

# 2013 Annual Report to Congress

Office of the Ombudsman  
for the  
Energy Employees Occupational  
Illness Compensation Program



OFFICE OF THE OMBUDSMAN  
UNITED STATES DEPARTMENT OF LABOR

Photo on the cover – Daily Life at Oak Ridge.  
Photo courtesy of Energy.Gov

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**U.S. Department of Labor**

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



**AUG 12 2014**

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

Dear Mr. President:

I am pleased to present the 2013 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

A handwritten signature in black ink, appearing to read "Malcolm D. Nelson", written over a horizontal line.

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



**AUG 12 2014**

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

Dear Speaker Boehner:

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Enclosure

## History of the Energy Employees Occupational Illness Compensation Program

The production of atomic/nuclear weapons can be divided into eight (8) general groupings of activities: (1) uranium mining, milling and refining; (2) isotope separation (enrichment); (3) fuel and target fabrication; (4) reactor operations; (5) chemical separation; (6) weapons component fabrication; (7) weapons operations; and (8) research development, and testing.<sup>1</sup> The decision by President Franklin D. Roosevelt to approve the development of an atomic bomb under the U.S. Army Corps of Engineers Manhattan Engineer District (MED), later known as the Manhattan Project, initiated work in these eight activities that over time grew into an industry employing hundreds of thousands of workers in mines, mills, laboratories, plants and other facilities all around the country. Estimates suggest that at its peak the U.S. nuclear weapons program employed more than 600,000 workers in the production and testing of nuclear weapons.<sup>2</sup> To date approximately 380 facilities located in 42 of the 50 states plus Puerto Rico, and the Republic of the Marshall Islands have or had some involvement with the production and/or testing of nuclear weapons.

The military operated the MED until 1947 when these functions were transferred to the civilian Atomic Energy Commission (AEC). In 1974 with the creation of the Energy Research & Development Administration (ERDA), the AEC was abolished. Subsequently, in 1977, the ERDA became the Department of Energy (DOE).

The work performed at these facilities often resulted in exposures to radioactive materials and/or other toxic substances. For example, the Site Exposure Matrices (SEM), a repository of information maintained by the Department of Labor (DOL) on toxic substances known to have been used onsite at various facilities lists 828 verified toxic substances onsite and used at the Paducah Gaseous Diffusion Plant; 1043 toxic substances onsite and used at the Rocky Flats Plant; and 101 toxic substances at the Uranium Mill in Durango.<sup>3</sup> Concerns for the health and safety of these workers led to the October 2000 enactment of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001.

EEOICPA originally consisted of two parts, Part B and Part D. Part B provides compensation to qualified employees (or their eligible survivors) and/or medical benefits/medical monitoring to qualified employees suffering from chronic beryllium disease (CBD), beryllium sensitivity, chronic silicosis, or from cancers related to radiation exposure. Part B also provides compensation to individuals (or their eligible survivors) awarded benefits under Section 5 of the Radiation Exposure Compensation Act (RECA). DOL administers Part B.

1 See Linking Legacies, Connecting the Cold War Nuclear Weapons Production Processes to Their Environmental Consequences, United States Department of Energy, January 1997, page 5

2 See United States Government Accountability Office, Report to Congressional Requesters: ENERGY EMPLOYEES COMPENSATION – Additional Oversight and Transparency Would Improve Program's Credibility, March 2010, GAO-10-132

3 SEM can be located at: [www.sem.dol.gov](http://www.sem.dol.gov). The cited statistics are as of December 31, 2013.

Part D directed DOE to provide assistance to claimants in obtaining state workers' compensation benefits. Due to obstacles that prevented its efficient administration, in 2004 Congress repealed Part D and enacted Section 3161 of Public Law 108-375, also known as Part E.

Section 3161 of Public Law 108-375 established Part E as a federal compensation scheme for DOE contractor and subcontractor employees, as well as uranium miners, millers and ore transporters as defined by Section 5 of RECA. This new law required DOL to prescribe regulations and begin the administration of Part E within 210 days of enactment. DOL prescribed interim final regulations on May 26, 2005, thereby meeting the 210 day deadline imposed by Congress.

