



U.S. Department of Labor

2011

# ANNUAL REPORT TO CONGRESS

## OFFICE OF THE OMBUDSMAN

for the  
Energy Employees  
Occupational  
Illness Compensation  
Program



Photo on the cover courtesy of the U.S. Department of Energy – South Tech area at Sandia National Laboratory.



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**U.S. Department of Labor**

Ombudsman  
Energy Employees Compensation Program  
Washington, D.C. 20210



**APR 16 2012**

The Honorable Joseph R. Biden, Jr  
President of the Senate  
Washington, DC 20510

Dear Mr President:

I am pleased to present the 2011 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor. This Report is submitted in accordance with 42 U.S.C. §7385s-15(e).

Sincerely,

A handwritten signature in black ink, appearing to read "Malcolm D. Nelson".

Malcolm D. Nelson  
Ombudsman for the Energy Employees  
Occupational Illness Compensation Program

Enclosure

**U.S. Department of Labor**

Ombudsman  
Energy Employees Compensation Program  
Washington, D.C. 20210



**APR 16 2012**

The Honorable John A. Boehner  
Speaker of the House  
Washington, DC 20515

Dear Speaker Boehner:

I am pleased to present the 2011 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor. This Report is submitted in accordance with 42 U.S.C. §7385s-15(e).

Sincerely,

Malcolm D. Nelson  
Ombudsman for the Energy Employees  
Occupational Illness Compensation Program

Enclosure



## INTRODUCTION

July 31, 2011, marked the 10<sup>th</sup> anniversary of the Department of Labor's administration of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). In those ten years, more than 88,000 claims were filed, which has resulted in more than \$7 billion in compensation and medical benefits paid. In fact, just in FY11 alone, more than \$1 billion was paid in compensation and medical benefits.

While numerous claims have been paid and one clearly sees progress in many aspects of the claims process, individuals continue to contact the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (the Office) with complaints, grievances and requests for assistance. As in previous years, the complaints received by the Office reflect every aspect of the EEOICPA claims process, and come from a wide array of sources, claimants, potential claimants, family members, authorized representatives, congressional staff members, physicians, health care providers, and others. Moreover, as we mark the 10<sup>th</sup> anniversary of the DOL's administration of the program, we continue to receive complaints and grievances raising novel issues.

Section 7385s-15(e) of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides that the Office shall submit to Congress an annual report that sets forth:

The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year, and

An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

This report is the fulfillment of that mandate. In this report we not only set forth the numbers and types of complaints, grievances, and requests for assistance received during the year, we also endeavor to provide the reader with a better understanding as to why, in spite of the vast amounts of monies paid to date, the Office continues to receive complaints, grievances, and requests for assistance related to the EEOICPA.



## ACKNOWLEDGEMENTS

Our review of the complaints, grievances, and requests for assistance received throughout the year quickly reminds us that there are a number of the individuals, organizations, and agencies who are invaluable in ensuring that the Office accomplishes its mission. Therefore, we would like to take this opportunity to acknowledge some of these individuals and agencies.

We want to thank all of the claimants, potential claimants, family members, authorized representatives, congressional staff members, health providers, physicians, and other interested parties who took the time to contact the Office with complaints, grievances, and requests for assistance concerning the EEOICPA. We realize that in many instances contacting the Office involved calling yet another agency, attending yet another meeting, or taking time out of already busy schedules. We appreciate your contributions.

In most case, in order to assist the claimants who contact the Office, we forward an inquiry to the Department of Labor's Division of Energy Employees Occupational Illness Compensation Program (DEEOIC). Accordingly, we want to take this opportunity to thank the DEEOIC for their prompt responses and for the wide range of effective assistance provided throughout the year.

In addition, there are a number of other agencies involved with the EEOICPA and we want to acknowledge and thank each of these agencies for all of the assistance, as well as for the prompt and cooperative manner in which assistance was provided. Accordingly, a sincere thanks goes out to the Department of Energy's Office of Health, Safety and Security, as well as the Former Worker Medical Screening Program; the National Institute for Occupational Safety and Health (NIOSH), as well as the Ombudsman to NIOSH, Ms. Denise Brock. I also want to extend a sincere thank you to the Department of Justice for the all of the assistance that they provided throughout the year.

Moreover, we would like to take this opportunity to acknowledge and thank the Joint Outreach Task Group (JOTG). This joint effort by the Department of Energy, the Department of Labor, the National Institute for Occupational Safety and Health, the Ombudsman to NIOSH, the Former Worker Medical Screening Program, and the Office continues to provide an effective means to broaden the scope EEOICPA outreach efforts and to ensure that potential claimants are provided all of the information needed to assist with their EEOICPA claims.



## LEGISLATIVE HISTORY OF THE EEOICPA

There are a number of steps involved in the development of an atomic weapon. Consequently, when the United States government initiated a program to develop an atomic weapon, multiple sites were required to perform all of the necessary steps. Over time, the efforts to develop and produce atomic/nuclear weapons grew into an industry employing hundreds of thousands of individuals in over 350 facilities located in approximately 40 states.

The work performed at these sites often involved exposure to radioactive materials, as well as other toxic substances. Ultimately, concerns for the health and safety of these workers led in October 2000 to the enactment of the Energy Employees Occupational Illness Compensation Program Act as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001.

When initially enacted, there were two parts to the EEOICPA, Part B and Part D. Part B, administered by the Department of Labor (DOL), provides compensation and/or medical benefits/medical monitoring to certain employees and their eligible survivors if they suffer from cancer that is at least as likely as not caused by exposure to radiation, if they suffer from chronic beryllium disease, beryllium sensitivity, or if the employee worked during the mining of atomic weapon test tunnels in Nevada or Alaska and suffers from chronic silicosis.

Part D directed the Department of Energy (DOE) to provide claimants with assistance in obtaining state-based workers' compensation. Unfortunately, due to a number of obstacles, the efficient administration of Part D proved elusive. In response to these obstacles, in 2004 Congress repealed Part D and enacted Section 3161 of Public Law 108-375. This law established Part E, a federal compensation scheme for DOE contractor and subcontractor employees and placed the administration of this Part E program with the DOL. The new law directed the Secretary of Energy to provide all applicable records, files, and other data to the Secretary of Labor, and mandated that the DOL prescribe regulations so that it could begin administration of Part E within 210 days of enactment. On May 26, 2005, the DOL prescribed interim final regulations, thereby meeting the 210 day deadline imposed by Congress.



## HISTORY OF THE OFFICE OF THE OMBUDSMAN

In addition to establishing Part E, Public Law 108-375 also created an Office of the Ombudsman (the Office). In establishing the Office within the DOL, the statute urged the Secretary of Labor to take appropriate action to ensure the independence of the Office, including independence from other officers and employees of the DOL engaged in activities related to the administration of the EEOICPA. While the duties of the Office initially only extended to Part E, Public Law 111-84, the National Defense Authorization Act for Fiscal Year 2010, enacted on October 28, 2009, expanded the authority of the Office to include Part B of the Act.

The statute outlines three specific duties for the Office:

1. To provide information on the benefits available under Part B and Part E and on the requirements and procedures applicable to the provision of such benefits.
2. To make recommendations to the Secretary of Labor regarding the location of resource centers for the acceptance and development of claims for benefits.
3. To carry out such other duties as the Secretary shall specify.

See 42 U.S.C. § 7385s-15(c).

In addition to these three duties, the statute also mandates that the Office submit an annual report to Congress. In this report, the Office is to set forth:

- a) The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year.
- b) An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

See 42 U.S.C. § 7385s-15(e).

To accomplish its statutory duties and to facilitate its ability to submit an annual report to Congress that sets forth the requested data and information, the Office:

- **Engages in outreach:** The participation in town hall meetings and other outreach events provides the Office with the opportunity to speak with groups of claimants and to engage in one-on-one conversations. During calendar year 2011, the Office hosted a town hall meeting in Aiken, South Carolina for workers and former workers (and surviving family members of workers) of the Savannah River Site.<sup>1</sup> The Office also participated in a town hall meeting sponsored by the Department of Energy's Former Worker Medical Screening Program in Oak Ridge, Tennessee and participated in six (6) town hall meetings/traveling resource centers sponsored by the Division of Energy Employees Occupational Illness Compensation:
  - o Albuquerque, New Mexico – (Sandia National Laboratories)
  - o Grand Junction, Colorado – (Grand Junction Operations Office)
  - o Bolingbrook, Illinois – (Fermi National Accelerator Laboratory and Argonne National Laboratory East)
  - o Amherst, New York – (Linde Ceramics Plant and Simonds Saw and Steel, Company)
  - o Galveston, Texas – (Texas City Chemicals, Inc.)
  - o Cincinnati, Ohio – (General Electric Company)

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<sup>1</sup>. Although outreach events often target workers at a specific facility anyone interested in the program is welcome to attend these meetings.



In an effort to work with other agencies and groups involved with the EEOICPA, the Office participated in a training program sponsored by the Ombudsman to the National Institute for Occupational Safety and Health (NIOSH) and once again attended the Health Resources and Services Administration's Office of Rural Health Policy 2011 Radiation Exposure Screening and Education Program Grantee Meeting.

- **Receives complaints and grievances:** Claimants, potential claimants, authorized representatives, congressional staff members, and others contact the Office with complaints and grievances. The issues raised address every aspect of the EEOICPA claims process and do not always involve the denial of a claim. We also receive complaints involving pending claims, as well as complaints involving difficulties that arise following a determination of eligibility for compensation and/or benefits.
- **Provides assistance:** Most claimants do not contact the Office merely to register a complaint or grievance. Rather, most claimants contact the Office because they want assistance with their claim. In fact, many claimants contact us only after other attempts to resolve the matter prove unsuccessful. As with the complaints that we receive, claimants seek assistance with practically every aspect of the EEOICPA claims process. Mindful of the limits of our authority, we endeavor to assist claimants whenever and wherever we are able.
- **Clarifies/explains documents and procedures:** Many of the claimants who contact the Office do not fully comprehend the technical medical, scientific and/or legal concepts discussed in the documents associated with their claim. We receive requests to explain words and phrases, as well as requests to explain entire documents. Furthermore, some claimants find that the rules governing the EEOICPA are not simple and/or straightforward. Therefore, many claimants contact us for assistance sorting through all of the applicable rules and regulations.

There are a host of tools/resources developed by the agencies involved with the administration of the EEOICPA designed to assist claimants with the claims process. However, in our experience some claimants are not aware of these tools/resources. Moreover, since some of these tools/resources are only available online, claimants with limited access to the internet are often limited in their ability to take advantage of these tools/resources. Throughout the year, we directed claimants to relevant tools/resources, and where claimants did not have access to the internet, we provided hard copies of relevant materials. In addition, consistent with our efforts to provide simplified information to claimants, the Office developed two brochures addressing matters that have been the subject of many inquiries. One brochure addresses the Special Exposure Cohort process. The other brochure addresses the relationship between the EEOICPA and the Radiation Exposure Compensation Act (RECA). Another project this year resulted in the posting on the Office's website of a list of some of the abbreviations commonly used in the EEOICPA claims process.

As we enter calendar year 2012, the Office continues to develop tools and resources to provide simplified information to claimants and to otherwise assist claimants with this oftentimes difficult process. Planning is already underway to sponsor, as well as attend, town hall meetings, and other outreach events where we will provide information on the benefits available under the EEOICPA. Most of all, we look forward to another year where, within the limits of our authority, we can assist claimants with the issues they encounter as they process claims under the EEOICPA.



## EXECUTIVE SUMMARY

The EEOICPA continues to be a tale of two programs. On the one hand, as noted in a recent report issued by the U.S. Government Accountability Office, as of January 2010 just over 39 percent of the EEOICPA cases filed were approved.<sup>2</sup> Thus as of December 31, 2011, the program had paid over \$7 billion in compensation and benefits to approximately 88,000 individual claimants.

Combined Part B and Part E Summary			
		Cases as of December 31, 2010	Cases as of January 1, 2012
Applications Filed		140,256*	149,676**
Covered Applications Filed		113,840	122,282
Total Compensation Paid	Payments	49,019	54,710
	Total Dollars	\$5,915,139,362	\$6,710,804,855
Total Medical Bills Paid	Total Dollars	\$659,674,597	\$992,659,352
Total Compensation + Medical Bills Paid		\$6,574,813,959	\$7,703,464,207

\* A total of 82,373 unique individual workers were represented by the 140,256 cases reported.

\*\* A total of 88,174 unique individual workers are represented by the 149,676 cases reported.

Moreover, even as we enter the tenth year of the DEEOIC's administration of the EEOICPA, we continue to see efforts by the DEEOIC to develop additional tools/resources and new initiatives designed to assist with the processing of EEOICPA claims. Some of the initiatives unveiled during 2011 include:

- the creation of an online Web-based claimant status page which allows claimants access to limited claims information
- an online listing of the names and medical specialties of the District Medical Consultants (DMCs) utilized by the DEEOIC
- the posting online of the Common-Law Marriage Handbook utilized by claims examiners and hearing representatives
- an internal reassessment of recommended decisions
- the issuance of a policy bulletin allowing the Rutenber Database as an additional piece of evidence to consider when claims examiners evaluate an employee's claim for inclusion in the Rocky Flats Plant Special Exposure Cohort
- expanded use of press releases in an effort to contact potential claimants
- the announcement of a partnership with the National Academy of Science to further enhance the Site Exposure Matrix (SEM) website.

On the other hand, in spite of the monies paid by this program and in spite of the assistance offered by the DEEOIC, as well as the other agencies involved with the administration of the EEOICPA, we continue to receive complaints, grievances, and requests for assistance from claimants and others concerning practically every aspect of the EEOICPA program. While some of the complaints that we received this year involve issues addressed in previous annual reports, there were other complaints/grievances brought to our attention this year involving novel issues, or novel variations of issues addressed in previous reports.

2. See United States Government Accountability Office's Energy Employees Compensation Additional Independent Oversight and Transparency Would Improve Program's Credibility, GAO-10-302 (Washington, D.C.: March 22, 2010).

The complaints, grievances, and requests for assistance that we receive address every aspect of the claims process. The annual report focuses on specific aspects of the claims process and addressing the complaints, grievances, and requests for assistance related to that aspect of the process. However, for purposes of the Executive Summary, we focus on six themes. Some variation of one or more of these themes is uttered by a vast majority of the individuals who contact the Office with complaints, grievances, and requests for assistance. More importantly, we believe that these themes offer a keen insight into understanding both the type of complaints and grievances raised with the Office, and why claimants, potential claimants, authorized representatives, or others are often aggrieved by the events prompting these complaints and grievances. These six themes are:

- The program is not what claimants were led to believe.
- There is not sufficient consideration given to the complexities of this program.
- There is not sufficient consideration given to the secrecy that surrounded this program.
- The assistance that is offered is insufficient.
- The program is not administered fairly.
- Claimants are afforded little (or no) respect and/or trust.

## The program is not what claimants were led to believe

An often repeated complaint indicates that the EEOICPA program is not what some claimants expected. Among many claimants there is a belief that in creating the EEOICPA, Congress intended to create a claimant-friendly program.<sup>3</sup> While claimants do not necessarily agree on all of the attributes expected of a claimant-friendly program, as a rule there is a consensus that at a minimum a claimant friendly EEOICPA program ought to:

- Cover all workers employed at facilities associated with the nuclear weapons program,
- Establish rules that are easy to understand and/or provide sufficient assistance, and
- Provide claimants with the benefit of the doubt, especially when relevant evidence does not exist.

Yet, despite of their specific expectations, many claimants contacted us throughout the year to let us know that the EEOICPA program did not measure up to their expectations of a “claimant friendly” program. Claimants are often surprised to discover that the EEOICPA only covers certain employees who worked at certain facilities, and in some instances, only covers employees suffering from certain illnesses. Some of these claimants question the reasons for extending EEOICPA coverage to certain employees and not extending coverage to other employees.

Many claimants believe that when the EEOICPA was enacted everyone knew (or should have known) that records would be difficult to locate. Consequently, many claimants expected a program that made allowances for the lack of relevant records. These claimants are often disappointed to learn that under the EEOICPA the burden of proof is placed on the claimant. Especially where records were destroyed or otherwise no longer exist, some claimants argue that the decision to place the burden of proof on them guarantees that their claim is denied.

## There is not sufficient consideration given to the complexities of this program

A common grievance that we hear notes that the decisions and letters forwarded to claimants are oftentimes written using technical legal, medical and/or scientific terminology that the average reader cannot understand. Moreover,

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3. In creating the EEOICPA, the statute does not specifically refer to a “claimant friendly” program. Still, the term is often used when referring to the program. For example, on October 23, 2007, the Senate Committee on Health, Education, Labor, and Pensions held a hearing entitled, “EEOICPA: Is the Program Claimant Friendly for Our Cold War Heroes.”



many claimants note that not only are these documents difficult to understand, but they often encounter difficulties locating anyone (sometimes including individuals associated with the DEEOIC) who can/will provide them with a concise explanation of these documents.

Some claimants find it troubling that the rules and procedures implementing this program are dispersed among a variety of documents (e.g., the statute, the regulations, the Procedure Manual (PM), and case law. Some claimants note that because the rules are dispersed among so many various documents, even where they put forth the time and effort, they can never be certain to have identified all of the relevant rules and procedures.

## There is not sufficient consideration given to the secrecy that surrounded this program

Claimants question whether those administering the EEOICPA fully appreciate the secrecy that surrounded this program. As one example, some claimants contacted us when asked to identify the specific toxins to which they were exposed in the course of their employment. In response to requests such as this, claimants emphatically remind us that these facilities operated on a “need to know basis.” Claimants assure us that in light of the perceived secrecy that surrounded these facilities, employees did what they were told and did not ask a lot of questions. Many claimants are not at all surprised when informed that there are no records documenting certain tasks they performed or certain accidents in which they were involved. In the opinion of these claimants, the lack of records merely reflects the way things were done.

The perceived secrecy surrounding this program can be especially troubling for the survivors of former workers. Since their loved ones were sometimes instructed not to talk about their employment, survivors often find it extremely difficult to assist with the processing of their claim. Since they did not possess any personal knowledge of the work performed by their loved one, some survivors indicate that they feel unequipped to pursue an EEOICPA claim.

Recently we discovered another way that the secrecy surrounding this employment sometimes impacts the processing of an EEOICPA claim. We encountered claimants who admit that in processing their EEOICPA claim they intentionally withheld information that they deemed sensitive. Although there is a process that permits a claimant concerned with revealing sensitive information to be interviewed by an individual with appropriate security clearance, many claimants are not aware of this process. Moreover, when made aware of this process, many claimants display a reluctance to utilize this process.

## The assistance that is offered is not sufficient

The DOL and the other agencies involved with the administration of the EEOICPA offer a host of tools and resources to assist claimants with the processing of EEOICPA claims. Without a doubt, there are individuals who take advantage of these tools/resources. Still there are claimants and authorized representatives who are not aware of these tools/resources and others who do not know how to locate these tools/resources. In addition, since these tools/resources are only available online, some claimants, especially those with limited access to the internet, may only have limited access to these tools/resources.<sup>4</sup>

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4. The internet offers the most effective mechanism for providing certain information. For instance, the expanded SEM is too voluminous to reduce to a booklet or pamphlet. Nevertheless, there are claimants who experience difficulties accessing information that is only available online.



As in previous years, a major grievance that we hear comes from claimants who note that some of these tools/resources are not as helpful as they were led to believe. Most of the tools/resources developed to assist claimants have limitations. In many instances, however, these limitations are not readily apparent. As a result, there are times when it is not until the claim is denied (or evidence is not accepted) that the claimant becomes aware of the limitations associated with a certain tools/resources. Where claimants only belatedly discover the limitations of a tool/resource, we sometimes receive allegations suggesting that claimants were misled as to the usefulness of the tool/resource. In these circumstances, some claimant also question whether the limitation were manufactured as part of a last minute effort to deny the claim.

In addition, in spite of the many tools/resources that are available, some claimants contend that the tools that they need are not available. For example, claimants have expressed the need for more guidance in developing medical evidence.

## The program is not administered fairly

Many of the complaints suggesting that this program is not administered in a fair manner focus on regulations and policies that, in the opinion of claimants, treat the government in a favorable manner. A common complaint comes from claimants who cite the strict deadlines imposed on them to take certain actions, and the penalties that attach if they fail to act in a timely manner. Claimants contend that it is unfair that in most instances there are no corresponding deadlines imposed on the government within which it must act, and/or no penalties that attach if the government fails to act in a timely manner.

