quantity of hearing devices dispensed. For example, if a provider dispenses one hearing device to a claimant, the provider is required to indicate the HCPCS dispensing fee for a monaural hearing device. Hearing aid dispensing fees will be reimbursed per the OWCP fee schedule. The CE only approves hearing aid dispensing fees when hearing aids have been authorized by DEEOIC.

- Chapter 30, Home and Residential Health Care:

- Ch. 30.4 has been revised. The language included in v2.3 read:

4. Conflict of Interest Policy. DEEOIC has developed a Conflict of Interest Policy regarding the role of ARs. (Refer to Chapter 12 – Representative Services.) Conflicts of interest can arise when a duly appointed AR has direct financial interests as a result of his or her role, aside from the permitted fee enumerated under the EEOICPA. Because the "role" of an AR is so important, DEEOIC will consider the AR to have a prohibited "conflict of interest" if that individual could directly benefit financially from their client's EEOICPA claim due to something other than the statutorily limited fee for representing a client in connection with his or her EEOICPA claim.

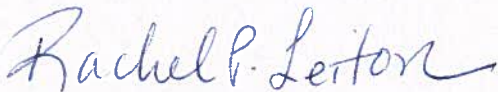
With regard to HHC services, a DEEOIC enrolled provider of medical services will be considered to have a prohibited conflict of interest if, in addition to being the client's AR,

they are also being paid by DEEOIC, directly or indirectly, as a provider of authorized medical services to that individual. Because there is an obvious conflict of interest in these circumstances, DEEOIC will not recognize the enrolled provider as an AR. Under these circumstances, DEEOIC will inform the claimant of the need to designate another person as AR, who does not have such a conflict.

It has been revised in v3.0 to:

4. Conflict of Interest Policy. DEEOIC has developed a Conflict of Interest Policy regarding the role of ARs, outlined in Chapter 12 – Representative Services.

- Exhibit 31-1, Instructions For Completing Offset Worksheet, has been edited to include a sample of the offset worksheet
- Exhibit 32-2, Instructions For Completing Coordination of SWC Benefits Worksheet, has been edited to include a sample of the SWC benefits worksheet
- Exhibit 35-9, Sample Overpayment Final Decision – Without Fault – Waiver Denied, has been edited to correct outdated reference to PM Ch. 0800.10a to Ch. 35.10a.
- Exhibit 35-10, Sample Overpayment Final Decision –Waiver Granted Based on Defeats Purpose of EEOICPA, has been edited to correct outdated reference to PM Ch. 0800.10a to Ch. 35.10a.
- Exhibit 35-11, Sample Overpayment Final Decision –Waiver Granted Based (Full or Partial) Based on Violate Equity and Good Conscience, has been edited to correct outdated reference to PM Ch. 0800.10b to Ch. 35.10b.



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