In a more general sense, there are many aspects of this program where claimants allege unfairness. Some of these include: (1) the placing the burden of proof on claimants when everyone knows that the necessary evidence is not available; and (2) creating a program where the rules and policies are difficult to locate, and even more difficult to understand.

## Claimants are afforded little (or no) trust and respect

A vast majority of the individuals associated with the administration of the EEOICPA program are dedicated employees who take their job very seriously and, within the limits of their authority, make a conscious effort to assist claimants. In fact, during the year a number of claimants contacted us to commend the assistance provided by DEEOIC personnel. Nevertheless, we continue to receive complaints where claimants and/or authorized representatives allege that they were not treated with due respect. These complaints range from allegations that telephone calls were not answered to allegations of rude/disrespectful comments made by DOL personnel. To bolster these complaints, some claimants and authorized representatives provided the Office with examples of what they deem disrespectful conduct.

Some claimants also feel aggrieved by what they see as a general lack of trust inherent in the program. This issue often arises in conjunction with the evaluation of evidence. Claimants question why their testimony and affidavits are not sufficient to satisfy their burdens of proof – especially when there is no evidence to the contrary. An often repeated comment notes that the claimants were trusted to work at these secret facilities and, true to their word, these claimants kept these secrets for years, often refusing to discuss their employment with their own spouses and children. Consequently, these claimants believe that they have earned some measure of trust and cannot understand why the credibility of the evidence that they submit is questioned – especially where the government is unable to produce evidence to the contrary.



The complaints and grievances discussed in this report address every aspect of the EEOICPA claims process – from complaints concerning the filing of claims all of the way to complaints concerning the provision of medical benefits following an award of compensation. In this report we will endeavor to illustrate how these six themes underline a vast majority of the complaints and grievances that we receive.

## THE 2011 ANNUAL REPORT

### NUMBERS AND TYPES OF COMPLAINTS, GRIEVANCES AND REQUESTS FOR ASSISTANCE RECEIVED DURING THE YEAR

Consistent with our statutory mandate, the following tables set forth the number and types of complaints, grievances, and requests for assistance received during the previous year:

- Table 1: A summary listing of complaints by nature/type.
- Table 2: Contacts by facility.

In spite of the efforts to accurately record every contact with the Office, there are factors that complicate this endeavor. A few of the factors to consider include:

1. Claimants contact the Office to discuss events or encounters. In many instances, the complaints and grievances do not neatly fit into specific categories.
2. One claimant may have multiple complaints. Each complaint is counted separately.
3. Only inquiries related to the EEOICPA program are included in these tables.
4. There are instances where it is impossible to effectively collect data. This is especially true at outreach events where the volume and the pace of interactions can be such that an accurate recording of each contact is impossible. In addition, because they wish to remain anonymous, some individuals limit the information that they provide.
5. While many claimants focus on their individual claim, some complaints and grievances potentially affect many claimants.<sup>5</sup>

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5. For example up to three people can be named as petitioners on a SEC petition. However, the SEC petition can ultimately impact hundreds of employees.



## TABLE 1: COMPLAINTS BY NATURE/TYPE

<b>Covered Employment</b>		
Locating Records	(15)	63
Establishing employment	(28)	
Definition of covered employee	(20)	
<b>Covered Facility</b>		8
<b>Covered Illness</b>		52
<b>Definition of survivor</b>		23
<b>Exposure</b>		
Difficulty locating records	(14)	30
Accuracy of Records	(7)	
SEM	(9)	
<b>Dose Reconstruction</b>		
50% requirement too high	(10)	69
Other issues	(59)	
<b>Special Exposure Cohort (SEC)</b>		36
<b>Causation</b>		
Difficulty finding doctor to address	(5)	57
Other issues	(52)	
<b>Impairment/Wage Loss</b>		
Impairment	(24)	36
Wage Loss	(12)	
<b>Medical Benefits Card</b>		31
<b>Home Health Care Issues</b>		44
<b>Reconsideration/Reopening</b>		24
<b>Offset/Coordination of Benefits</b>		5
<b>Cap of Maximum Benefits</b>		4
<b>Death nullifies or reduces award</b>		2
<b>Processing of claim takes too long</b>		46
<b>Administration of the program</b>		
Change in claims examiner	(7)	196
Issues with DMC	(10)	
Needs more explanatory info	(34)	
Documents confusing	(23)	
Staff Rude	(22)	
No response	(59)	
Misc	(41)	
<b>Concerns with authorized representative</b>		5
<b>Consequential Illness</b>		11
<b>Questions related to taxing of benefits</b>		17
<b>Attorney Fees</b>		5
<b>Requests Assistance</b>		250
<b>Terminal Illness</b>		12
<b>Weighing of the Evidence</b>		53
<b>Misc</b>		44
<b>TOTAL</b>		<b>1123</b>



**TABLE 2 - COMPLAINTS BY FACILITY**

<b>FACILITY</b>	<b># OF CONTACTS</b>
Albany Research Center	6
Albuquerque Operations Office	3
American Chain and Cable Company	1
Ames Laboratory	4
Anaconda Company	1
Argonne National Laboratory – East	1
Battelle Laboratories – King Avenue	2
Bendix Aviation (Pioneer Division)	5
Beryllium Corporation of America – Hazelton, Pa	1
Bethlehem Steel	10
Brookhaven National Laboratory	4
Carborundum Company	1
Clarksville Facility	3
Electro Metallurgical	1
Feed Material Production Center	1
Fermi National Accelerator Laboratory	3
Fernald	6
General Atomics	4
General Electric Company	1
Grand Junction Operations Center	5
Hanford	17
Idaho National Engineering Laboratory	8
Iowa Ordnance Plant	7
Kansas City Plant	17
Ladish Company	1
Lawrence Berkeley National Laboratory	4
Lawrence Livermore National Laboratory	24
Linde Ceramics Plant	11
Los Alamos National Laboratory	10
Massachusetts Institute of Technology	1
Mathieson Chemical Company	1
Metals and Controls Corporation	2
Mound Plant	4
Nevada Site Office	1
Nevada Test Site	16
Nuclear Metals, Inc	1
Oak Ridge	55

<b>FACILITY</b>	<b># OF CONTACTS</b>
Ore Buying Station at Grants, NM	5
Ore Buying Station at Shiprock, NM	1
Pacific Proving Ground	1
Paducah Gaseous Diffusion Plant	21
Pantex Plant	14
Piketon Facility	4
Pinellas Plant	6
Piqua Organic Moderated Reactor	2
Portsmouth Gaseous Diffusion Plant	14
Rocky Flats	15
Sam Laboratories, Columbia University	1
Sandia National Laboratories	6
Sandia National Laboratories – Livermore	3
Santa Susana Field Laboratory	1
Savannah River Site	23
Texas City Chemicals, Inc.	1
United Nuclear Corporation	5
Uranium Mill in Durango, CO	2
Uranium Mill in Monticello, UT	1
Uranium Mine	34
Ventron Corporation	1
Wah Chang	6
West Valley Demonstration Project	1
Westinghouse Atomic Power Development Plant	1
Westinghouse Nuclear Fuels Division	1
Miscellaneous	71
<b>TOTAL</b>	<b>538 *</b>

\* While the total number of complaints reflected in Table 1 is 1123, the total number of contacts by facility reflected in Table 2 is 538. Table 1 (complaints by nature/type) tallies every complaint recorded in our database and in many instances, one individual is responsible for reporting multiple complaints. Table 2 (contacts by facility) tallies each instance where a facility is identified as the covered work site. For each individual who contacts the Office, there is one entry designating the work site(s).



# ASSESSMENT OF THE MOST COMMON DIFFICULTIES ENCOUNTERED BY CLAIMANTS AND POTENTIAL CLAIMANTS DURING CALENDAR YEAR 2011

Every year we are presented with the challenge of developing an effective format in which to present an assessment of the most common difficulties encountered by claimants and potential claimants during the preceding calendar year. This challenge is made more difficult by the realization that the complaints, grievances, and requests for assistance that we received address every aspect of the EEOICPA claims process. In an attempt to provide some order to the discussion, this report will focus on various aspects/requirements of the claims process and will address the complaints, grievances, and requests for assistance that we received addressing this aspect/requirement. In the end, it is our ultimate goal to ensure that this report discusses the most common complaints, grievances, and requests for assistance received during the preceding year.

## I. POTENTIAL CLAIMANTS NOT AWARE OF THE EEOICPA PROGRAM

Although this program has been in existence for more than ten years, we continue to encounter individuals who only recently became aware of the program, or only recently became aware of their eligibility under the program. While some of these individuals are happy to finally learn of the program, others question why more was not done to inform them earlier of the program. Some claimants find it troubling that the government never directly contacted them to inform them of their potential eligibility under this program and instead they only learned of the program from a neighbor or colleague. This is the precise argument raised by a gentleman who notes that his mother, the claimant, lives in the same house that the family lived in when the father worked at the covered site. This gentleman cannot understand why his mother never received an official notice of this program and instead only learned of the program from a neighbor.

This lack of knowledge about the program is not the result of a lack of effort. Both the DOL and the DOE devote a considerable amount of time and attention to outreach. Representatives of the DOE's Former Worker Medical Screening Program routinely attend events where they believe former workers may be in attendance. In addition, among its many efforts directed at outreach, the DEEOIC recently initiated a project to utilize press releases to disseminate information about this program. Moreover, we are aware of and have attended numerous town hall meetings sponsored by each of these agencies (as well as the town hall meetings sponsored by the Office).

Yet, these efforts are not perfect. A recent town hall meeting sponsored by the DEEOIC in Albuquerque, New Mexico highlights this fact. Although there have been at least two prior town hall meetings in Albuquerque, the town hall meeting held this year drew a number of individuals who admitted that media coverage announcing this meeting marked the first time they heard of the EEOICPA program.<sup>6</sup>

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6. Prior to the recent town hall meetings in Albuquerque, New Mexico, in addition to sending out individual notices, the DEEOIC issued a press release. As a result of this press release, an article appeared in a local newspaper announcing the meetings.



## II. COVERAGE

Many claimants believe that in enacting the EEOICPA it was Congress' intent to create a program that covered every employee who worked at sites associated with the U.S. nuclear weapons program. However, a review of the actual language of the EEOICPA reveals that this program only compensates for certain illnesses (and deaths) where the employee worked at a DOE facility (except for those pertaining to the Naval Nuclear Propulsion Program), or worked at an atomic weapons employer or a beryllium vendor. Consequently, we are approached by claimants who are disappointed to discover that they are not eligible under the EEOICPA due to their job status or the designation given to their work site. It is especially frustrating for claimants when the employee is not deemed a covered employee, yet there are other employees who worked at the same site who are deemed covered employees. As a result, some claimants question why the classification of one's job and/or the designation of one's job site are of such importance when determining eligibility under this program. In addition, some claimants complain that the DEEOIC is too strict and/or too technical in its interpretation of the statute.

### A. Not all employees are covered; not all facilities are covered

The EEOICPA specifically identifies and defines the employees covered under this program.

Part B	Part E
Department of Energy contractor	Department of Energy contractor
Department of Energy subcontractor	Department of Energy subcontractor
Approved RECA Section 5 claims	RECA Section 5 uranium miner, miller, ore transporter
Employees of Atomic Weapons Employer	
Employees of Beryllium Vendors	
Department of Energy Employees	

Chart 1

Accordingly, even though the employment was associated with the nuclear weapons program, some claims are denied because the employee does not meet the statutory definition of a covered employee.

Similarly, some claims are denied because the employment is not specifically mentioned in the statute. For example, we received a number of inquiries this year involving employment by subcontractors of atomic weapons employers. The Act specifically extends coverage to subcontractors employed by the DOE, see 42 U.S.C. §7384l (11), and to subcontractors of beryllium vendors, see 42, U.S.C. § 7384l (7). However, the Act does not extend coverage to subcontractors of atomic weapons employers and as a result, these particular employees are not covered employees under the Act. See generally, EEOICPA Bulletin NO. 03-27. The same result occurs where the employee was a member of the military or an employee of a federal government agency, other than the DOE. This employment is not specifically included in the Act and as such, is not covered employment.

We also encountered instances this year where coverage was denied because the statute specifically excludes operations pertaining to the Naval Nuclear Propulsion Program.<sup>7</sup> In light of this exclusion, individuals such as former employees of Betchel Laboratory in Pennsylvania are not covered under the Act.

<sup>7</sup> Executive Order 12344 and 42 U.S.C. § 7384l(12) excludes from the definition of a "Department of Energy facility" a building, structure, premises, grounds, or operation pertaining to the Naval Nuclear Propulsion Program.



This year we also heard from former employees of Bethlehem Steel who argued that although they worked at this facility subsequent to the time period covered under the program, they ought to be eligible for EEOICPA benefits based upon exposure to residual radiation. For purposes of the EEOICPA, Bethlehem Steel is designated as an Atomic Weapons Employer for the years 1949 to 1952. The statutory definition of atomic weapons employee includes

*...a facility with respect to which the National Institute for Occupational Safety and Health, in its report dated October 2003 and titled "Report on Residual Radioactive and Beryllium Contamination at Atomic Weapons Employer Facilities and Beryllium Vendor Facilities", or any update to that report, found that there is a potential for significant residual contamination outside of the period in which weapons-related production occurred...*

See 42 U.S.C. § 7384l(3)(B). We were assured by NIOSH that the residual report had been updated and revised several times, and it never found a potential for significant residual contamination at Bethlehem Steel outside of the covered period.

While there are instances where coverage is denied based upon the specific language of the statute, there are other instances where the denial of coverage is due to the interpretation of the statute. Some claimants contend that the denial of their claims were the result of an overly restrictive and technical interpretation of the statute. Some of the complaints that we received this year that raised this contention include:

- **Wholly-owned subsidiaries of atomic weapons employers:** Bethlehem Steel is designated as an atomic weapons employer (AWE) and South Buffalo Railroad is a wholly owned subsidiary of Bethlehem Steel. Citing the separate and distinct nature of a wholly-owned subsidiary, as well as the strict regulatory and statutory definition of an AWE facility, the DEEOIC determined that a wholly-owned subsidiary of a DOE-designated AWE cannot be an AWE unless the wholly-owned subsidiary itself is designated as an AWE. See EEOICPA Bulletin NO. 04-12. Since they physically worked at the Bethlehem Steel site and directly contributed to the operations of this facility, employees of South Buffalo Railroad maintain that it is unfair that they are not covered under the EEOICPA.
- **Employees engaged in delivery and loading and unloading of goods.** The definition of "Department of Energy contractor employee" includes "a contractor or subcontractor that provided services, including construction and maintenance, at the facility." 42 U.S.C. § 7384l (12)(B)(ii). In EEOICPA Bulletin NO. 03-27 the DEEOIC indicated that the delivery and loading or unloading of goods alone is not a service and is not covered for any occupation. Some claimants argue that such a blanket rule is too broad and does not give consideration to the amount of time or the nature of the work performed at the covered site. One case involved an employee engaged in the hauling of materials during a construction project. According to this employee he was at the site 3 to 4 times a week and while the amount of time at the site varied, his longest stays occurred whenever the truck was contaminated and he had to wait while it was decontaminated. This employee questions whether it was Congress' intent to cover the employees directly engaged in this construction project, but not cover the employees who hauled the contaminated materials.<sup>8</sup>
- **Predecessor agencies.** The Albany Research Center (ARC) was established as part of the U.S. Bureau of Mines, and in the 1940's produced zirconium for a nuclear submarine in collaboration with the U.S. Navy

8. Throughout this report we refer to instances where claimants question whether a regulation, policy, or decision is consistent with the intent of Congress. Obviously, these are questions that could be appealed to federal court. In our experience, very few claimants actually endeavor to appeal a case to federal court. Based on our observations, this is, at least in part, due to the fact that the appeals process can be very daunting and many claimants cannot find attorneys willing to handle EEOICPA claims.



and the Atomic Energy Commission. In 1995 the U.S. Bureau of Mines closed and the Materials Partnership Program at the ARC was transferred to the Department of Energy. Since the Act defines “Department of Energy” (see 42 U.S.C. § 7384l (10)) as including the predecessor agencies of the DOE, one claimant argued that the ARC was a predecessor agency. In the opinion of this employee, the DEEOIC response defining a predecessor agency as one that “existed independently only prior to the establishment of the DOE in 1977” is overly technical.

## B. Differences in Coverage Provided by Part B and Part E

There are two parts to the EEOICPA, Part B and Part E. While there is some overlap, each Part has its own criteria for coverage.

Part B	Part E
Department of Energy Contractor	Department of Energy Contractor
Department of Energy Subcontractor	Department of Energy Subcontractor
Approved RECA Section 5 Claims	RECA Section 5 uranium miner, miller, or ore transporter <sup>9</sup>
Beryllium Vendor	
Atomic Weapons Employer	
Department of Energy Employee	

Chart 2

In addition, Part B and Part E have differing criteria as to the illnesses covered.

Part B	Part E
<ul style="list-style-type: none"> <li>Any cancer (other than chronic lymphocytic leukemia) at least as likely as not caused by radiation exposure</li> <li>Chronic Beryllium Disease</li> <li>Beryllium Sensitivity</li> <li>Chronic Silicosis (if employed during mining of atomic weapons tunnels in Nevada or Alaska)</li> </ul>	<ul style="list-style-type: none"> <li>Any occupational illness for which exposure to a toxic substance was at least as likely as not a significant factor that caused, aggravated, or contributed to such illness</li> </ul>

Chart 3

As a result of the differences outlined above, we are approached by (1) employees of beryllium vendors, (2) employees of atomic weapons employers, as well as (3) employees of the DOE, who all question why they are covered under Part B if their cancer is caused by radiation exposure, but not eligible under Part E for any illness (including cancer) related to toxic exposure.

Another problem that we encounter arises from the fact that some individuals commonly refer to Part B as the “cancer program.” As a result, there are DOE contractors and subcontractors who assume that Part B is the only avenue available to them to pursue a claim for cancer, when in reality these employees are potentially eligible to also pursue a claim for cancer under Part E. In light of this misunderstanding, we occasionally encounter DOE contractors and subcontractors who although potentially eligible, never pursued a Part E cancer claim.<sup>10</sup>

9. Under Part B claimants with approved RECA Section 5 claims are eligible. Under Part E, the claimant merely needs to qualify as a RECA Section 5 uranium miner, miller, or ore transporter. Under Part E an approved RECA Section 5 claim is not necessary.

10. In recent years, the DEEOIC undertook efforts to ensure that where applicable employees were advised of their potential eligibility under both Part B and E. As a result, we encounter fewer instances where claimants are not aware of this fact. Nevertheless, on occasion we still encounter claimants who have not explored all of the available options for eligibility.



## C. De-Listed Employers

The de-listing of employers was the subject of complaints brought to our attention this year. This issue involves situations where employers are initially listed as covered employers, but following further review are de-listed. Claimants question the reasons advanced for these de-listings. A frequent argument that we hear questions why, if the reasons advanced for the de-listing are correct, these facilities were initially listed as covered employees. There are also instances where claimants question the timing of the decision to de-list the facility. Claimants find it troubling that both Mathieson Chemical and the National Bureau of Standards – Van Ness Street were de-listed subsequent to the filing of a Special Exposure Cohort petition. The chart below addresses the de-listings brought to our attention during the year.<sup>11</sup>

Name	Reason for De-Listing	SEC Petition filed prior to de-listing?
National Bureau of Standards – Van Ness Street (NBS)	U.S. Government cannot be an AWE. NBS was part of the U.S. Department of Commerce.	Yes
Mathieson Chemical	No material produced that was used in the production of an atomic weapon	Yes
Albany Research Center (ARC) Note: the ARC was ‘delisted:’ as an AWE. This did not impact its designation as a DOE facility.	U.S. Government cannot be an AWE. The ARC was part of the U.S. Bureau of Mines.	No
Spencer Chemical, Kansas City, Mo	No radioactivity ever utilized on behalf of the nuclear weapons program	No

## D. Coverage of RECA Claimants

On the one hand, individuals with approved Section 5 RECA claims are eligible for compensation and benefits under Part B. On the other hand, individuals who qualify as a RECA Section 5 uranium miner, miller, or ore transporter are eligible under Part E.<sup>12</sup> In previous years, we encountered RECA claimants who were not aware that they were also potentially eligible for compensation and/or benefits under the EEOICPA, as well as individuals who did not realize that in order to pursue a claim under each program, they had to file separate claims. However, in light of the affirmative steps taken by the DOJ and the DOL there has been a noticeable decrease in the number of recipients of compensation under Section 5 of RECA who are not also aware of their potential eligibility under the EEOICPA.

The issue involving the RECA that prompted complaints this year involved section 7385j of the Act which provides that a claimant compensated for cancer under Section 4 of RECA will not be eligible to receive compensation under EEOICPA for cancer, even though they may otherwise qualify for compensation and benefits under the EEOICPA.<sup>13</sup> See 42 U.S.C. § 7385j. In conversations with a number of the individuals impacted by this provision, we were assured that one of the reasons that these individuals decided to take the RECA compensation was the fact that the prospects of prevailing under the EEOICPA were extremely remote. These claimants note that when they made their decision to take the RECA compensation they never imagined that (years later) the addition of a new SEC class would greatly enhance their chances of prevailing under the EEOICPA. These claimants contend that it

11. A full listing of all of the de-listed sites can be found on the Department of Energy's list of covered facilities.

12. Coverage under Part E is not dependent on an approved RECA claim. Rather the individual must simply qualify as a RECA Section 5 uranium miner, miller, or ore transporter.

13. A claimant who receives compensation under Section 4 of RECA is eligible for compensation and benefits under the EEOICPA for non-cancer conditions.

is unfair to now bind them to a decision made when circumstances were so drastically different. Hoping to avoid this prohibition, one claimant asked if she could repay the RECA Section 4 compensation and thereby reinstate her eligibility under the EEOICPA. The DOJ responded that repayment of the Section 4 RECA compensation was not permissible in order to qualify under the EEOICPA. [A claimant found eligible for RECA Section 4 payments can reject those payments and pursue a claim under the EEOICPA. If the EEOICPA claim is unsuccessful, the claimant can submit a new claim form to the DOJ].

## **E. Illnesses Suffered By Non-Workers**

During the year, we were also contacted by individuals who never worked at a covered facility but who nevertheless believe that they, or a loved one, suffers from an illness (or died) as a result of toxins originating from a covered site. There are wives who believe that they miscarried because of exposure to toxins brought home by their husbands, as well as families who believe that a child suffers from an illness passed on by a covered parent.

This year we met individuals who told us that as children they lived (with their parents) at the uranium mines. These individuals contend that in addition to being exposed to whatever was in the air, they drank, bathed and swam in the water. Some of these individuals now suffer from illnesses that they strongly suspect are related to the toxins to which they were exposed while living at these mines.

While in Grand Junction, Colorado, we were approached by a number of individuals concerned with their exposure to mill tailings. Mill tailings are residue from the processing of uranium. These individuals told us, and the DOE confirmed, that for years mill tailings were used in concrete, in gardens, and generally used as filler in both residential and business properties.<sup>14</sup> The subsequent Uranium Mill Tailings Remedial Action (UMTRA) Program remediated sites in ten states, with over 4,000 vicinity properties remediated in the Grand Junction area alone. This cleanup program was voluntary and had an ending date in 1998. In spite of the efforts of the UMTRA, individuals in Grand Junction assured us that they still receive high readings when a Geiger counter is used while standing in their yards and other individuals asserted that due to the health dangers posed by these mill tailings, they were not allowed to build additions onto their homes.

Eligibility under the EEOICPA is premised on an illness or death of a covered employee. Thus, where the illness (or death) does not concern the covered employee, the EEOICPA is not applicable. Individuals who were not employed by these covered facilities but who nevertheless believe that their illness is related to the operations of these facilities question why there often is no program in existence to address their concerns.

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14. We were told of piles of mill tailings made available for anyone's use.



### III. Locating Evidence of Employment

#### A. Employment Records

To be eligible under the EEOICPA the worker must qualify as a covered employee and must have worked at a covered facility. We are contacted by claimants who cannot believe that there are not adequate records verifying their employment at these facilities. In light of all of the security associated with these facilities, some claimants have a hard time accepting that records were destroyed, lost, or cannot be found. Moreover, claimants question the fairness of placing this burden of proof on them to verify employment, especially in circumstances where it is obvious that relevant employment records no longer exist.

When a claim is filed, in addition to the information provided on the employment verification form, the DOL contacts the DOE for employment verification. In some circumstances, the DOL also endeavors to verify employment through the Oak Ridge Institute for Science and Education, the Center for Construction Research and Training, Social Security Administration wage data, and corporate verifiers. While some claimants question the thoroughness of the process for verifying employment, generally our inquiries reveal that the DOL and/or the DOE thoroughly search for available records.

However, there are instances where the DEEOIC is unable to verify employment. In some instances:

- **Records do not exist:** While primary DOE contractors were required to turn over employment records prior to the close out of the contract, in many instances this was not case when it came to subcontractors.<sup>15</sup> In the years since the enactment of this program, the DOE has endeavored to compile listings of subcontractor employees, but given the time that has elapsed since the work took place this has been very difficult and not always successful. As a consequence, many of the complaints concerning difficulties verifying employment come from subcontractor employees. Claimants complain of futile searches for employers who are no longer in business, as well as instances where employers are located only to discover that relevant records were destroyed years ago. In an effort to locate records that might verify employment, some claimants inquire into the availability of the sign-in logs that recorded movement on and off of these sites. In rare cases, the DOE has been able to locate and compile this information, but in many instances, claimants are disappointed to discover that in the normal course of record retention these logs were destroyed after seven years.

In the opinion of many claimants the fact that contractors and subcontractors were not required to provide employment records and the destruction of the sign in sheets illustrate the unfairness of placing the burden of proof on claimants, especially in those instances where it is known that through no fault of the claimant, the evidence needed to satisfy this burden of proof was destroyed, lost, or never maintained.

- **Records are incomplete:** Some claimants contend that in verifying employment they encounter incomplete records. For example, claimants note that there are instances where the government concedes that only partial records can be located. In other instances, the claimant or the authorized representative questions whether existing records are complete. It is common to hear claimants suggest that there were certain events and certain tasks that were never recorded (either due to security concerns or an in effort to conceal the event). Moreover, beyond questioning whether records are complete, we also received complaints questioning the amount of documentation needed to amend existing records. Over the course of this year

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15. The DOE continues to work on an "Access to and Ownership Records" clause which will be inserted into current and future contracts. The intent of this clause is to require contractors/subcontractors to provide certain records such as personnel and industrial hygiene monitoring to the DOE upon termination. As of the submission of this report, this clause has not been finalized.

we were contacted by a number of claimants who contend that evidence submitted to amend/revise existing records was summarily rejected (or ignored).

- **Existing records are not sufficient:** Many claimants find it hard to accept when existing records are not deemed sufficient to verify employment. One example of this arises when a claimant submits wage records to verify employment and unfortunately, the address on these wage records is the home office of the contractor or subcontractor, not the address of the covered work site. While these records may establish that the employee was employed by the contractor/subcontractor, these records may not be very helpful in verifying employment at the covered site.

## B. Records involving former couriers

Usually when a claimant questions whether there has been a thorough search for relevant employment records, following an inquiry to the DOL and/or the DOE, the Office is able to assure the claimant that a thorough search was made and that all relevant records were considered. One claim this year proved to be the exception to this rule. The case involved a former courier.<sup>16</sup> When the dose reconstruction report did not address all of the sites that he visited this courier made an inquiry to the DOE. In its response, while the DOE did not provide this courier with additional evidence of employment, there was a reference to boxes in Seattle. By coincidence, this courier remembered completing trip reports after each visit, and more importantly, remembered a subsequent assignment where he placed trip reports into boxes. Thus, this courier filed a Freedom of Information Act (FOIA) request and in April 2011 asked the Office to pursue this matter.

In September 2011 we were informed that after a review of a sample of this record collection the DOE was unable to determine how the information could be applied to compensation claims under the EEOICPA.<sup>17</sup> Accordingly the DOE indicated that it intended to ask the DOL if and when DOL would like to review the records. In October 2011, the DEEOIC informed us that the information in the boxes was not organized in a way to make it feasible for the DEEOIC to use this information.<sup>18</sup> We were also informed that in response to the FOIA request the DOE would advise the courier that in light of the burden imposed by his request, there would be a cost associated with answering the FOIA request. We were cited an estimated cost of \$5,000 to \$10,000 to address this FOIA request.

## C. Difficulties encountered by survivors

The problems associated with locating employment records are magnified when the employee is deceased. Employees were instructed not to discuss their employment with their families. Therefore, we hear from surviving family members who contend that they do not have a clue as to the nature of the work performed by their loved one. Therefore, these survivors assure us that they have no idea where to look for employment records, and even if they knew where to look, they would not know what to look for.

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16. We are aware of instances where claims filed by couriers were negatively impacted since records documenting the various sites that they "visited" could not be located. For example, since the claimant could not establish all of the sites where he/she had worked, the exposures encountered at specific sites could not be considered in performing the dose reconstruction. In addition, due to the lack of records, some couriers find it difficult to establish the 250 days at SEC sites required to qualify for inclusion in a SEC class.

17. Between April and September we received periodic updates assuring us that the DOE was reviewing this matter.

18. The decision that it was not feasible to use the records in these boxes appears to be premised on two factors: (1) the burden required to review the information in these boxes and (2) to the extent that the courier wants to establish eligibility to a SEC class, most of the records in these boxes are dated after 1974 and most, but not all, SECs cover time periods prior to 1974.



## D. Affidavits

The use of affidavits to verify employment is an issue that generates a lot of complaints. According to the policy of the DEEOIC, while affidavits may assist in placing employees at certain locations, affidavits must be reviewed in conjunction with other supporting documentation. In the experience of many claimants who contact the Office, in practical terms this policy means that an affidavit alone cannot verify employment, rather there must be other supporting documentation. A number of claimants believe that such a policy misses the point. Claimants argue that it is precisely when there is no other supporting documentation that the use of affidavits is most critical. According to claimants where other evidence does not exist, if the affidavit prepared by the claimant is not sufficient, the claimant often has no chance of prevailing. Furthermore, since the statute does not specifically require supporting affidavits in order to accept an affidavit, some claimants question the origin of this policy and whether it is consistent with Congress' intent.

Some claimants and authorized representatives contend that the DEEOIC policy regarding the use of affidavits reflects a mistrust of claimants, and believe that this mistrust is pervasive throughout the DEEOIC. As one example of this mistrust, a number of claimants and authorized representatives refer a discussion concerning the use of affidavits that arose during a May 25, 2011 meeting of the Advisory Board on Radiation and Worker Health. These individuals believe that the DEEOIC's response indicating that other verification is needed to support an affidavit submitted by the worker reflects an unwillingness to accept the testimony of former workers. See transcript, United States Of America Centers For Disease Control, National Institute For Occupational Safety and Health, Advisory Board On Radiation And Worker Health, 77th Meeting, Wednesday, May 25, 2011.

In response to these concerns, the Acting Director, Office of Workers' Compensation Programs (OWCP) indicated that are many cases in which affidavits are used to supply relevant facts that contribute to determinations that result in payment of EEOICPA benefits. The Acting Director further indicated that the DEEOIC's response merely "reflected the direction set forth in the current regulations and procedures concerning use of affidavits." He also asserted that affidavits were treated "exactly like any other pertinent evidence in that their relevance, credibility and overall weight must be judged in the context of the entire body of evidence in the case file in order to determine whether the evidence is sufficient to establish entitlement to compensation." In spite of the response by the Acting Director some claimants and authorized representatives continue to believe that this approach to affidavits prepared by workers illustrates an attitude of mistrust that permeates the DEEOIC.



## IV. SURVIVOR ELIGIBILITY

### A. Survivor Eligibility: Part B vs. Part E

The fact that the Part B eligibility requirement for survivors differs from the eligibility requirement for survivors under Part E continues to be the source of many complaints.

Part B	Part E
Eligible Spouse	Eligible Spouse
Children (regardless of age)	Child, who at the time of the employee's death was: Under the age of 18, Under the age of 23 and a full time continuous student; or Any age, if incapable of self-support
Parents	
Grandchildren	
Grandparents	

We continue to receive complaints from children who meet the eligibility requirement for surviving child under Part B but do not meet the eligibility requirement for surviving child under Part E. Many of these individuals tell us that they cannot understand the reason for the differing survivor eligibility requirements under these two Parts.

We hear accounts where the Part E survivorship eligibility requirement leads to family dissension. We are contacted by the children (of workers) who do not satisfy the Part E eligibility requirements who assert that they were the ones who took time away from their jobs to care for the parent, or were the ones who moved the parent into their homes. These children note that they did not undertake these sacrifices with any expectation of compensation. Nevertheless they think that it is unfair that those who made these sacrifices are sometimes excluded from coverage while those who did not make the same level of sacrifice are oftentimes the ones compensated under Part E.

Claimants also contend that it is unfair for the government to have waited so long to enact this legislation and then to place such severe limitations on the eligibility of surviving children. Some claimant believe that waiting so long to enact this law and then restricting the eligibility of survivors under Part E significantly decreased the number of potential eligible claimants.

We are approached by claimants who ask for an explanation for the differing treatment of survivors under Part B and Part E. These claimants are often disappointed to discover that the statute does not provide an explicit explanation for this distinction.

### B. Step Children

Generally under the EEOICPA, if the employee is deceased and there is a surviving eligible spouse, compensation is paid to the spouse. This is true even where the employee dies leaving both a spouse and children. The exception to this rule is where there is a surviving spouse plus at least one child of the covered employee who is living and who is not a recognized natural child or adopted child of the surviving spouse. In these instances, one half of



the compensation is paid to the surviving spouse and the other half is divided among each child of the covered employee who is living and meets the other eligibility requirements outlined in the statute.<sup>19</sup>

- This exception is not well known. Surviving spouses are often surprised when they only receive one half of the compensation that they expected. In many instances, it is even more shocking when the spouse discovers that the reason for the reduction in the amount of compensation that he/she receives is the existence of a potentially eligible step child.
- Once this provision is invoked, the surviving spouse receives one half of the compensation while the other half is held in abeyance pending a determination as to the eligibility of the potentially eligible children. Some surviving spouses attribute subsequent delays in resolving the eligibility of these children to recalcitrance on the part of one or more of these children. There are instances where spouses suggest that the step children are well aware that they are not eligible for compensation under the EEOICPA, but delay responding to the DEEOIC as a way to hurt the spouse.

### C. MISC.

- We received inquiries questioning whether an individual qualified as a common law spouse, and if so, whether the individual was an eligible survivor under the EEOICPA. To assist in understanding these determinations, the *Common-Law Marriage Handbook* was recently posted on DEEOIC's webpage.

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19. Under Part B, if there is a surviving spouse plus at least one child of the covered employee who is living and who is not a recognized child or adopted child of the surviving spouse, then one half of the compensation is paid to the surviving spouse and the other half is paid to each child of the covered employee who is living and a minor at the time of payment. 42 U.S.C. §7384s(f). Under Part E, one half of the payments are made to the covered spouse and the other half is made in equal shares to each child who meets the requirements for Part E coverage who is living at the time of payment. 42 U.S.C. §7385s-3(c)(3).



## V. DIAGNOSED CONDITION

In order to be eligible for compensation and/or benefits under the EEOICPA, the employee must have (or had) a diagnosed condition. This requirement continues to be a source of confusion.

### A. Screening vs. diagnosis

Some claimants are confused over the distinction between a screening and a diagnosis. The primary purpose of a screening is to find conditions at an early stage and to refer those individuals for diagnoses and treatment. On the other hand, a diagnostic exam is used to provide additional in-depth testing to confirm a suspected condition identified through a screening exam. The DOE's Former Worker Medical Screening Program (FWP) provides no-cost medical screening to all former DOE Federal, contractor, and subcontractor employees. These screenings focus on the early detection of health conditions that may be related to occupational exposures such as beryllium, asbestos, radiation, silica, etc. The goal of the program is to identify medical conditions in the early stages so the odds of successful treatment can be increased. Some claimants submit the results of the FWP screening to establish a diagnosed illness (or to establish the link between an illness and a particular toxin). However, because the FWP is a screening program, it does not provide for follow-up testing and generally does not include diagnoses or offer an opinion on causation.<sup>20</sup> Nevertheless, some claimants cannot understand why the results of a screening are not sufficient to establish a diagnosis of a condition. In addition:

- While the DOE continues to promote the program, we continue to encounter former workers who indicate that they are not aware of this program.
- A number of claimants question why the screening program is limited to the early detection of conditions. These claimants want a program that also offers treatment for detected abnormalities.

### B. There must be a diagnosis, not a list of symptoms

We are approached by claimants who become frustrated when their medical evidence is deemed a list of symptoms and thus insufficient to establish a diagnosed condition. In some instances, claimants believe that the attempt to distinguish between a diagnosis and a symptom is another example of the DEEOIC's overly technical approach to EEOICPA claims.

### C. Difficulties documenting a diagnosed condition

When the illness (or death) occurred many years ago, some claimants find it difficult to locate evidence specifically diagnosing the condition. A frequent grievance argues that prior to the creation of this program, there often was no need to pursue a specific diagnosis (and there was no way anyone could have anticipated that a specific diagnosis would ever be so critical). Similarly, family members tell us of illnesses detected when the worker was already in a terminal state and how rather than subjecting their loved one to additional procedures, they chose to forego the additional testing required to definitively diagnose the newly detected illness. Based on their experiences, claimants tell us that if an illness is not diagnosed by the treating physician, it is often extremely difficult to locate a physician willing to diagnose that illness for the first time years later. Moreover, as with other records, claimants note that with passage of time it is not unusual to discover that records were destroyed or lost, or that physicians cannot be located.

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20. Some claimants take exception with the determination that the results of a screening are not sufficient to constitute a diagnosis or to base an opinion on causation. However, the FWP concedes that its screenings generally do not include sufficient testing to allow a diagnosis or to address causation.



One example of the difficulties encountered attempting to establish a diagnosed condition involves a claim where the employee passed away 50 years ago. Since the pathology report simply notes, “metastatic cancer of unknown origin,” the pathology report was not sufficient to establish a diagnosis of a specific cancer. Relying upon medical documents that she located, the claimant was able to submit medical reports and research documents that suggest that the cancer more than likely originated from the bone and metastasized to the brain, and thus the claimant believes that she has submitted sufficient evidence to support a diagnosis of a SEC cancer. The DEEOIC initially held that claimant’s additional evidence was not sufficient to establish a diagnosis of a SEC cancer. The claim is now under further review.



## VI. EXPOSURE TO RADIATION/TOXINS

In order to be entitled to benefits under the EEOICPA, the covered employee must have been exposed to toxins while working at the covered site. The DEEOIC developed the SEM to assist claimants in establishing exposure to toxins. Nevertheless, the burden ultimately rests with the claimant to establish exposure to toxins. We receive complaints indicating that it can be difficult to meet this burden.

### A. Difficulties establishing exposure

- **Records are unavailable:** The destruction of employment records often renders it difficult, if not impossible to prove that an employee worked in certain buildings/locations, and this in turn renders it difficult to establish that the worker was exposed to the toxins used in particular buildings. In addition, there are instances where due to the passage of time dosimetry badges and other exposure records can no longer be found. Some claimants find it hard to accept that with such emphasis on security, data such as exposure records were destroyed.
- **Information never disclosed to the workers:** Claimants assure us that these facilities operated on a need to know basis and in such an environment workers were provided with limited information and did not ask a lot of questions. Claimants assert that it never crossed their mind to ask for a listing of all of the toxins to which they were exposed and many claimants seriously doubt, had they asked, if anyone would have provided them with this information.<sup>21</sup> Moreover, some workers indicate that they never learned the proper names of the various toxins to which they were exposed. In discussing their exposure to toxins, some claimants simply refer to “the brown gas,” “that icky stuff” or to containers marked “XXX.”<sup>22</sup>
- **Existing records not accurate:** Even where exposure records exist, claimants question the accuracy of these records. Claimants suggest that existing records do not always reflect all of the duties/assignments performed by the worker and thus do not address all of the exposures that the worker encountered. Claimants are also troubled when existing exposure records either omit or minimize the impact of mishaps and accidents. Claimants frequently tell us that as a result of accidents that occurred, their tools and clothes were taken away and destroyed, and they were sent home for a few days and yet to the disappointment of these claimants, existing records make no mention of these accidents. It is also common to hear claimants assert that in order to reduce the officially recorded levels of radiation exposure they were sometimes ordered, during the course of the day, to remove their dosimetry badges.

Claimants cite exposure records as another example where the burden has been placed on claimants even though relevant records are not available (and claimants were not responsible for maintaining these records). Some claimants suggest that if the DOL and the DOE cannot locate records documenting exposure, it is unjust to expect claimants to locate this evidence. This is also another instance where because workers did not discuss their employment with their families, survivors tend to have no idea of the toxins to which their loved ones were exposed.

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21. A review of the SEM reveals that at some sites hundreds of toxins are known to have been used. Moreover, according to the expanded SEM a number of toxins were often used at particular buildings.

22. The expanded SEM identifies toxins by alias or property. However, this feature does not address every toxin.



## B. SEM

SEM is a repository of information on toxic substances present at DOE and RECA sites covered under Part E. In previous reports, we addressed complaints suggesting that SEM merely listed all of the toxins known to have been used onsite at a facility, and how some claimant found these listings unmanageable since they oftentimes contained hundreds of toxins. In 2010 as a result of a culmination of efforts by the DOL and the DOE, the DOL unveiled an expanded SEM. The expanded SEM provides additional information, including a listing of the toxins known to have been used at particular building, area and labor category. (The expanded SEM can be located at [www.sem.dol.gov](http://www.sem.dol.gov)).

Since the unveiling of the expanded SEM, there has been a decrease in the number of complaints involving SEM. Nevertheless, there are some issues concerning SEM that continue to generate complaints.

- **The accuracy of SEM:** There are complaints suggesting that SEM does not list all of the toxins used at particular sites, buildings, or areas. Claimants also suggest that some toxins were used more extensively throughout a facility than acknowledged by SEM.
- **Updating SEM:** On its Web site, the DEEOIC invites input from the public in updating SEM. We receive complaints asserting that attempts to update SEM were never addressed. These concerns were discussed with the DEEOIC who noted that there have been updates to SEM based on information provided by the public. In spite of these assurances, we continue to encounter individuals who argue that they never received a response to their submissions concerning an update to SEM.
- **Limits of SEM:** Some claimants assume that if they worked at a facility and SEM lists a toxin as having been used at that facility, then exposure to the toxin is verified. This is not necessarily true. There are instances where a toxin was used at a site, but the evidence does not indicate that the employee was ever present at a building where the toxin was used. In such an instance, the mere fact that the toxin was used at the site does not establish that the employee was exposed to the toxin. Similarly, there are instances where SEM indicates that the employee was exposed to a toxin, yet it is ultimately determined that the employee did not have sufficient exposure to be a factor in his/her illness. Consequently, we receive a number of complaints where claimants do not fully understand how to interpret the information provided by SEM.
- **SEM is only available online:** Because it is only available online, some claimants are unable to access SEM.

## C. Synergistic Effects

Authorized representatives and claimants are troubled by the fact that SEM does not address the possibility that an illness may be the result of a combination of ionizing radiation and chemical exposure (a synergistic effect). In response, the DEEOIC acknowledges that SEM does not address synergy, but asserts that this is due to the fact that currently there is insufficient peer reviewed medical literature to support such information. According to the DEEOIC, evidence of synergy submitted by the claimant is considered. Unfortunately, the time and expense needed to develop evidence of synergy is often prohibitive. Consequently, some authorized representatives and claimants argue that the expense of developing evidence of synergy ought to be borne by those who exposed the employees to these dangers (i.e., the government and/or the employers).



## VII. DOSE RECONSTRUCTION AND SPECIAL EXPOSURE COHORTS

Dose reconstructions and the running of the Special Exposure Cohort petition process are two functions administered by NIOSH's Division of Compensation Analysis and Support (DCAS, formerly known as OCAS, the Office of Compensation Analysis and Support). We receive numerous complaints addressing each of these functions.

### A. Dose Reconstruction

Dose reconstructions are intended to characterize the occupational radiation environment to which workers were exposed using available worker and/or workplace monitoring information. If radiation exposure in the workplace environment cannot be fully characterized based on available data, default values based on reasonable scientific assumptions are used as substitutes. Where a dose reconstruction is performed, entitlement to compensation is based on the probability that the worker's cancer was at least as likely as not caused by his/her exposure to ionizing radiation during employment at a covered facility. The most common complaints that we receive concerning dose reconstructions include:

- **The length of time that it takes to conduct a dose reconstruction:** As the chart below indicates, NIOSH has made steady progress in reducing the amount of time that it takes to process a dose reconstruction.

	FY2003	FY2005	FY2007	FY2009
Average # of days to process DR	865	486	289	Not reported
Cases received in 2001 without an initial DR	1104	500	6	2
Number of cases at NIOSH greater than 2 years old	0	5345	1498	503

**NIOSH Program Area: Radiation Dose Reconstruction, Figures 1, 2 and 3.** Nevertheless, as it stands today, sending a case to NIOSH for a dose reconstruction adds approximately one year to the processing time of a claim. Since the death of the worker or claimant can potentially reduce the amount of compensation paid under the EEOICPA, claimants are very anxious to have their EEOICPA claims resolved as expeditiously as possible. Therefore, claimants are very concerned with the amount of time that it takes to perform a dose reconstruction.

- **Methodology of dose reconstructions:** Some claimants want the opportunity to formally challenge the methodology utilized by NIOSH in determining dose reconstructions. However, pursuant to 20 C.F.R. §30.318(b) the methodology used by HHS (NIOSH) in arriving at reasonable estimates of the radiation doses received by an employee is binding on the Final Adjudication Branch. While some claimants raise their concerns directly with NIOSH, we are approached by claimants who would prefer the opportunity to use the adjudicatory process to directly challenge the methodology utilized in determining dose reconstructions.
- **Data used to perform dose reconstructions:** Claimants question whether the records utilized by NIOSH to perform dose reconstructions identify all of their employment and/or all of his/her exposures. Accordingly, since they question the information relied upon in performing the dose reconstruction, these claimants have no confidence in the resultant determination of the dose reconstruction. In response, NIOSH indicates that in performing dose reconstructions they utilize the information provided by the DEEOIC.
- **Dose reconstructions involving Part E claims:** A dose reconstruction is performed on all claims for cancer – both Part B and Part E claims for cancer. We were contacted by claimants who believe that performing a dose reconstruction on certain Part E claims simply results in unnecessarily delaying the claim. These



complaints involve claims where the claimant believes that there is sufficient evidence to establish that the Part E illness was related to exposure to a toxin other than radiation. In these situations, claimants question the need to perform a dose reconstruction especially since there is no assertion that the illness is related to radiation exposure, no one expects the dose reconstruction to result in a probability of causation (PoC) greater than 50%, and everyone knows that a dose reconstruction will take approximately one year to perform.

- **Overestimates:** The practice of overestimating certain dose reconstructions continues to trouble claimants. Since accurately estimating an employee's exposure can be time consuming, in order to simplify the dose reconstruction process, NIOSH makes assumptions on dose estimates that are favorable to the claimant. One assumption is to significantly over-estimate the exposure based on the highest levels of exposure observed (or possible) for the facility. This approach assumes that if the claim is not compensable using these significantly over-estimated exposures then the claim will not prevail using a more accurate determination of the dose reconstruction.

Confusion sometimes arises where an overestimate was used for the initial claim and the employee subsequently develops an additional cancer. If the new cancer creates a potentially compensable case, the dose reconstruction is refined using more probable and precise exposure estimates and this often results in an estimate that is lower than the initial estimate that was premised on the overestimate.

Although the dose reconstruction report clearly states whenever a dose estimate is premised on an overestimate, many claimants either overlook or do not understand the significance of this notice.<sup>23</sup> Therefore we are confronted by claimants who cannot understand how an earlier dose reconstruction conducted for one cancer resulted in a certain PoC, and a subsequent dose reconstruction conducted for multiple cancers resulted in a lower PoC. In spite of our efforts to explain the concept of overestimates, some claimants see this as another indicator of the irrationality inherent in this program.

- **Subsequent cancers:** Based on our conversations, it is clear that some claimants are not aware that the diagnosis of an additional cancer may warrant a new dose reconstruction. We especially see this with skin cancer. We encounter instances where the initial claim for skin cancer was denied and while the claimant subsequently developed additional skin cancers, the claimant never filed a new claim for the additional cancers.
- **Use of co-worker and surrogate data:** Where there is little or no personal exposure information, NIOSH uses information from technical documents such as technical basis documents, site profile documents, technical information bulletins, and data from other workers at the site to perform the dose reconstruction. In addition, where information for a particular facility needs to be supplemented to adequately characterize the workplace exposure conditions, the model used by NIOSH may incorporate non-facility-specific data (surrogate data).

Many claimants do not believe that data relating to other workers at the same site or data from other sites is a viable substitute for personal exposure information. Some claimants suggest that whenever personal exposure information is not available, the claim ought to be eligible under the SEC criteria.

## B. Special Exposure Cohorts

Generally, a dose reconstruction is performed for all cancer claims. The exception to this rule is when the employee

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<sup>23</sup>. NIOSH provides the claimant with a copy of the dose reconstruction report.



qualifies for inclusion to the Special Exposure Cohort (SEC). If the employee qualifies for inclusion to the SEC then the eligible claimant can be compensated without the completion of a dose reconstruction and without a determination of the PoC.

The EEOICPA originally established four (4) SEC classes which included employees who worked on Amchitka Island, Alaska, as well as employees who worked at the gaseous diffusion plants in Paducah, Kentucky; Portsmouth, Ohio; and Oak Ridge Tennessee.<sup>24</sup> However, the EEOICPA also authorizes the Secretary of Health and Human Services (HHS) to add other classes of employees to the SEC.<sup>25</sup> Since the inception of this program HHS has added at least 70 additional SEC classes to the four (4) statutory classes.

To qualify for compensation as a member of an SEC class, a covered employee must have worked for a specified period of time at an SEC work site, and must have developed at least one of the 22 specified cancers. While the SEC process is intended to ease the burden placed on claimants, it also generates a number of complaints:

- **How are SECs selected:** According to the statute additional classes of SECs can be added where: (1) it is not feasible to estimate with sufficient accuracy the radiation dose that the class received, and (2) there is a reasonable likelihood that such radiation dose may have endangered the health of members of the class. 42 U.S.C. §7384q(b). Some claimants question whether this criterion is applied fairly in all cases. Claimants cannot understand why some facilities qualify for a SEC, while others do not.
- **The 22 cancers:** Pursuant to the statute, there are 22 specified cancers covered under the EEOICPA. We often receive inquiries asking why the statute only specifies these 22 cancers for purposes of SECs.<sup>26</sup> Moreover, since this list was established with the inception of the program, some claimants question whether it is time to reassess this list.
- **Chronic lymphocytic leukemia:** Section 7384l(17) specifically excludes chronic lymphocytic leukemia (CLL) as a SEC cancer. See 42 U.S.C. §7384l(17).<sup>27</sup> In our 2008 Annual Report we indicated that claimants had submitted literature challenging the notion that CLL was not a radiogenic cancer. It is our understanding that HHS has proposed to reverse its decision to exclude CLL as a radiogenic cancer and has invited comments on such a proposal. [A new rule addressing CLL was published in the Federal Register on February 6, 2012].
- **Partial dose reconstruction:** A site qualifies as a member of an SEC class when it is not feasible to estimate with sufficient accuracy the radiation dose that the class received. Unfortunately, there are individuals with cancer who worked at SEC sites (and who worked at the site during the time period covered by the SEC class), who do not qualify for inclusion in the class. Two examples are individuals who cannot establish the requisite 250 days of employment, as well as individuals who do not have one of the 22 specified cancers. In such instances, although a dose reconstruction must be performed on the cancer claim, NIOSH can only reconstruct a portion of the dose. NIOSH considers these partial dose reconstructions as complete (and a best estimate given that all reliable data available was used). However, since it is conceded that some data is not usable, claimants question the accuracy of a partial dose reconstruction.

24. With respect to the four (4) SECs established by the EEOICPA, employees had to be diagnosed with a specified cancer and have worked at gaseous diffusion plants in Paducah, Portsmouth or Oak Ridge for a total of at least 250 days before February 1, 1992 and were monitored for radiation exposure with dosimetry badges or had jobs with similar exposures to those monitored, or were employees who worked before January 1, 1974, on Amchitka Island and were exposed to radiation related to the Long Shot, Milrow or Cannikin underground nuclear tests. See 42 U.S.C. §7384l(14).

25. According to the statute additional members of a SEC class can be added where: (1) it is not feasible to estimate with sufficient accuracy the radiation dose that the class received, and (2) there is a reasonable likelihood that such radiation dose may have endangered the health of members of the class. 42 U.S.C. §7384q(b).

26. The statute defines the specified cancers at 42 U.S.C. §7384l(17).

27. The statute at 42 U.S.C. §7384l(17) excludes CLL as a SEC cancer. Prior regulations promulgated by NIOSH excluded CLL from dose reconstructions.



This is the situation that confronted a former employee of the Los Alamos National Laboratory. This employee worked at the site from 1946 to 1953, which are years covered by the SEC for this site. While admittedly there are no dosimetry records prior to 1950 and no ambient radiation monitoring records prior to 1965, since this employee did not qualify for inclusion in the SEC class, a partial dose reconstruction was performed resulting in a PoC of less than 50%. This employee has no confidence in the results of a partial dose reconstruction where the only dose assigned prior to 1950 is the medical dose based on a model.

- **Establishing 250 days – couriers:** Couriers face an especially onerous burden attempting to qualify as a member of a SEC class. Since there generally are no records documenting their presence at specific sites, couriers often encounter difficulties establishing the requisite 250 days at SEC work sites. At Section III B, we discussed the claim of a former courier who discovered that there are boxes in Seattle that possibly contain trip reports that document his visits to various sites. This employee believes that these records could assist him in documenting the requisite 250 days at SEC sites. However, the DEEOIC determined that it was not feasible to review the contents of these boxes and the DOE will respond to his FOIA request by providing him with the cost that it will charge in order to answer this request.<sup>28</sup>

While in Albuquerque, New Mexico, we met the surviving child of another courier. This claimant has documentation indicating that his father, the courier, drove a truck that sometimes contained radioactive materials. However, due to a lack of existing records, this claimant cannot establish the specific sites that his father visited. As an alternative, the claimant inquired into the feasibility of submitting a SEC petition focusing on his father’s employment. The response cited to the statute which in addressing the designation of additional SECs specifically refers to a “class of employees at any Department of Energy facility who likely were exposed to radiation at that “facility”...” See 42 U.S.C. §7384q(a). [Emphasis added]. Since the statute specifically refers to a “facility,” it was determined that the truck that the father drove would not meet the definition of a DOE facility, and thus could not be the basis for an SEC class.

- **SEC process takes to long:** This year, we were contacted by individuals who are concerned with the length of time that is taking to process certain SEC petitions. The chart below lists the complaints that we received this year:

Site	Petition Received by NIOSH	Minimum Qualifications	SEC Petition Evaluation Report	Effective Date of Class
Pantex	09/08/2006	12/17/2007	08/08/2008	01/20/2012
Texas City	03/13/2007			02/05/2011
United Nuclear Corporation	06/19/2008	11/28/2008	02/01/2010	Still pending
Savannah River Site	XXXXXX 11/19/2010 <sup>29</sup>	03/10/2008	11/14/2008 05/04/2010 08/09/2011	Unless there is action by Congress, this class will become effective March 3, 2012
Hooker Electrochemical	03/06/2009	10/30/2009	05/03/2010	In a letter dated February 2, 2012, HHS denied this class.

28. The DEEOIC also noted that the records in these boxes were generally dated after 1972 and that most, but not all SECs covered time periods prior to 1972.

Claimants and authorized representatives contend that delays such as this have a significant impact on claims – especially where eligible workers and/or survivors pass away while the petition is pending.<sup>29</sup>

- **SEC for the Mound Plant:** As reported in last year’s report, in August 2010, a new SEC class was established for the Mound Plant. The SEC class covers all employees who worked at the Mound Plant between March 1, 1959 and March 5, 1980 who had at least one tritium bioassay sample and have the requisite 250 days of employment. However, issues arose concerning the criterion for this SEC class, and specifically whether everyone who had a tritium bioassay was listed in certain logbooks. This issue was prompted by the presence of additional evidence suggesting that there were employees not included in the logbooks who were nevertheless monitored for exposure to tritium. Finally, on September 23, 2011, the DEEOIC determined that the “Mound Plant Tritium Exposure Report” is also affirmative evidence that an employee had a tritium bioassay as required for inclusion in the SEC. In spite of this resolution, there are individuals who continue to be concerned with the amount of time that it took to resolve this matter.
- **Claimants not aware when new SECs added:** When a new SEC member is added, a notice is posted in the Federal Register and an announcement is posted on the DEEOIC’s Web site. In addition, on many occasions the DEEOIC will host an outreach event near the facility. More importantly, when a new SEC is added, the DEEOIC identifies the previously denied claims potentially impacted by the new SEC and re-reviews these claims pursuant to the requirements of this new SEC. If the review by the DEEOIC results in a change in the status of the claim, the DEEOIC notifies the claimant.

Claimants potentially impacted by new SECs constantly contact our Office with the following concerns:

- o They do not understand why the DEEOIC does not automatically notify them when a new SEC is added, and
  - o They question why they are only notified of the results of the DEEOIC’s review if that review results in a change in the status of the claim.
- **Metastases:** The list of 22 SEC cancers is interpreted as including instances where cancers other than one of the 22 specified cancers metastasizes to the lung, bone or kidney. This interpretation is not widely known. We are aware of instances where the claim for a primary cancer was denied and it was only when subsequently advised of this interpretation that the claimant sought and obtained evidence of metastases. Some claimants complain that had they earlier known of this interpretation, they could have developed evidence of metastases at an earlier stage in the claims process.

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29. While up to three individuals can be petitioners on an SEC petition, the approval of an SEC petition can potentially impact hundreds of claimants. We often find that many claimants only become aware of an SEC petition if and when the petition is approved.



## VIII. PART E CAUSATION

*For Part E claims, the evidence must establish that there is a relationship between exposure to a toxin and an employee's illness or death. This relationship defines the intensity, duration, and route of exposure, which is characteristic of that specific toxin and illness or death. The evidence further needs to demonstrate whether it is "at least as likely as not" that such exposure at a covered DOE or RECA section 5 facility during a covered time period was a significant factor in aggravating, contributing to, or causing the employee's illness or death, and that it is "at least as likely as not" that exposure to a toxic substance(s) was related to employment at a covered DOE or RECA section 5 facility. EEOICP Procedure Manual, Chapter 2-1000, subchapter 17.*

The requirement under Part E that the evidence establish a relationship between exposure to a toxin and the employee's illness or death continues to generate a number of complaints. Many of these complaints concern the fact that claimants do not understand what is needed to establish causation.

### A. SEM and causation

Many claimants do not understand that generally SEM is not conclusive proof of causation. We encounter claimants who assume that if SEM identifies a toxin as having been used at a covered site and there is literature generally linking that toxin to the illness in question, then causation is definitively established. Similarly, because SEM contains a listing of approximately 130 illnesses and the occupational toxins known to be linked to these illnesses, many claimants assume that if this listing shows a link between an illness and a toxin, there is no need to submit additional evidence. Neither of these assumptions is correct. As a rule, even where SEM identifies a toxin as having been used at a site or where there is a general link between an illness and a toxin, the claimant still must submit medical evidence addressing this link.

### B. Little guidance provided to assist in developing evidence of causation

During the year there were a number of complaints alleging that little, if any, guidance is provided to claimants to assist them in understanding what the DEEOIC is looking for when it comes to evidence of causation. A common complaint suggests that it is only when the evidence submitted by the claimant is rejected that the claimants is sometimes provided guidance as to what is needed to satisfy the causation requirement.

In our experience, in order to establish causation a medical report needs to identify the specific toxic exposures and explain how and why these exposures were a significant factor in causing, contributing to, or aggravating the claimed illness. Furthermore, the medical report needs to provide a sound rationale and objective findings including references to scientific or medical literature in support of the opinion. During the year, claimants and authorized representatives shared with us documents that they believe illustrate the inconsistency and lack of guidance that is often provided.

One claimant shared with us a letter forwarded to a physician in 2010. The letter reads,

*If you determine that there is a connection between toxic exposures during the covered employment... and the condition of ...please provide us with the following information. Please identify the specific toxic exposures that ...experienced...and explain how and why the exposures were a significant factor in causing, contributing to, or aggravating [the diagnosed condition]...The medical evidence report should provide sound rationale and objective findings including references to scientific or medical literature in support of the opinion concluded.*



A second letter forwarded to a claimant in 2011 states,

*The evidence you will need to submit should show the toxic substance(s) you may have been exposed to at...that caused, aggravated, or contributed to the claimed condition. In addition, we need medical or scientific evidence from a physician fully explaining the medical rationale regarding how exposure to the specific toxic substance(s) was a significant factor in causing, aggravating, or contributing to ...*

The third letter forwarded to a claimant in 2011 reads in pertinent part,

*To determine if you qualify for benefits under the EEOICPA, we will be seeking information from you or other sources to establish the following...A link between the covered employment exposures and the medical conditions established. Part E of the Act requires a finding that it is 'at least as likely as not' that toxic exposure at a covered facility during a covered time period was a significant factor in aggravating, contributing to, or causing your illness, and that it is 'at least as likely as not' that exposure to the toxic substance was related to employment at that facility."<sup>30</sup>*

Claimants believe that these three letters highlight their concerns with the guidance provided to them. The first letter refers to a medical opinion that provides sound rationale and objective findings including references to **scientific or medical literature in support of the opinion concluded**. The second letter does not refer to scientific or medical literature in support of the opinion concluded, but rather asks for **medical or scientific evidence from a physician**. The third letter makes no reference to scientific or medical literature or evidence.

We also receive complaints from claimants alleging that guidance is provided in a piecemeal fashion. A frequent complaint comes from claimants who contend that they were provided certain guidance and it was only when they submitted evidence consistent with that guidance that they were advised of additional criteria that had to be met.

- Claimants argue that it is preferable to have clear guidance as early as possible in the claims process. Many claimants initiate the development of evidence prior to filing their claims and would prefer to have access to guidance when they begin to develop evidence. Claimants continually complain of having to return to physicians who are not happy when asked to supplement or amend reports previously prepared reports. Many claimants note that these unpleasant encounters with physicians could be avoided if claimants were able to provide the physicians with sufficient guidance prior to the preparation of the initial report.<sup>31</sup>

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30. In this case the claimant was asked to provide any evidence that can be used to establish that he was exposed to toxic substances that are linked to his covered condition.

31. Although not every claimant has access to the internet, those who do have access contend that placing this guidance on the internet would make it readily available



## IX. THE EVALUATION OF EVIDENCE

A number of claimants focused their concerns this year on the evaluation of evidence. In a general sense, there are two concerns that we hear: (1) the bar is set too high in terms of the evidence claimants are expected to produce, and (2) the evaluation of the evidence does not reflect a claimant-friendly program.

### A. The bar is set too high

Many of the claimants who contact the Office believe that the DEEOIC sets a very high bar when it comes to evaluating evidence submitted by claimants. Some claimants argue that in evaluating evidence the DEEOIC does not give sufficient consideration to the amount of time that has elapsed since the employment occurred, or to the fact that relevant evidence was destroyed and colleagues have passed away.

One example where claimants believe that the bar has been set too high involves the use of affidavits, especially affidavits prepared by the workers. As we discuss in Section III D, according to the DEEOIC policy concerning the use of affidavits, while affidavits may assist in placing employees at certain locations, affidavits must be reviewed in conjunction with other supporting documentation. Claimants believe that this policy does not give adequate consideration to the fact that in many instances, through no fault of the claimant, evidence addressing employment does not exist (and colleagues are dead, cannot be located, or do not have the capacity to complete an affidavit). As a result many claimants contend that it precisely where there is no supporting documentation that the reliance on an affidavit is most critical.

Another example involves the requirements for establishing a diagnosis of cancer. Pursuant to the EEOICP Procedure Manual (PM), a tissue examination (pathology report, surgical pathology report, autopsy report, or post-mortem examination report) is the most conclusive method for making a cancer diagnosis. The PM further notes that a diagnosis of cancer can sometimes be made by cytology report or imaging (x-ray, CAT scan or MRI) and if the employee is deceased and none of the listed tests are available, a diagnosis of cancer in a survivor's claim can be based on hospital admission/discharge report, hospice records or death certificate. See EEOICP Procedure Manual Chapter 2-0900, subchapter 3.

Claimants complain that the PM overlooks the fact that hospitals and physicians are only required to maintain medical records for ten years. Where the employee passed away more than ten years ago, tissue examination reports, cytology reports, imaging reports, hospital admission or discharge reports, and hospice reports generally are not available. In addition, if the employee had cancer, but the cancer was not the cause of death, it might not be listed on the death certificate. Throughout this year, claimants contacted our Office to complain of instances where they felt that the bar for establishing a diagnosis of cancer was set way too high. A few of these instances include:

- A physician submits a pathology report supporting a diagnosis of skin cancer. The same physician also submits a letter stating that he removed an earlier skin cancer from the employee. (Due to the length of time that has elapsed, records relating to the removal of the earlier skin cancer were destroyed). In spite of the letter from the physician, the DEEOIC continues to ask the claimant for more information to document the diagnosis of this earlier skin cancer.
- While there are no existing medical evidence addressing the original site of the cancer, claimant locates evidence indicating that there is a 91% chance that the original site was one of three SEC specified cancers. The claimant was encouraged to submit this evidence to his CE. Claimant awaits the outcome of the DEEOIC's review of this evidence.



Complaints alleging that the bar is set too high are not limited to evidence establishing a diagnosis of cancer. These complaints involve practically every aspect of EEOICPA claims. Other examples include:

- The certainty required of medical reports addressing causation. Claimants contend that the DEEOIC does not adequately consider that physicians rarely speak with absolute certainty, and this is especially true when the issue concerns the link between an illness and toxins. We are approached by claimants who complain that the DEEOIC deemed the report by their physician as speculative, when the doctor was simply being reasonable and recognizing in many instances no one can be 100% certain of the facts in question.
- Claimants cannot believe that in order to establish that an employer is a covered employer they may be required to establish that there was a contract between the employer and the DOE. Claimants argue that while working at these sites they had no reason to inquire into the existence of a contract between their employer and the DOE (or the DOE contractor). Thus, claimants contend that it is unrealistic to expect them to be able to establish the existence of a contractual relationship. In the alternative, some claimants contend that, in the absence of evidence to the contrary, evidence establishing that they worked at the covered facility ought to be sufficient to establish that a contract existed between the employer and DOE. In addition, some claimants point to this as another example where the burden of proof is placed on the claimant even though the government or the employer is in the best position to establish the fact in question.
- Where there is no other evidence addressing employment, claimants also believe that evidence indicating that they obtained a “Q” clearance should be sufficient to establish that they were employed at the covered facility.

## **B. Complaints alleging that the evaluation of evidence is not consistent with the Act**

Claimants approach us with concerns as to whether the evaluation of evidence is consistent with the Act. Some claimants believe that since this Act is intended to be “claimant friendly” Act, there is an obligation to provide claimants with the benefit of the doubt. However, there is no provision in this Act authorizing such a shift in the burden of proof.<sup>32</sup>

Throughout the year, we also received complaints questioning whether the evaluation of evidence was consistent with the Act. Many of these complaints involve situations where the language of a regulation/policy did not precisely mirror the language of the Act, thus causing claimants to question whether the regulation/policy was consistent with the Act. Take for instance:

- The Act defines DOE contractor or subcontractor employee as a contractor or subcontractor that provided services. 42 U.S.C. §7384l (11) (B). Nevertheless, EEOICP Bulletin NO. 03-27 provides that the delivery and loading or unloading of goods alone is not a service and is not covered for any occupation.
- Part B of the statute provides very specific criteria for establishing CBD. See 42 U.S.C. §7384l (13). Part E of the statute does not incorporate the Part B criteria for establishing CBD, and does not otherwise provide any criteria for establishing CBD. Recently, however, the DEEOIC determined that an abnormal beryllium lymphocyte proliferation test is needed for a successful CBD claim under Part E.

32. The RECA contains a specific provision that mandates that “[a]ll reasonable doubt with regard to whether a claim meets the requirements of this Act shall be resolved in favor of the claimant.” 42 U.S.C. §2210 note (2006), §6(b)(1); 28 C.F.R. § 79.4(b). There is no similar provision in the EEOICPA.



- Lung cancer is one of the 22 specified cancers. We were contacted when a claimant did not qualify for the SEC class in a situation where the employee's cancer metastasized to the pleura of the lung. This claimant questioned whether in creating this list of 22 cancers, Congress intended to distinguish between lung cancer and cancer of the pleura of the lung.

### C. Weight accorded physicians:

Some claimants and authorized representatives believe that under this program there is an inherent bias towards accepting the opinion of district medical consultants over the opinion of treating physicians. In response to these suggestions, the DEEOIC firmly denies any bias towards district medical consultants.

Claimants also argue that there is a bias against accepting the opinion of treating physicians. Some claimants point to the policy outlined in Chapter 2-0800, subchapter 6 of the PM as evidence of this bias. The policy reads:

How to Evaluate Evidence. In evaluating the merits of medical reports, the CE assigns greater value to:

- (1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information.
- (2) A well-reasoned or well-rationalized opinion over one that is speculative.
- (3) The opinion of an expert in the relevant medical field over the opinion of a general practitioner or an expert in an unrelated field.<sup>33</sup>

Some claimants are concerned that this policy results in a mechanistic assignment of more weight to the physician with the superior credentials without consideration to whether that physician ever examined the worker or had access to the complete medical file. Some claimants also believe that this policy can lead to assigning more weight to the physician with superior credentials without proper consideration to whether the credentials have any relevance to the matter at issue.

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33. Claimants fear that many CE's read this as three separate criteria and thus give more weight to a physician simply because that physician is an expert in the relevant medical field.

## X. ISSUES RELATED TO CHRONIC BERYLLIUM DISEASE

There were a number of complaints this year concerning the diagnosis and treatment of chronic beryllium disease.

**A. Part E CBD:** Under Part B, the statute outlines very specific criteria for establishing CBD. While Part E covers any illness, including CBD, related to exposure to toxic exposure at a covered facility, Part E does not contain any specific criteria for establishing CBD. This year an authorized representative contacted us when advised that a LPT test was required to establish CBD under Part E. In response to our inquiry, we were initially informed that a LPT test was required for Part E claims. A few days later, we received clarification indicating that a LPT test was not required for Part E claims. A month later we were advised that the matter was again under review. Six months later we were informed that if employees want a specific CBD determination under Part E, a confirming LPT test is needed.<sup>34</sup>

Since the statute does not contain any specific criteria for establishing CBD under Part E, this authorized representative questions the basis for this most recent determination. The authorized representative also believes that this incident highlights a concern with consistency – i.e., the fact that prior to this most recent determination, the DEEOIC staff did not appear to have a consistent understanding of this policy. Moreover, in light of the DEEOIC’s most recent determination on this subject, the authorized representative questions whether and to what extent efforts will be undertaken to ensure that both the DEEOIC staff, as well as the public are aware of this determination.

**B. Establishing pre-1993 CBD by x-rays:** For diagnoses of CBD before January 1, 1993, in addition to the presence of occupational or environmental history, or epidemiologic evidence of beryllium exposure, the claimant must establish any three of five listed criteria. Two of the listed criteria are, “[l]ung pathology consistent with chronic beryllium disease,” and “[c]linical course consistent with a chronic respiratory disorder. See 42 U.S.C. §7384l (13) (B)(ii)(III) and (IV). A third criteria addresses x-rays and provides for, “[c]haracteristic chest radiographic (or computed tomography (CT)) abnormalities.” See 42 U.S.C. § 7384l (13)(b)(ii)(I).

There are claimants and authorized representative who argue that since the statute does not include the phrase “consistent with chronic beryllium disease” when referring to x-ray evidence of pre-1993 CBD, this indicates that Congress intended that any x-ray abnormality would be sufficient to satisfy this criterion. In spite of these arguments, the DEEOIC has consistently held that in order for an x-ray to satisfy the criteria for pre-1993 CBD, the x-ray must be characteristic of chronic beryllium disease. See the EEOICPA Procedure Manual, Chapter 2-1000, subchapter 6.

**C. Issues involving one particular medical provider:** The Office continues to receive complaints involving one particular medical provider.

- One complaint questions why, as part of the claims process, workers are referred to this particular medical provider. Some authorized representatives specifically allege that the DEEOIC sends workers to this particular provider. In response, the DEEOIC has consistently stated that it does not send individuals to any specific provider.

34. The response that we received recognized that specific criteria for CBD were delineated under Part B and that the standard for CBD under Part E is “more flexible.” Nevertheless the response concluded that a LPT test was needed under Part E because it was an essential method of (1) distinguishing CBD from other pulmonary diagnosis with similar lung manifestations and (2) it is an important aspect of making the link between exposure to beryllium and causation of the lung disease. The response further noted that many types of particulate will cause scarring and fibrosis of the lung and any of these that are occupational in nature have the potential for coverage under Part E. However, if an employee wants the specific CBD determination, then the confirming LPT is needed.



This medical provider is one of the facilities where former DOE workers are offered free medical screenings through the FWP. As a general rule, whenever possible, screenings are conducted within 60 miles of an individual's residence. Moreover, screenings are not part of the EEOICPA claims process and the DEEOIC is not involved with the screening program.

If the screening results in findings that are abnormal, the worker is encouraged to seek further medical assistance. Moreover, where the abnormal findings are indicative of CBD, the worker is provided with a list of facilities known to have an expertise with CBD along with a letter detailing the results of their medical exam. This medical provider is on this list. The FWP is adamant that this list of medical providers is given to workers solely for informational purposes - workers are free to use any facility that they choose, including facilities not on the list. Recognizing that it is possible that some workers do not realize that they are free to seek the services of any physician, the FWP reviewed their results letters to ensure that they clearly state that workers are not required to use the facilities on the enclosed list. Nevertheless, we continue to receive complaints suggesting that claimants are sent to this particular medical provider. In order to resolve any confusion, at least one authorized representative suggested that the FWP cease its distribution of this list. However, other authorized representatives and claimants have told us that they appreciate this list.

As noted, the DEEOIC is not involved with the screening program and is not involved with the referrals that follow abnormal findings. Rather, the DEEOIC's involvement with a claim begins when a claim is filed.<sup>35</sup> In numerous discussions with the DEEOIC concerning the allegations that claimants are sent to particular facilities, the DEEOIC was adamant that it does not direct claimants to particular physicians. The DEEOIC's asserts that when it comes to developing medical evidence to support a claim the claimant is free to go to the physician of his/her choosing. In spite of these assertions, we continue to receive complaints alleging that personnel associated with particular Resource Centers and/or District Offices referred claimants to certain physicians. The management of the Resource Centers, as well as of the DEEOIC, insists that such referrals are contrary to their policies, and ask that violations of this policy be brought to their attention.

- Another issue involving this medical provider concerns the criteria that it applies in diagnosing CBD. Under the post-1993 criteria for establishing CBD in Part B claims, a claimant must produce an abnormal LPT test in addition to one of the following: (i) a lung biopsy showing granulomas or a lymphocytic process consistent with chronic beryllium disease; (ii) a computerized axial tomography scan showing changes consistent with chronic beryllium disease; or (iii) pulmonary function or exercise testing showing pulmonary deficits consistent with chronic beryllium disease. 42 U.S.C. §§7384l (8) and (13). We receive complaints suggesting that while the statute provides three options for evidence that can be submitted in addition to the LPT test, this particular medical provider tends to require a lung lavage before diagnosing CBD.<sup>36</sup> In a 2010 conversation with a representative of this medical provider it was acknowledged that this provider often asked claimants to undergo a lung lavage in order to accurately diagnose and treat CBD.<sup>37</sup> Noting that a lung lavage is such an unpleasant procedure, some authorized representatives question the insistence on a lung lavage, to the exclusion of the other options provided by the statute for diagnosing CBD. These authorized representatives argue that because of this insistence on a lung lavage, it is often difficult to obtain a diagnosis of CBD from this medical provider.

35. The DEEOIC could also become involved if a potential claimant seeks information concerning the program.

36. The EEOICP Procedure Manual includes a lung lavage within its definition of a lung biopsy. See EEOICP Procedure Manual, Chapter 2-1000, subchapter 7.

37. The medical provider asserted that a lung lavage assisted in distinguishing between CBD and other potential lung diseases.

## D. Evaluation of evidence of CBD

Over the course of the year, claimants contacted us with concerns related to the evaluation of evidence submitted in support of a claim for CBD.

- Complaints suggesting a preference for a lung lavage are not limited to grievances involving NJH. Some authorized representatives and claimants believe that in evaluating CBD claims, the DEEOIC also gives a preference to claims where there is lung lavage. In fact some individuals believe that if the claim does not contain a lung lavage, the chances of prevailing are very slim, and this is true even where there is evidence that could potentially satisfy the alternative options for diagnosing CBD. The DEEOIC consistently denies any preference for lung lavages.
- It is argued that LPT tests are not always a reliable indicator of whether an individual has CBD. For instance, it is noted that a history of steroid use may cause a “false-negative” on the LPT test result. To address the fact that a history of steroid use may return a normal or borderline result, the DEEOIC made a programmatic decision to permit an exception to the requirement for an abnormal LPT. Therefore, in claims that contain a normal or borderline LPT, the claims examiner may nevertheless accept the claim for CBD if the lung tissue biopsy confirms the presence of granulomas consistent with CBD. See EEOICP Procedure Manual, Chapter 2-1000, subchapter 7(2). In spite of this exception, we encounter individuals who contend that too much emphasis is placed on the LPT test.
- The evaluation of evidence of CBD often depends on whether the evidence is consistent with chronic beryllium disease. While the statute does not contain specific guidelines for determining whether evidence is consistent with CBD, guidance is found in the EEOICP Procedure Manual, Chapter 2-1000, subchapter 6 and 7. Some claimants contend that the Procedure Manual does not address every finding that may be consistent with CBD. Consequently there are allegations suggesting that claims are denied because the medical findings do not exactly mirror the guidance outlined in the Procedure Manual.

In one recent case, an authorized representative contacted the Office when the case was referred to the DMC. What bothered this representative was that in referring the case to the DMC for a determination of whether the evidence supported a diagnosis of CBD under the pre-1993 guidelines, the DEEOIC did not provide the DMC with a copy of the pre-1993 guidelines for CBD. In response to this concern, the DEEOIC stated that the determination of whether a case meets the guidelines is an adjudicatory function of the District Office and that under Part B the DMC is queried as to whether certain medical components are consistent with the condition in question. The DEEOIC further indicated that DMCs often know these guidelines.

Although the claim was ultimately accepted, this authorized representative continues to question the decision not to provide the DMC with a copy of the guidelines. While the representative recognizes that the ultimate determination of whether a case meets the guidelines is an adjudicatory function, she questions whether a physician can accurately address whether findings are consistent with CBD without reference to the applicable guidelines. In addition, it troubles this representative that instead of providing the DMC with a copy of the guidelines, the DEEOIC chose to assume that the DMC knew of (or would refer to) these guidelines. The representative questions the need to assume that the DMC was aware of these guidelines when providing the DMC with a copy of the guidelines would have resolved all doubts.



## XI. IMPAIRMENT AND WAGE LOSS

**Impairment:** monetary compensation for the permanent loss of function of a body part or organ, specific to the accepted illness/condition. Impairment is determined by a qualified physician using the American Medical Association's (AMA) Guide to the Evaluation of Permanent Impairment, 5th Edition.

**Wage loss:** wage loss compensation is payable for those years worked before Social Security Administration regular retirement age during which wage loss occurred as a result of the accepted condition/illness.

### A. Filing for impairment and/or wage loss

Under Part E, if a claim filed by an eligible worker is approved, the worker is entitled to the payment of medical benefits associated with the approved condition from the date of the claim. Monetary compensation is paid on claims filed by workers under Part E if the worker is found eligible for impairment and/or wage loss compensation. In addition, DOE contractors and subcontractors employees found eligible for compensation under Part B, may also be eligible for compensation for impairment and/or wage loss under Part E.<sup>38</sup> In the past we encountered numerous Part B and Part E claimants who did not realize that they were also potentially eligible for compensation for impairment and/or wage loss under Part E. Many of these instances involved situations where the worker was aware that the program offered compensation for impairment and/or wage loss, but did not realize that he/she needed to separately file a claim for impairment and/or wage loss. Efforts by the DEEOIC and the Resource Centers to notify claimants when they are potentially eligible for compensation for impairment and/or wage loss has resulted in a noticeable decrease in these situations. Nevertheless, we come upon instances where workers are not aware that they must separately file for impairment and/or wage loss benefits.

A determination of impairment and wage loss is based on the accepted condition/illness. However, there are some claimants who assume that where a claim is accepted and an illness is determined to be a “covered illness,” any condition that is a consequence of the covered illness is automatically covered. However, that is not the case. Rather there must a determination finding a condition to be a consequential illness. As a result, we are sometimes contacted when claims for impairment or wage loss are rejected (or the claimant is asked to submit additional evidence) because the supporting medical evidence takes into consideration conditions/illnesses that have not been accepted. Especially where claimants believe that the link between the accepted condition and the consequential illness is obvious, claimants question the need to establish that an illness is a consequential illness/condition.

This year we also received a number of inquiries concerning the timing for filing additional claims for wage loss or impairment. We were contacted by claimants who wanted to know how to calculate the two years for purposes of requesting a re-evaluation for impairment.<sup>39</sup> [According to DEEOIC policy, it is two years from the date of the previous final decision addressing impairment].

### B. Fee arrangement for impairment ratings

Recently an authorized representative contacted us with two issues involving the payment to physicians for performing impairment ratings. Both issues involve instances where the authorized representative believes that the DEEOIC is exhibiting a preference for physicians with whom it has a contract. In one matter, the authorized

38. Where a claim filed by an eligible Part E survivor is approved, the eligible survivor is entitled to monetary compensation ranging between \$125,000 and \$175,000 depending upon the level of proven wage loss.

39. A claimant may request a re-evaluation for impairment (or additional impairment) every two years.

representative asked why non-contract physicians are paid in accordance with the OWCP fee schedule, while contract physicians (physicians or providers who have a formal agreement or contract with the DEEOIC) are not limited to the fee schedule. In the opinion of this representative, allowing contract physicians to receive a higher fee for an impairment rating than the fee paid to non-contract physicians results in a bias against non-contract physicians. The response from the DEEOIC indicates that because payment is derived from the contract requirements, it is possible that a contract physician could receive a higher fee than that set out in the OWCP fee schedule.

The other matter involves the timeliness of reimbursements to physicians. In particular, the representative asked if the DEEOIC had changed any policy affecting the timeliness in paying non-contract physicians. Review of this matter revealed that the issue involved the application of the Prompt Payment Act (PPA). When the PPA is applicable, bills must be processed within seven calendar days from receipt in the District Office. Contracted vendors are reimbursed in accordance with the PPA. However, in a policy directive the DEEOIC determined that non-contract employees do not fall under the PPA. The DEEOIC recognizes that in the past there were some non-contract physicians who were reimbursed for impairment evaluations under the PPA, but according to the DEEOIC steps were taken to enforce the existing policy. The representative questions why all bills for impairment ratings are not paid within seven days from receipt in the District Office. [The DEEOIC notes that whether a physician is a contract or non-contract provider, it has always been the policy of the DEEOIC to process and pay medical bills in a timely manner].



## XII. THE ADMINISTRATION OF THE PROGRAM

With respect to the administration of the program, the vast majority of the complaints that we receive involve interactions between claimants/authorized representatives and the DEEOIC. Over the course of a year, personnel associated with the DEEOIC interact with thousands of claimants and potential claimants. It is our observation that many claimants are satisfied with the service that they receive from the DEEOIC. In fact during the year some claimants contacted the Office to compliment the DEEOIC personnel who assisted them with their claims. However, we are also aware of claimants and authorized representatives who are not satisfied with the service that they received from the DEEOIC.<sup>40</sup> Here are the most common complaints that we received concerning the administration of the program:

### A. Prefer face to face contact/difficulties communicating with DEEOIC

Many claimants prefer face to face conversations when discussing their claim. For this reason, claimants who live close to the Resource Centers often take advantage of this proximity to visit these centers to discuss their claim directly with the staff. However, when a claim is forwarded to the District Office, most contact between the claimant and the District Office is via letters and the telephone.<sup>41</sup> Some claimants strongly believe that they would be better served if they were able to establish a rapport with their claims examiner.

### B. Change in claims examiners (CE)

We continue to receive complaints that contend that during the claims process, the claim was assigned to a number of different CEs. Many claimants believe that when their case is reassigned to different CEs, this further delays the processing of their claim. For instance, claimants complain that once their case is assigned to a new CE, it often takes weeks or longer, for the new CE to get up to speed, and while they wait for this new CE to get up to speed, there is no movement on their claim and it can be difficult to receive information. Claimants also bemoan the lack of continuity that results from these reassignments. A frequent complaint that we receive suggest that following the assignment of the claim to a new CE, instructions or advice provided by the previous CE were rescinded (or ignored) by the new CE. Moreover, many claimants note the disappointment that arises when they believe that they established a rapport with a particular CE only to discover that the claim was reassigned.

In response to the complaints concerning changes with CEs, the DEEOIC notes that the resignation, retirement, or promotion of a CE compels the reassignment of cases. In a few instances brought to our attention, claimants mentioned that they were informed that the CE had resigned, retired, etc. In many other instances, it is unclear why there was a change in the CE. While most claimants prefer to avoid the experience of having their cases assigned to multiple CEs, claimants also note that whenever reassignments are made, it would be nice if they were notified of these changes. In the opinion of claimants this would avoid those awkward moments when they ask to speak to a CE only to be told that the person no longer works there.

Another issue that generates a number of complaints involves situations where the Final Adjudication Branch (FAB) remands a case to the District Office. A number of claimants noted that upon reviewing the final decision, they had immediate questions. However, when they called FAB they were told that since the claim had been remanded, FAB no longer had the case, and then when they called the District Office they could not find anyone who was able to discuss the case.

40. As a rule, the Office endeavors to bring allegations of inappropriate conduct by DEEOIC or Resource Center personnel to the DEEOIC's attention. However, there were a number of instances this year where, because of fear of retribution, the complaining individual specifically asked us not to relay their concerns to the DEEOIC.

41. For most matters, the DEEOIC does not permit the use of e-mails to discuss claims.

### C. Bias against certain authorized representatives

Over the course of FY11 some authorized representatives reported incidents in which they believe Resource Center or DEEOIC personnel made inappropriate comments. One allegation suggests that a staff member of one of the Resource Centers told a claimant that he [the claimant] did not need to utilize the services of this particular authorized representative. Another allegation suggests that in the presence of claimants, a staff member of a Resource Centers and/or a District Office questioned the competence of the authorized representative. Similarly we were contacted by numerous authorized representatives who contend that when they telephone the District Offices, more often than not, the telephone is not answered. These representatives further maintain that when they leave a message, it takes an inordinate amount of time to receive a return telephone call. In one instance, in order to bolster her complaint that her telephone calls were not answered, the authorized representative provided the Office with the dates and times that she called the District Office, as well as the length of time that the telephone rang without an answer. Moreover, we hear from some authorized representatives who believe that the DEEOIC applies a higher standard when reviewing their claims.

In response to these allegations of bias, both the Resource Centers and the DEEOIC vehemently deny any bias against authorized representatives. In some specific instances, the DEEOIC provided an explanation for its actions – often explaining that their actions were prompted by the statute, regulations, policy and/or facts of that case. There were also a couple of instances, where in response to allegations of bias, the DEEOIC raised its own concerns about the conduct of certain authorized representative. The concerns by the DEEOIC which are limited to a small number of authorized representatives include allegations of abusive conduct towards DEEOIC or Resource Center staff and the failure to adhere to established procedures and policies.

### D. Processing of claims takes too long

The length of time that it takes to process an EEOICPA claim is the source of a number of complaints directed to the Office. Due to medical and other bills that continue to mount as the claim is processed, as well as the understanding that the death of the employee and/or claimant could impact the award of compensation and benefits, claimants are anxious to have their claims processed as expeditiously as possible. This desire for prompt action on a claim is highlighted by a conversation we had with a claimant who conceded that while she awaited a resolution of her EEOICPA claim, she had other insurance that covered the medicals costs associated with her claimed condition. Yet, even with this other insurance, the claimant noted that the co-pays associated with this other insurance were a financial hardship. We hear from a number of individuals who assure us that they have pressing needs for the compensation and/or medical benefits for which they are applying. In addition, there are many other claimants who tell us that they simply want to have the opportunity to enjoy the compensation to which they believe they are entitled. Consequently, perceived delays in the processing of claims often cause anxiety and frustration. Some of the delays that generated complaints this year include:

- **Dose reconstructions:** As discussed in Section VII A, forwarding a claim for a dose reconstruction on average adds an additional year to the processing of a claim. NIOSH continues to work to reduce the length of time that it takes to process dose reconstructions.
- **Delays in processing SEC petitions:** There are some SEC petitions that have been pending for years. See discussion at Section VII B.
- **New CE:** Some claimants contend that following the assignment of a new CE, the processing of claims is often delayed as the new CE gets up to speed.



- **Further development of the claim:** As discussed in Section VIII B, some claimants argue that they are not given adequate guidance concerning the evidence needed to establish their claim. Accordingly, claimants contend that delays ensue when evidence is returned because it is not sufficient and the claimant then has to undertake efforts to correct the deficiencies. Claimants argue that it would be more efficient if they were initially provided better guidance concerning the evidence needed to satisfy their burdens of proof.

Another complaint suggests that the DEEOIC's review (or development) of evidence sometimes results in inordinate delays. A number of claimants indicated that they experienced inordinate delays in the processing of their claim while the DEEOIC developed further evidence or when their case was sent to Washington. As a result of such delays, a frequent grievance that we hear notes that claimants are usually given specific deadlines within which to submit evidence. Consequently, claimants find it unfair that there are no apparent limitations placed on the DEEOIC when it comes to its review (or development) of evidence. One claimant noted that he was usually provided a 30 day deadline within which to submit his evidence, yet he waited over two months for a response from the DOL regarding whether state workers' compensation coordination was required.

In another instance, the claimant notes that he was provided 60 days within which to request a hearing, yet it took almost 90 days to schedule the hearing that ultimately will be held almost 120 days following his request.<sup>42</sup>

- **Delays caused by lack of personnel:** There are a couple of claimants who contend that were told (by individuals associated with the DEEOIC) that the processing of their claim was affected by a backlog of cases (or a backlog in scheduling hearings) in the District Office. In response to these assertions, the DEEOIC contends that there are no backlogs.

## E. Issues related to the use of DMCs

According to the DEEOIC, DMCs play a vital role in resolving medical issues by evaluating medical evidence and rendering independent medical opinions. Throughout the year, we received a number of complaints concerning the use of DMCs

- **Notice and reason for referral to the DMC:** We are approached by claimants who contend that it was only after the referral of the claim to the DMC that they became aware of this referral. These claimants question why they did not receive advance notice that the DEEOIC intended to forward their claim to the DMC. In addition, claimants also complained that they did not receive any explanation for the referral. Such complaints are often raised by claimants who believe that the evidence submitted on their behalf is sufficient to establish eligibility. In light of this belief, these employees do not understand the need for the referral to the DMC. Where no explanation is provided for the referral, some claimants assume that the referral was made in order to negate the evidence submitted by the claimant. [The DMC report often explains the reasons for the referral. Unfortunately claimants must specifically request a copy of this report. Since some claimants do not realize that they can request a copy of the DMC report, these claimants never see the DMC report and thus are never apprised of the reasons for the referral].

42. In May 2011, this claimant received a recommended decision addressing his Part E claim. In June 2011, the claimant objected to the recommended decision and requested a hearing. In July 2011, a recommended decision issued denying claims filed under Part B and E. In response to his inquiry concerning the status of his request for a hearing, the claimant was informed that he needed to object to (and request a hearing on) the July decision. While the claimant always intended to object to the July decision, he never received an adequate explanation as to why a hearing was not scheduled based on his June request. Still later in July, the DEEOIC received claimant's objections and request for a hearing based on the July decision. In October 2011 the DEEOIC notifies the claimant that his hearing is scheduled for November 2011.



- **DMCs not provided with all available documentation:** Some claimants (and authorized representatives) question whether the DEEOIC includes all available medical evidence when it refers a case to a DMC. In response, the DEEOIC asserts that all evidence in the file is provided when a case is referred to a DMC. Other complaints question the ability of the claims examiners to develop appropriate questions for the DMC, especially where the issue involves very technical medical concepts.

One complaint questioned the materials provided to the DMC involving the CBD guidelines for CBD. The question presented to the DMC was whether the evidence supported a diagnosis of CBD under the pre-1993 guidelines. It troubled this authorized representative that in forwarding questions to the DMC, the DEEOIC did not provide the DMC with a copy of the CBD guidelines. As discussed in Section X D, although this case resulted in an acceptance of the claim, the representative remains troubled by a policy that assumes that the DMC knows or will refer to the necessary guidelines. The representative believes that any doubts as to the DMCs understanding of the proper guidelines could be eliminated if the DEEOIC provided the DMC with the relevant guidelines.

- **The DMC’s credentials:** Over the years, we received numerous inquiries where claimants asked to be provided with the credentials of the DMCs. This year the DEEOIC unveiled on its website a listing of the DMCs. This listing contains the name, medical degree, medical specialty, and impairment certification (if any) of the individuals utilized as DMCs.
- **A copy of the DMC report:** While claimants are entitled to receive a copy of the DMC report, pursuant to the policy of the DEEOIC, claimants must specifically request a copy of the report. We talk to claimants who are not aware that they can request a copy of this report. In addition, some claimants are put off by the need to make a specific request for a copy of this report – they see this as another unnecessary hurdle placed in their way.

Many claimants contend that review of the DMC report is often crucial in order to understand the recommended decision and thus do not understand how anyone could expect them to fully understand the decision without a copy of the DMC report. One instance of this involves a claim for wage loss. In 2006 the claim for secondary bone cancer was accepted under Part E and in 2007 the claimant was awarded wage loss for this illness covering the years 2002 through 2004. In subsequent decisions the claimant was awarded wage loss from the secondary bone cancer for years 2005 through 2009. Nevertheless, this claimant encountered difficulties with his claim for wage loss from the secondary bone cancer for year 2010. In pertinent part, the decision that the claimant received reads,

*...Specifically, the DMC was asked whether there was evidence of a causal relationship between the secondary bone cancer and the consequential neuropathy, and if so, was there sufficient medical evidence to support a wage loss claim for the accepted conditions.*

*In response the DMC opined that “there is little evidence one way or the other concerning a post-treatment duration of peripheral neuropathy lasting as long as a decade, as is alleged to be the case... He further opines that the preponderance of the evidence available would indicate that his neuropathy is a consequence of the secondary cancer.*

*The DMC further opined that there is not “sufficient medical evidence of record to support a causal relationship between the covered illness and the wage loss claimed. He further states that the medical evidence is insufficient to support a wage loss determination “because there is no clinical data to support the broad claim made by...that...is unable to work due to problems with mobility or daily functioning.*



In the opinion of the claimant, this discussion does not explain why the evidence submitted with the 2010 request for wage loss, which is similar to the evidence submitted and accepted with his wage loss claims from 2002 to 2009, is suddenly not sufficient.

The claimant immediately objected to the decision, asked for additional time to submit additional evidence, and requested a copy of his file (which would include the DMC report). In a subsequent letter, the DEEOIC granted the claimant 30 days from receipt of the letter to submit additional evidence and then informed the claimant that the case file, including the DMC report would be sent to him. Claimant’s authorized representative contacted the Office arguing that it was unfair to only provide 30 days to submit additional evidence, especially since the DEEOIC had not honored the request for the case file. The Office brought this matter to the DEEOIC’s attention and in response the DEEOIC offered to have the CE call and ask if the claimant/authorized representative needed additional time to review the case file.<sup>43</sup>

## F. Lack of independence of claims examiners and hearing officers

Since claims examiners and hearing officers are employees of the DEEOIC, some authorized representatives and claimants contend that their claims do not receive independent review. For instance, if an objection raised by a claimant challenges a policy established by the DEEOIC, claimants and authorized representatives believe that the claims examiner or hearing officer will simply adhere to the DEEOIC policy without independent consideration as to whether the policy is reasonable or consistent with Congressional intent.

## G. Reasoned and explained decisions

This year, the DEEOIC asked the Office to provide examples of areas where there could be improvement in the drafting of recommended decisions. Our review of the decisions to which we had access revealed that in recent years there has been significant improvement in the drafting of recommended decisions. Some of the areas where we saw improvement include:

Improvement	Reason for Improvement
Early identification of claims as a Part B or Part E claim	As the claim proceeds, some claimants lose track of whether the claim is a Part B or E case. This is especially true when there are claims for multiple illnesses and/or where issues are bifurcated.
Provide a summary of the relevant findings of the DMC	Many decisions rely upon the findings of the DMC. If the claimant does not have a copy of these findings, it can be difficult to understand the decision. [Note: claimants must specifically request a copy of the DMC’s report]. A discussion of the relevant findings of the DMC is especially helpful when the claimant does not have a copy of the DMC’s report.
Identify relevant evidence that has been submitted	Where the decision does not mention evidence submitted by the claimant, some claimants question if the fact finder is aware that this evidence was submitted.

There were two areas where we encouraged continued efforts to build on the improvements that we had seen:

Recognize when evidence submitted by claimants address a specific issue	Where evidence submitted by the claimant is relevant, the decision should not just acknowledge, but also discuss this evidence. Otherwise claimants question whether their evidence was considered in reaching the determinations.
Provide a rationale for the ultimate conclusion and in so doing, explain why relevant evidence submitted by the claimant is insufficient.	Claimants look to decisions for guidance – i.e., why was the evidence that they submitted deemed insufficient? Claimants argue that such an understanding ensures that when they develop additional evidence they do not obtain evidence that contains the same deficiencies.

43. The case file fills three accordion folders and will be provided to the claimant more than three weeks after the date of the letter that granted claimant 30 days from the date of the letter to submit additional evidence.

We appreciate that the DEEOIC offered us the opportunity to provide input and we hope that this dialog continues. Furthermore, we hope that a similar effort is initiated to address final decisions.

We also received a couple of complaints suggesting that correspondence and/or literature prepared by the DEEOIC was not very clear:

- A physician's office contacted the Office because they did not know how to proceed when presented with the claimant's medical benefits card and literature discussing the program. Since this physician's office was not familiar with the EEOICPA, they were especially concerned with the references in the literature to Part B. These references initially caused this physician to fear that accepting the EEOICPA medical benefits card might affect his/her status as a Medicare Part B provider. The physician's office was encouraged to contact the Resource Center for more information.
- Where the DEEOIC is unable to verify employment at the Savannah River Site, the DEEOIC forwards a request for employment verification to the DOE. At the same time that this request for verification is forwarded to the DOE, the DEEOIC also forwards a letter to the claimant. In pertinent part, the letter reads,

*You claimed employment at the Savannah River Site (SRS) in Aiken, SC from...to an undetermined end date. At present, we have been unable to confirm this employment. To assist us in verifying employment please have co-workers and union officials complete the enclosed Employment History Affidavit (EE-4). You may make additional copies if needed. If you are current employed at the SRS, a letter from your personnel department would be of help. We have also forwarded your completed Social Security Request (form SSA-581) to the Social Security Administration to affirm past employment.*

According to a DOE staff member, because this letter states that employment has not been verified, but does not indicate that the DOE is reviewing its records to verify employment, the DOE is often approached by claimants who believe that the DOE has been unable to verify their employment. This staff member felt that adding a sentence to the letter advising claimants that the DOE was still in the process of reviewing its record to verify employment would ease the concerns of claimants.

## H. Inconsistent Decisions/Policies

This year we received a number of allegations suggesting that the DEEOIC issued inconsistent decisions. Many of these allegations come from authorized representatives who are able to base these allegations on their experiences working with multiple claims. Here are just a few of the complaints that we received this year alleging inconsistent decisions:

- A representative contacted us when informed that the claimant needed to submit a LPT test to establish CBD under Part E. When the Office inquired into this matter, we were initially told by the DEEOIC "yes" a claimant needed to submit a LPT test in order to establish CBD under Part E. Subsequently, we received clarification indicating that a claimant did not need to submit a LPT to establish CBD under Part E. Thereafter we were told that the issue was again under review and most recently we were told "yes" a LPT test is required to establish CBD under Part E.<sup>44</sup>
- An authorized representative asserts that in attempting to establish a consequential psychological condition, she was informed that the claimant had to submit a report by a psychiatrist. The representative noted

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44. Claimants now question whether the requirement for a LPT under Part E is consistent with the law. See discussion at section



that the DEEOIC personnel insisted upon a report by a psychiatrist even though the PM includes “clinical psychologist” in its definition of a physician. When this matter was raised with the DEEOIC, the Office was assured that a report by a clinical psychologist was acceptable.

- In defining “chronic silicosis,” the statute refers to “a written diagnosis of silicosis.” See 42 U.S.C. §7384r(e) (2). In spite of the statute’s reference to a “written diagnosis of silicosis” one representative reported that she was required to submit a written diagnosis of chronic silicosis. Upon further discussion it appears that a written diagnosis of silicosis is sufficient.
- There are allegations that the procedures applied by the various District Offices are not always consistent. A number of authorized representatives suggest that one District Office permits them to submit certain documents, while another District Office requires the claimant to submit the same document.
- In addressing coverage of employees who worked at Linde Ceramics, the Director of DEEOIC in a letter date January 14, 2011 stated, “...DEEOIC clearly recognizes the difficulty in determining exact locations where employees may have worked years or decades ago. Thus, if claims staff at the Cleveland district office, which is responsible for claims arising out of employment at the Linde Ceramics Plant, are able to verify employment at that location, they will presume that the employee worked in all five buildings unless the evidence specifically indicates otherwise...”

In one case brought to our attention, the employee initially submitted an affidavit indicating that he only worked in Building 14 of the Linde facility. Later, the employee submitted a second affidavit explaining that Building 14 was his primary work site, but not his only work site during the covered time period. In response to the second affidavit, the claimant received a decision indicating that:

*The bulk of the evidence suggests that during the covered time period, you performed duties primarily within Building 14 as a ... While it is understood that Building 14 was not the only building you worked in during your overall tenure at Linde, the evidence strongly suggests this was your primary duty station during the covered period. Work in this building does not qualify under Part E. [Emphasis added].*

The authorized representative questions why the determination that Building 14 was the primary duty station is not sufficient to invoke the presumption that, during the covered period, the claimant worked in other buildings at Linde Ceramics, thus qualifying the employee for Part E. [According to the DEEOIC, since the initial statement by the claimant indicated that he only worked in Building 14, the employee must provide additional and independent corroboration to establish that he also worked in buildings other than Building 14].

- Some of the complaints alleging inconsistent application of the law are in reality instances where there was a change in the application of a law or policy. When this occurs, some claimants question the lack of sufficient notice. One example discussed in more detail at Section XIV involves authorizations for home health care. Numerous claimants complained that for years they utilized certain procedures to obtain authorization from the DEEOIC for home health care and then, all of a sudden, the policy changed. The DEEOIC responds noting that there was no change in policy, rather a “more robust and rigorous application of existing policies.” The DEEOIC further indicates that notices were provided to claimants and providers outlining the information required to approve a request for home health services. In spite of the DEEOIC’s assertions, many claimants note that since they had utilized the same procedures for years with no suggestion of any problems, they assumed that these letters did not

apply to them. Claimants further argue that the distinction between a “change” and a “more robust and rigorous application of existing policies” is mere semantics. Claimants argue that to the extent that the procedures accepted in the past were no longer sufficient, they should have been provided with clear and explicit notice.

Many of the claimants and authorized representatives who contact the Office firmly believe that instances of inconsistent application of the law or policy are not limited to a few isolated incidents. However, because most EEOICPA decisions are not available for public review, these claimants and representatives argue that it is impossible to accurately gauge the extent of this problem. Moreover, claimants and authorized representatives question the extent to which the DEEOIC reviews prior decisions to determine the extent to which previous claims were negatively impacted by these inconsistencies.

## I. Errors in decisions/claims

Considering the volume of claims handled by the DEEOIC on a yearly basis, there are bound to be errors. Nevertheless, every year claimants bring to our attention errors uncovered in decisions (as well as errors orally communicated to them). Many of these errors involve typographical errors or erroneous references such as referring to the claimant by an erroneous name. While many errors appear to have no discernible impact on the outcome of the claim, some claimants view any error as indicative of a general lack of attention afforded to the processing of claims.

Other errors brought to our attention clearly impact the outcome of claims. As you find with the allegations of inconsistent decisions, some individuals question the number of errors that go unnoticed.

- Over the telephone the claimant is informed that his requests for medical coverage will be denied. When the Office inquires into the matter, we are told that this determination was based upon the date of the acceptance of the Part E claim. In fact, the determination should have been based on the acceptance of the Part B claim.
- The DEEOIC letter to the lay representative states that the current claim is a duplicate claim and thus will not be developed. The representative pursues this matter and upon further review it is determined that the current claim requires further development.
- Since the employee (correctly) believes that he qualifies for a SEC, he questions why his claim was forwarded to NIOSH for a dose reconstruction. The DEEOIC explains that there was initial confusion over whether the employee worked for Linde Air Products, which does not have an SEC or Linde Ceramics, which has an SEC. (The claimant worked for Linde Ceramics which has an SEC). Claimant is able to correct the confusion.
- Claim identifies cancer, and specifies brain and lung as the diagnosed conditions. The death certificate states that,

*“hemorrhage cancer brain” with 1 day interval from onset to death due to or as a consequence of mesothelium brain with an interval of 3 years since onset.”*

Unfortunately the hand written death certificate is mistakenly interpreted as referring to “mesothelioma” instead of “mesothelium.” Once, the DEEOIC was apprised of this confusion, the case was remanded for further consideration.



Some claimants and authorized representatives argue that an opportunity to review the Statement of Accepted Facts (SOAFs) at an early stage in the proceeding would help reduce the impact of errors.

We also encounter instances where claims are overlooked. This usually occurs when claims are bifurcated and in the ensuing process, one of the bifurcated claims is lost. Here is one example:

- o May 20, 2008 - claim filed for renal failure and leukemia
- o February 2, 2009 – RO denies claim for renal failure
- o April 23, 2009 – hearing is held addressing the denial of the claim for renal failure.
- o May 13, 2009 – RO denies Part B and E claims for myelodysplastic syndrome.
- o December 15, 2009 – Final decision denies claims for myelodysplastic syndrome.
- o As of June 8, 2011 claimant still awaiting a final decision on claim for renal failure

## **J. Rude Behavior/Insensitivity/Poor Service**

In previous years, we received complaints from claimants and authorized representatives alleging that DEEOIC personnel engaged in rude behavior or uttered insensitive comments. This year, certain claimants and authorized representatives attempted to bolster their allegations by providing examples of offending conduct. In addition, there are complaints suggesting that a basic lack of respect for claimants (and for authorized representatives) can be found at all levels of the DEEOIC. In the opinion of many claimants and authorized representatives, there was one incident that arose this year that highlights their belief that there is a lack of respect for claimants that permeates the DEEOIC.

The incident involved the manual utilized by the DEEOIC to train new staff. An authorized representative asked for a copy of this manual and was shocked by some of the examples used in the manual. One example referred to a claimant nicknamed “Freddie Krueger” who reportedly suffered from depression, dementia and skin cancer and who passed away on October 31st. The manual also referred to a claimant nicknamed “Jack Bauer” and a pathologist nicknamed “Hannibal Lechter.” In response to an inquiry concerning these references, the Acting Director of OWCP agreed that the use of “names of fictional characters with negative attributes was inappropriate” and stated that those names had been removed from the training materials. While authorized representatives and claimants are happy that these references were removed, they question why it took a complaint to spur the DEEOIC to realize the inappropriateness of these references. In the opinion of some claimants and authorized representatives, the fact that the DEEOIC approved and utilized a manual containing such inappropriate references is itself an indication of a lack of sensitivity.

Nevertheless, most of the complaints that we receive alleging rude behavior concern interactions with the staff of the district offices, and on occasion the staff of the resource centers. For example, one claimant was annoyed that his CE thought that everything was funny. We were also contacted by an authorized representative who reported that in spite of receiving faxes from the DEEOIC on numerous previous occasions, in the midst of a tense conversation with a DEEOIC staff member, she was told that the DEEOIC did not send faxes. [In response to an inquiry, the DEEOIC clarified that it was possible to forward documents via fax]. In another instance, based on assurances from his physician that small lymphocytic lymphoma was the same as CLL (the covered condition), the claimant submitted a request for reimbursement for a bill associated with treatment of his small lymphocytic lymphoma. The claimant became very upset when the DEEOIC staff member suggested that the claimant may have committed fraud in submitting the bill for this treatment.



We also received a couple of complaints alleging that a District Office lost materials, thus causing further delay when everyone had to wait while these documents were re-created. Moreover, an authorized representative found it troubling when the Resource Center informed her that they would not provide her with (print out) a copy of SEM.

There were also a number of claimants and authorized representatives who specifically requested that their complaints not be forwarded to the DEEOIC and that we not address their complaints in this report. These individuals feared that there could be reprisals if it became known that they had registered a complaint.

While, claimants and authorized representatives are troubled whenever they encounter behavior that they deem insensitive or rude, there are also other concerns that arise as a result of these encounters:

- **No formal procedure for reporting behavior:** Claimants complain that they cannot find established procedures for reporting incidents of rude behavior or less than satisfactory service. Consequently, we hear of instances where in order to report a failure to answer the telephone the claimant had to leave a message using the telephone number that no one ever answered. Similarly, we are told of instances where in order to report rude behavior the claimant had to try to convince the rude person to transfer the call to another person.
- **No action taken on complaints:** Some claimants find ways to register their complaints. Some write letters, some call other officials associated with the DEEOIC, and some contact the Office. In addition, there are claimants who receive a satisfactory response to his/her complaints. For instance, we are aware of one instance where in response to a complaint of numerous unanswered telephone calls and letters, the District Director contacted the claimant, apologized for the delay in responding, listened to the claimant's complaints, and promised to further respond once the matter was reviewed.

Other claimants and authorized representatives report little, if any, response (or feedback) to their complaints of rude behavior. In addition, there were a number of instances where claimants concede that following the filing of a complaint, they finally received a return telephone call or a response to their letter, yet many of these claimants were nevertheless disappointed because they never received an explanation (or apology) for the delay.

In some instances claimants find the response to their complaints lacking. In one such instance, the issue involved letters found in the claimant's file. The claimant acknowledges that she drafted a letter complimenting the service that she received from a particular CE. However, when the claimant reviewed the file, she discovered three other letters purportedly signed by her complimenting other members of the DEEOIC staff. The claimant was adamant that she did not send these other three letters. The claimant was disappointed with the DEEOIC's response in which it acknowledged that the letters appeared to be from an unreliable (and unknown) source and thus simply removed the letters from the file.

Another experience that really upsets claimants occurs when the CE (or other DEEOIC personnel) promises to call the claimant or to provide the claimant with documents on a certain date, and (with no notice), this promise is not kept.



## XIII. MEDICAL BENEFITS

### A. Fee schedule

There is a fee schedule that outlines the payment for medical services. According to the regulations promulgated by the DEEOIC, a “provider whose fee for services is partially paid by OWCP as a result of the application of the fee schedule...shall not request payment from the employee for the unpaid amount of the provider’s bill.” 20 C.F.R. §30.713. We receive inquiries from claimants asking us to confirm the existence of this provision prohibiting providers from requesting payment from the employee for the unpaid amount of the provider’s bill.

Moreover, we are told of physicians who refuse to enroll as DEEOICPA providers because they do not want their fees limited by this fee schedule. For this reason, some claimants view the fee schedule as a mechanism to discourage claimants from using their own physicians.<sup>45</sup>

### B. Prompt Pay Act (PPA)

An authorized representative inquired whether there was a new policy affecting the prompt pay of physicians retained by claimants to perform impairment ratings. In its response, the DEEOIC indicated that there was no new policy. According to the DEEOIC under the PPA bills submitted by contracted vendors must be processed within seven calendar days from the date of receipt in the District Office. However, a policy directive determined that bills for non-contract providers do not fall under the PPA.<sup>46</sup> Acknowledging that in the past there were some non-contract physicians reimbursed for impairment evaluations under the PPA, the DEEOIC noted that necessary steps were taken to enforce the existing policy. [The DEEOIC further asserts that whether a physician was a contract or non-contract provider, it has always been its policy to process and pay medical bills in a timely manner]. The authorized representative questions why all physicians who perform impairment ratings are not paid in accordance with the PPA. This representative believes that this policy directive is another instance of a bias against claimants (and those assisting claimants).

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45. A contract physician is not necessarily limited to the fee schedule

46. The DEEOIC defines non-contract physicians and providers as physicians or medical providers who do not current have a formal agreement or contract to accept a set fee for services provided to DEEOIC claimants. Reimbursement to non-contract physicians and medical providers for impairment evaluations and diagnostic services related to impairment evaluations are paid in accordance with the OWCP fee schedule.

## XIV. HOME HEALTH CARE

Normally issues relating to home health care are addressed as a subsection of the complaints concerning medical benefits card/medical benefits. However, due to the volume and variety of complaints that we received over the past year involving the receipt of home health care, the subject is addressed as a separate issue in this report. At the core of these complaints is a determination by the DEEOIC to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner. Ultimately, this determination was the source of a number of complaints received by the Office.

### A. Background

Following an internal review of home health claims, the DEEOIC began to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner.<sup>47</sup> The DEEOIC provided letters to claimants and providers informing them of the documentation needed to approve requests for home health care services. In particular this letter emphasized that claimants would need to obtain substantive medical documentation from the treating physician explaining both the medical necessity for in-home health care and the linkage to the accepted medical condition(s). The letter also stressed that it was not merely a matter of obtaining a prescription or Plan of Care from any physician, but rather ensuring that the treating physician (if there is one) had actually conducted a face to face examination with the employee within 60 days of a home health care authorization request. According to the letter, evidence of such an examination was to be documented in a medical narrative demonstrating that the physician had knowledge of the patient's physical status, functional capacity, and the need for home health care due to an accepted condition(s).

### B. Change in policy?

In response to the decision to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner, the DEEOIC forwarded letters to claimants and health care providers.<sup>48</sup> As soon as they received these letters, claimants and providers began to contact the Office with questions. Some of the inquiries asked for the reasoning behind this change in policy. In response, the DEEOIC indicated that there was no change in policy and noted that the procedures for authorizing home health care were outlined in Chapter 3-300 of the EEOICP Procedure Manual.

While it is true that the procedures for authorizing home health care did not change, claimants viewed the decision to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner as a drastic change from the procedures accepted by the DEEOIC in the past. Numerous claimants assured us that in the past requests for approval for medical services had been accepted based on medical documentation signed by individuals other than treating physicians. Consequently, while the DEEOIC did not view this application as a change, many claimants felt that this was just semantics and that the DEEOIC did in fact change its approach.

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47. In November 2011, an individual pled guilty to health-care fraud and money laundering associated with the bilking of \$3.4 million. The fraud and money laundering was related to services for EEOICPA claimants.

48. It is not clear if letters were mailed to every claimant receiving medical benefits or only to those identified as impacted by this issue. Because we only heard from claimants directly impacted by this issue and because all of the claimants who contacted our Office lived in the southwestern part of the country, it appears that these letters were sent to a select group of claimants.



## C. Notice to claimants and providers

To advise claimants and providers of the determination to apply the home health care procedures in a significantly more robust and rigorous manner, the DEEOIC sent letters to claimants and providers informing them of the information required by the DEEOIC in order to approve requests for home health care services.

- **The letters were not clear:** Prior to receipt of these letters, many claimants had successfully requested authorization for home health care utilizing certain procedures, with no one ever suggesting that these procedures were not proper. Since the letters from the DEEOIC were not personalized and did not identify specific problems with the procedures utilized by the claimant, some claimants assumed that the letter did not apply to them. For instance, the letter refers to a physical examination by a physician. There were claimants who in the past had successfully submitted requests for authorization signed by a physician's assistant. Since no one ever suggested that the use of a physician's assistant was improper, these claimants did not read the letter as indicating that there was a problem with utilizing a physician's assistant. We also talked to claimants who confided that they simply did not understand the letter.
- **Some claimants were not aware of these letters:** As a consequence of their covered illnesses, and/or other conditions, some claimants relied on others to assist with the handling of their affairs. In some cases, this assistance included opening and processing mail. We were contacted by claimants who contend that the first they knew that there was an issue with the authorization of their request for home health services was when their current provider told them that it was the last day of service. In a number of these instances, the claimant called with only days before their current authorization was scheduled to expire to ask if there was any way to get an extension of time to submit the necessary documentation. [In the experience of the Office, there were numerous instances where requests for extensions of time were granted. These usually involved circumstances where the physician submitted documentation and the DEEOIC was awaiting clarification from the physician. On the other hand, we are aware of instances where claimants encountered difficulties receiving an extension. In many of these instances, the request for an extension of time was made just days before the current authorization was scheduled to expire and (for any number of reasons) the claimant had not taken any affirmative action to pursue a reauthorization].

There were also a couple of cases where it appears that all notices addressing the reauthorization for home health care were forwarded to the claimant's authorized representative (attorney). It is our understanding that normally when an authorized representative is designated, correspondence is forwarded to both the representative and the claimant. However, we talked to a few claimants who maintain that all correspondence addressing the issues related to home health care were only mailed to the attorney, and for reasons that are not clear, these attorneys did not forward the correspondence to the claimant.<sup>49</sup> These claimants assert that they only became aware of the problem with the authorization for their home health care when advised by the provider.<sup>50</sup> Similarly, there were instances where because the claimant never revised (or cancelled) the authorization designating an authorized representative, the DEEOIC could not share any information with the family members who called on behalf of claimants trying to gain more information about these matters.

49. In one instance, the DEEOIC indicates that several letters addressing home health care were mailed in the care of the attorney. It is not clear if the DEEOIC policy allows the authorized representative to direct that mailing not be forwarded to the claimant and if so, whether this is what occurred on this occasion.

50. In instances such as this it is not entirely clear how the claimant successfully applied and received home health care, especially since correspondence was not directly mailed to the claimant.



## D. Burdensome procedures

A number of providers and claimants argue that requiring physicians to provide substantive medical documentation for in-home health care as well as requiring face to face examinations within 60 days of the authorization request merely adds to the already heavy work loads of physicians. Claimants and providers fear that over-burdening these physicians could cause some physicians to refuse to treat EEOICPA claimants. All of the claimants who contacted us with concerns relating to the reauthorization of their home health care live in the southwestern part of the country, and often in areas where medical services are not abundant and oftentimes are not located in close proximity. These claimants and providers do not want to discourage the physicians who are willing to treat EEOICPA claimants.

Moreover, to authorize a request for in-home health care, the DEEOIC requires the treating physician to provide substantive medical documentation explaining both the medical necessity for the care and the linkage to the accepted medical condition(s). In addition, the physician needs to provide evidence of a face to face meeting that demonstrates the physician's knowledge of the patient's physical status, functional capacity, and the need for home health care due to an accepted condition. A number of the complaints that we received suggested that the DEEOIC did not provide sufficient guidance outlining what constituted acceptable documentation to support a request for care. Some claimants and providers contend that their fear of over-burdening physicians materialized when the initial documentation supplied by these physicians was deemed insufficient and the claimant had to return to the physicians for additional documentation.<sup>51</sup> Some of these individuals argue that the need to return to the physician for supplemental information could have been avoided if the DEEOIC initially provided better guidance (or examples).

## E. Inquiries not answered

Many of the complaints concerning claims for authorization for home health care involved situations where the current authorization was scheduled to expire in a few days. Included with many of the complaints were allegations that claimants found it difficult to talk to anyone at the District Office concerning their claim and/or that their telephone calls were not returned. In many instances with only days before their current authorization was scheduled to expire, some of these individuals were extremely anxious to talk to someone.<sup>52</sup> One claimant reported that she was told not to call the District Office to inquire on the status of her authorization request because this would "hold up" the CE from working on claims.

## F. Necessary documentation not received by the DEEOIC

A number of the inquiries regarding home health care involved claimants who were anxious because their current authorization for home health care was scheduled to expire and they had not heard from the DEEOIC concerning this request. In some instances when we inquired into the matter, we discovered that the DEEOIC was awaiting documentation from the claimant's physician. Concerned that their current authorization would expire prior to the receipt of the documentation from the physician, claimants questioned why the DEEOIC never advised them that the physician had not submitted the requested documentation. In response, the DEEOIC noted that it was the claimant's responsibility to ensure that the necessary medical information to support the request for home health care was forwarded to the DEEOIC.

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51. We are aware of claims where the treating physician either failed to submit the requested medical documentation or submitted documentation but failed to submit the additional documentation that was later requested.

52. Initially we were told that the DEEOIC had no intention of just terminating medical services. As time transpired, we came to understand that this meant that the DEEOIC did not intend to terminate medical services without providing written notice. We are aware of instances where home health care was terminated at the end of the existing period of authorization.



## G. Concerns of physicians

The problems stemming from the more robust and rigorous application of the procedures for accepting home health care also generated concerns from physicians.

- A couple of physicians felt that they were caught in the middle of a dispute between the DEEOIC and the home health providers. These physicians note that as a result of the DEEOIC's more robust and rigorous application of the procedures, they were approached by claimants (or providers) who asked them to sign pre-prepared authorization forms. When they refused to sign these pre-prepared forms (because they disagreed with the care outlined on the form), they were accused of working with the DEEOIC to deny reauthorizations for home health care.
- Similarly, some physicians contend that they were put on the defensive when, based on their examination, the employee was deemed entitled to less home health care than that approved in the past by the DEEOIC.

## H. Misc.

- One claimant reported that a physician refused to submit documentation relating to authorizations for home health care until the criminal investigation into fraud was resolved. It does not appear that this physician was involved in any criminal investigation. Rather, having heard of the criminal investigation involving EEOICPA, but not knowing the specifics, the physician decided to wait until a resolution of this investigation before submitting any additional documentation relating to requests for home health care.
- The Office was contacted by a former employee presumably of the individual who pled guilty to health care fraud and money laundering. This employee who indicated that she was calling on behalf of herself and other employees had two concerns: (1) her place of employment had closed abruptly and the employees did not know who to turn to for assistance in receiving payments due to them and (2) these employees did not know what to tell former patients who called asking for assistance with continuing home health care.



## XV. ATTORNEY FEES

The statute specifically outlines a schedule for attorney fees under Part B. Specifically the statute provides that a representative may not receive more than the following percentages for services provided under Part B:

- (1) 2 percent for the filing of an initial claim for payment of lump-sum compensation; and
- (2) 10 percent with respect to objections to a recommended decision denying payment of lump-sum compensation.

42 U.S.C. § 7385g. Under Part E the statute simply incorporates the provisions applicable to Part B. See 42 U.S.C. § 7385s-9. During the year, a number of representatives raised concerns with aspects of the attorney fee provisions. In general, these complaints contend that: (1) the Part B attorney fee provision is ill suited for Part E claims and (2) in general there are gaps or omissions in the attorney fee provisions.

### A. The Part B attorney fee provision is ill suited for Part E.

If an employee is found eligible under Part B, the employee receives \$150,000 lump sum compensation and is entitled to appropriate medical benefits.<sup>53</sup> However, an employee found eligible under Part E is only entitled to medical benefits. In order to be eligible for monetary compensation under Part E, the employee must separately file and be determined eligible for impairment and/or wage loss compensation.<sup>54</sup> We receive complaints noting that the attorney fee provision does not address those instances where the Part E employee is found eligible (for medical benefits), but is not entitled to wage loss or impairment compensation.<sup>55</sup> Numerous authorized representatives have assured us that there are cases where they expend considerable time and effort establishing a claimant's eligibility for Part E, yet the claimant is not eligible for impairment or wage loss compensation. Individuals also question whether this statutory provision discourages authorized representatives from assisting Part E claimants if the representative cannot reasonably expect to ultimately succeed in the claim for impairment and/or wage loss.

### B. Gaps/omissions in the attorney fee provision

As discussed above, the attorney fee provision outlined for Part B, and which is incorporated in Part E, provides for a fee of up to 2 percent for the filing of an initial claim and 10 percent with respect to objections to a recommended decision denying benefits. Authorized representatives contend that this provision fails to address other circumstances where services rendered by an authorized representative results in a positive outcome. In particular:

- As discussed above, the statute does not address the situation where the claimant is found eligible for Part E, but is not entitled to impairment or wage loss compensation.
- Another circumstance not addressed by the statute arises when the initial recommended decision results in an acceptance of the claim. According to the statute an authorized representative is entitled to a fee of up to 10 percent with respect to objections to a recommended decision denying payment. See 42 U.S.C. § 7385g (b)(2). [Note: the applicable regulation reads 10 percent of the difference between the lump-sum payment made to the claimant and the amount proposed in the recommended decision with respect to **objections** to a recommended decision. See 20 C.F.R. § 30.603(b)]. Authorized representatives contend that as written

53. The exception is where the covered illness is beryllium sensitivity. A claimant found eligible under Part B for beryllium sensitivity is only entitled to medical monitoring.

54. This applies to claims filed by employees under Part E. Under Part E a survivor found eligible is entitled to compensation ranging from \$125,000 to \$175,000 depending upon wage loss.

55. In such circumstances, depending upon the facts of the case, the authorized representative may be entitled to 2 percent for the filing of an initial claim.



the statute does not provide for a fee in those instances where their time and effort results in a favorable recommended decision. As a result of this gap there are suggestions that a few authorized representatives intentionally withhold evidence to ensure an unfavorable recommended decision. These representatives then submit this evidence following the recommended denial with the knowledge that an acceptance of the claim following the initial denial will result in entitlement to a fee of up to 10 percent of the difference between the lump-sum payment made to the claimant and the amount proposed in the recommended decision.<sup>56</sup>

- The statute refers to a fee of up to 2 percent for the filing of an initial claim. With respect to Part E, it is suggested that some authorized representatives demand a 2 percent fee for filing the Part E claim even before the compensation amount is determined (and sometimes even before there is a determination of eligibility). There are suggestions that claimants have been asked to pay as much as 2 percent of \$250,000 (the maximum compensation allowable under Part E) even though the actual compensation paid in the claim turns out to be considerably less than \$250,000.

Similarly it is suggested that a few authorized representatives collect the 2% fee as soon as the Part B claim is filed.

### **C. Use of authorized representatives when a new SEC is announced**

As discussed in Section VII B, when a new SEC is announced, the DEEOIC automatically reviews all previously denied claims to determine if these claims are impacted by the new SEC. In spite of the DEEOIC's review, we encounter claimants with previously denied claims who retain the services of an authorized representative to pursue a claim following the announcement of a new SEC. We fully recognize that the decision whether to retain an authorized representative clearly rests with the claimant. We simply question whether in retaining the services of an attorney, these claimants are aware that the DEEOIC automatically reviews all previously denied claims to determine if they are impacted by the new SEC.<sup>57</sup> Some individuals maintain that the DEEOIC needs to do more to inform claimants of its automatic review whenever a new SEC is announced. Other individuals go further and suggest that when a new SEC is announced, the DEEOIC ought to individually inform claimants that their claims will be reviewed and then ought to inform claimants of the results of that review.

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56. While we have received "suggestions," to date no one has presented us with any proof of these acts. Additionally, no one has presented us with specific instances.

57. When a new SEC is announced, claimants are only notified of the DEEOIC's review if the case is impacted by the new SEC and a new recommended decision issues. If the claim is not impacted by the new SEC, there is no notice to the claimant. However, the DEEOIC will respond to inquiries concerning the status of its review.



## XVI. MISCELLANEOUS CONCERNS

- One claimant inquired if it was possible to receive lost interest where there was an initial error in determining his impairment rating. In 2007, the claimant's impairment was determined to be 57%. Four years later, it was determined that the 2007 impairment rating should have been 58%. The claimant argues that he ought to be entitled to the lost interest.
- We continue to encounter claimants who are upset that the statute sets maximums for the amount of money that a claimant can receive under Part B (\$150,000) and Part E (\$250,000). In one instance where the employee had already received \$150,000 under Part B, the claimant could not understand why he could not receive any additional monetary compensation under Part B, especially since the additional cancers were “worse” than the cancer for which he received compensation.<sup>58</sup>

## XVII. SUMMARY AND RECOMMENDATIONS

### Summary

In the past calendar year there was over \$1 billion paid in EEOICPA compensation and benefits. Thus, contrary to some of the comments that we hear, there are claimants who receive compensation and/or benefits under the EEOICPA. Yet, in spite of the success enjoyed by some claimants, we encounter claimants, potential claimants, authorized representatives and others who have complaints, grievances, and requests for assistance generated by their experiences with the EEOICPA program. In this vein, we feel that it is important to note that not all of the complaints that we receive come from individuals who are unhappy because their claim was denied. We routinely receive complaints, grievances, and requests for assistance from individuals with pending claims, as well as individuals found entitled to benefits, but who encounter subsequent problems with their claim and/or benefits. As this report clearly illustrates, the complaints, grievances, and requests for assistance that we received this year address every aspect of the claims process, and come from a wide array of individuals including, claimants, potential claimants, authorized representatives, health care providers, congressional staff members, reporters, and others.

Some of the complaints that we receive question certain provisions of the statute. The fact that under the EEOICPA the burden of proof is placed on claimants continues to be the subject of many inquiries. In addition, claimants contacted us this year with complaints involving the statutory definition of covered employee/covered employment and/or covered facility, as well as with questions pertaining to the different statutory requirements for Part B and Part E claims. Where a complaint involves the language of the statute as written, neither this Office nor the DEEOIC (or the DOL) have the authority to amend or revise the statute. Therefore, consistent with our statutory mandate, we endeavor to ensure that the most common of these complaints, grievances, and requests for assistance are discussed in this Annual Report to Congress.

Other complaints, grievances, and requests for assistance address the various regulations, procedures and policies that implement this program. Many of these complaints question whether specific regulatory, procedural, or policy initiatives are consistent with the statute and/or Congress' intent in enacting the EEOICPA. We commonly hear from claimants who believe that when it comes to evaluating evidence needed to satisfy the burdens of proof that have been placed on claimants, the bar is set too high. These concerns often persist notwithstanding the DEEOIC's insistence that its policies and evidentiary requirement are consistent with the statute and congressional intent.

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<sup>58</sup> Even where a claimant reaches the statutory maximum, the claimant can file a claim and if eligible would be entitled to medical benefits for the additional covered illnesses.



Although some of the complaints questioning the DEEOIC's application/interpretation of certain regulations, procedures and/or policies can be appealed to federal court, few claimants/authorized representatives pursue this option. Even where they firmly disagree with the application/interpretation of a regulation, procedure or policy, many claimants tell us that the time, expense, and expertise needed to pursue an appeal, as well as the lack of representation, often serve as disincentives to pursuing an appeal. Consequently, there are a number individuals who maintain that there is a need for independent review of the regulations, policies, and procedures that are at the heart of these complaints.

Additionally, there are other complaints, grievances, and requests for assistance that address the administration of the program. While there are tools/resources available to assist with the processing of claims, we receive complaints contending that some tools/resources are not adequate. Other complaints suggest that additional tools/resources, such as guides (or examples) of evidence that would satisfy the various burdens of proof, need to be developed. In addition, interactions with employees of the Resource Centers and the DEEOIC continue to be the subject of numerous complaints and grievances. Over the course of the year, claimants and authorized representatives alleged that telephone calls or letters went unanswered, while others complained of rude/inappropriate comments. Some claimants and authorized representatives noted that it was difficult, if not impossible, to forward complaints addressing rude behavior to management of the DEEOIC while claimants and authorized representatives who were able to forward complaints to management sometimes noted that they never received a response to their complaints (or received what they deemed an inadequate response). Moreover, there are authorized representatives who believe that the DEEOIC harbors a particular bias against them. The DEEOIC (and the Resource Centers) denies any biases, and asserts that it has procedures in place to ensure that telephone calls and letters are answered. Nevertheless, we continue to receive these complaints.

The encouraging news is that the DEEOIC, as well as the other agencies involved with the administration of the EEOICPA continue to implement new initiatives and programs to assist claimants with their EEOICPA claims. Accordingly, we are hopeful that in the year to come new policies and initiatives are developed that address many of the complaints, grievances, and requests for assistance discussed in this report.

In March 2010, the Government Accountability Office issued a report entitled, ***ENERGY EMPLOYEES COMPENSATION - Additional Independent Oversight and Transparency Would Improve Program's Credibility.*** We also believe that additional transparency would improve the credibility of this program. There is no one or two changes that will satisfy all of the complaints that we receive. Nevertheless, we believe that efforts are needed to improve the credibility of this program. Two areas that ought to be a focus are: (1) improving the information made available to claimants (as well as ensuring that this information is provide in a timely fashion and is provided in a manner that is easily understood by claimants); and (2) providing more transparency in the processing of claims. Following are just a few recommendations that we believe address the need to improve information and to provide more transparency:

1. We continue to encounter individuals who only learn of this program from neighbors or from the media. While, the DEEOIC and the other agencies involved with the EEOICPA employ a variety to initiatives to disseminate information concerning this program, it is evident that more needs to be done.
2. When covered facilities close some former workers (and/or their families) relocate to other parts of the state or country. Similarly some former workers relocate following retirement. Efforts at outreach need to extend beyond the areas simply in the vicinity of these covered facilities. Outreach efforts should extend to those areas where former workers (and/or their families) may have relocated.



3. We commend the DEEOIC's efforts to ensure the quality of recommended decisions. Nevertheless, more ought to be done to ensure that recommended decisions clearly articulate a rationale for the ultimate conclusions and ensure that this rationale is explained. We also hope that a similar effort is undertaken with final decisions.
4. Review of the DMC report is often crucial in order to understand the decision that issues (and/or to understand the evaluation of the evidence). While claimants have the right to request a copy of the DMC report, we encounter some claimants who are not aware of this right, and others who view the need to make this request as just another unnecessary hurdle placed in their way. Claimants ought to be able to fully understand the rationale and reasoning of the decisions that they receive.
5. The DEEOIC continues to add useful tools to its website. Many of these tools/resources are clearly denoted on the website. Other tools are not as visible and/or not easily accessible. We look forward to discussions with the DEEOIC where we can discuss the visibility/accessibility of certain tools.
6. Upon receiving a decision, claimants often have questions. We have been told that where there is a decision by FAB to remand the case for further review, some claimants encounter a period of time when it is difficult to locate someone to answer their questions. According to these claimants, when they contact FAB, they are told that the claim was remanded to the District Office, yet when they contact the District Office, they are told that the District Office has not received the case. Claimants would appreciate a means to get an immediate answer to their questions.
7. As noted in last year's report, the Office of the Ombudsman now forwards complaints alleging rude behavior to the DEEOIC. While some claimants contact the Office and ask that we forward their complaints to the DEEOIC, there are other claimants who tell us that they would prefer a procedure whereby they could directly lodge their complaints with the DEEOIC. In addition, whenever a complaint alleging rude behavior (or other unacceptable conduct) is lodged, other claimants have noted that they would like to receive a specific response to their complaint.
8. In the opinion of many claimants, public notice whenever there is a change in policy or procedure would not only ensure that the public is aware of these determinations, but would also ensure that the DEEOIC staff is aware of these changes.
9. Many individuals question whether the statute, policies, procedures, and regulations are interpreted in a consistent manner and/or interpreted in a manner consistent with Congress' intent in creating EEOICPA. We have received a number of suggestions of how best to answer these concerns. Some of the suggestions include: (a) posting all EEOICPA decisions for public review; (b) creating a board/panel with the authority to review EEOICPA decisions for consistency; (c) having the DEEOIC engage in a more robust and transparent review of past decisions; and/or (d) taking steps to assist claimants in effectively utilizing the appeals process. Unless and until these concerns are addressed, claimants, potential claimants, authorized representatives, and others will continue to contact us with their complaints, grievances, and requests for assistance.



## APPENDIX I

### ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

<b>ARC</b>	Albany Research Center
<b>AWE</b>	Atomic Weapons Employer
<b>CBD</b>	Chronic beryllium disease
<b>CE</b>	Claims examiner
<b>CLL</b>	Chronic lymphocytic leukemia
<b>DEEOIC</b>	Division of Energy Employees Occupational Illness Compensation
<b>DOE</b>	Department of Energy
<b>DOJ</b>	Department of Justice
<b>DOL</b>	Department of Labor
<b>DMC</b>	District medical consultant
<b>EEOICPA</b>	Energy Employees Occupational Illness Compensation Program Act
<b>FOIA</b>	Freedom of Information Act
<b>FWP</b>	Former Worker Medical Screening Program
<b>HHS</b>	Department of Health and Human Services
<b>JOTG</b>	Joint Outreach Task Group
<b>LPT test</b>	Beryllium lymphocyte proliferation test
<b>NBS</b>	National Bureau of Standards – Van Ness Street (DC)
<b>NIOSH</b>	National Institute for Occupational Safety and Health
<b>PM</b>	Procedure Manual
<b>PoC</b>	Probability of causation
<b>PPA</b>	Prompt Payment Act
<b>RECA</b>	Radiation Exposure Compensation Act
<b>SEC</b>	Special Exposure Cohort
<b>SEM</b>	Site Exposure Matrix
<b>The Act</b>	The Energy Employees Occupational Illness Compensation Program Act
<b>The Office</b>	The Office of the Ombudsman, Energy Employees Occupational Illness Compensation Program
<b>UMTRA</b>	Uranium Mill Tailings Remedial Action Program



## APPENDIX II

### DEEOIC Statistics as of January 1, 2012

Data as of 1/1/2012

Statistical data updated weekly on Mondays

<b>Combined Part B and E Summary</b>			
		CLAIMS	CASES
Applications Filed		223,567	149,676*
Covered Applications Filed		171,607	122,282
Total Compensation Paid	Payments	74,653	54,710
		Total Dollars	\$6,710,804,855
Total Medical Bills Paid	Total Dollars	\$992,659,352	
Total Compensation + Medical Bills Paid		\$7,703,464,207	

\*A total of 88,174 unique individual workers are represented by the 149,676 cases reported.



## Part B

	CLAIMS	CASES
Applications Filed	122,795	79,522
Non Covered Applications (show details)	18,993	15,003
Non Covered Employment	7,760	5,528
Condition Not Covered	11,233	9,475
Covered Applications Filed	103,802	64,519
Recommended Decisions <sup>*1</sup>		
Approved	54,714	35,202
Denied	38,435	25,206
Total	93,149	60,408
Final Decisions <sup>*1</sup>		
Approved	53,630	34,741
(show details) Denied	36,605	24,241
Survivor Not Eligible	3,916	722
Cancer Not Work Related <sup>*2</sup>	23,537	17,254
Medical Info Insufficient to Support Claim	9,152	6,265
Total	90,235	58,982
Compensation Paid		
Payments	51,132	32,776
Total Dollars		\$4,200,477,773

\*1 With regard to covered applications only

\*2 Probability of Causation is less than 50 percent

## Part E

	CLAIMS	CASES
Applications Filed	100,772	70,154
Non Covered Applications (show details)	32,967	12,391
Non Covered Employment	4,829	3,997
Survivor Not Covered <sup>5</sup>	28,138	8,394
Covered Applications Filed	67,805	57,763
Recommended Decisions <sup>3</sup>		
Approved	31,321	28,749
Denied	25,133	23,274
Total	56,454	52,023
Final Decisions <sup>3</sup>		
Approved	30,408	28,158
(show details) Denied	24,075	22,480
Cancer Not Work Related <sup>4</sup>	8,339	7,955
Medical Info Insufficient to Support Claim	15,736	14,525
Total	54,483	50,638
Compensation Paid		
Payments	23,521	21,934
Total Dollars		\$2,510,327,082

<sup>3</sup> With regard to covered applications only

<sup>4</sup> Probability of Causation is less than 50 percent

<sup>5</sup> Per EEOICPA amendments of 2004, adult children are not covered under Part E.



## Part B Cancer Cases - NIOSH and SEC Statistics

<b>Part B - Status and Location of NIOSH Referrals</b>	
Cases Referred to NIOSH for Dose Reconstruction (DR)	36,404
<b>Cases Returned by NIOSH</b>	
With Dose Reconstruction (DR)	30,197
Without Dose Reconstruction (DR)* <sup>6</sup>	4,233
Total	34,430
<b>Cases that are Currently at NIOSH</b>	
Initial Referral to NIOSH	1,430
Reworks or Returns to NIOSH	544
Total	1,974
* <sup>6</sup> Most cases without a DR are cases withdrawn from NIOSH for DOL review and approval based on a new SEC designation. Other reasons for withdrawal include administrative closure, death of claimant.	
<b>Part B - Cases with Dose Reconstruction (DR) and Final Decision</b>	
Final Decision to Accept and Probability of Causation (POC) 50% or Greater	8,604
Final Decision to Deny and POC Less Than 50%	16,532
Total	25,136

<b>Part B Cancer Cases with Final Decision to Accept<sup>7</sup></b>	
<sup>7</sup> Accepted Part B Cancer cases are defined by either a NIOSH or SEC approval; additional medical conditions could also be included within the Final Decision.	
<b>Accepted DR Cases</b>	
Cases Approved	8,072
Cases Paid	8,039
Individuals (Claimants) Paid	11,401
Amount Paid	\$1,198,890,064
<b>Accepted SEC Cases</b>	
Cases Approved	14,749
Cases Paid	14,642
Individuals (Claimants) Paid	24,559
Amount Paid	\$2,187,215,103
<b>Cases Accepted Based on SEC Status and POC 50% or Greater<sup>8</sup></b>	
Cases Approved	532
Cases Paid	531
Individuals (Claimants) Paid	657
Amount Paid	\$79,550,000
<sup>8</sup> For these cases at least one specified cancer was approved based on SEC employment and at least one other cancer was approved based on the DR process resulting in a POC of 50% or greater.	
<b>TOTALS: All Accepted SEC and DR Cases</b>	
Cases Approved	23,353
Cases Paid	23,212
Individuals (Claimants) Paid	36,617
Total Amount Paid	\$3,465,655,167



# NOTES



## NOTES









U.S. DEPARTMENT OF LABOR  
OFFICE OF THE OMBUDSMAN  
ENERGY EMPLOYEES OCCUPATIONAL  
ILLNESS COMPENSATION PROGRAM  
200 Constitution Avenue, N.W. Room N-2454  
Washington, D.C. 20210