The Division of Energy Employees Occupational Illness Compensation (DEEOIC), within the Office of Workers' Compensation Programs at DOL, administers Part B and Part E. Nevertheless other agencies also have a role with EEOICPA. The National Institute for Occupational Safety and Health (NIOSH) conducts activities to assist claimants and support the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; developing methods to estimate worker exposure to radiation (dose reconstruction); using the dose reconstruction regulation to develop estimates of radiation dose for workers who apply for compensation; overseeing the process by which classes of workers can be considered for inclusion in the Special Exposure Cohort (SEC); and providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and SEC petitions. The Ombudsman to NIOSH for EEOICPA assists petitioners in compiling materials needed to file a SEC petition, as well as conducts outreach to promote a better understanding of EEOICPA and the claims process.

DOE works to ensure that all available worker and facility records and data are provided to DOL and NIOSH. This includes providing information to DOL and NIOSH related to individual claims, such as employment verification and exposure records; supporting DOL, NIOSH and the Advisory Board on Radiation and Worker Health in larger-scale records research and retrieval efforts at various DOE sites; and conducting research, in coordination with DOL and NIOSH to support claims processing, dose reconstruction and claim adjudication.

As of December 29, 2013, DEEOIC had paid out a total of \$10,079,073,944 in compensation and medical benefits on claims representing 99,831 unique workers.<sup>4</sup> These totals continue to grow.<sup>5</sup>

<sup>4</sup> This \$10,079,073,944 represents \$5,221,042,188 in compensation paid under Part B, as well as \$3,112,895,075 in compensation paid under Part E, and \$1,745,136,681 paid for medical bills. Updated statistics can be found at: [www.dol.gov/owcp/energy/regs/compliance/weeklstats.htm](http://www.dol.gov/owcp/energy/regs/compliance/weeklstats.htm).

<sup>5</sup> Current statistics for EEOICPA can be found at: [www.dol.gov/owcp/energy/regs/compliance/weeklstats.htm](http://www.dol.gov/owcp/energy/regs/compliance/weeklstats.htm).

## The Office of the Ombudsman

Public Law 108-375 not only repealed Part D and established Part E it also created the Office of the Ombudsman (the Office). Pursuant to this law, the Secretary of Labor (the Secretary) is to ensure the independence of the Office within DOL, including independence from other officers and employees of DOL engaged in activities related to the administration of EEOICPA.

Public Law 108-375 also contained an express sunset date, terminating the requirements for the Office on October 28, 2007. On October 22, 2007, shortly before the effective date of the sunset provision, former Secretary of Labor Elaine Chao issued a Memorandum determining that, in the event that the statutory requirement expired, DOL should continue to have an Office of the Ombudsman. This Memorandum took effect on October 28, 2007. Thereafter, on January 28, 2008, Section 3116 of the FY08 Defense Authorization Act, Public Law 110-181, effectively reinstated the statutory requirement for the Office by extending the sunset date until October 28, 2012. On October 24, 2012, shortly before the sunset date of October 28, 2012, former Secretary of Labor Hilda Solis signed a Memorandum continuing the Office under the authority of the previous Memorandum signed on October 22, 2007.

EEOICPA outlines three specific duties for the Office:

1. Provide information about the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits;
2. Make recommendations to the Secretary regarding the location of resource centers for the acceptance and development of claims under Part B and Part E; and
3. Carry out such other duties as the Secretary specifies.<sup>6</sup>

See 42 U.S.C. §7385s-15(c).

In addition to these three specific duties, EEOICPA also requires the Office to submit an annual report to Congress setting 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.

See 42 U.S.C. §7385s-15(e).

Most of the individuals who contact our Office do not want to simply register a complaint or discuss difficulties they encountered with their claim. Rather, these individuals generally want some level of assistance with their claim. The assistance sought from our Office includes, but is not limited to: (1) directing individuals to the appropriate office to file a claim; (2) explaining the EEOICPA

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<sup>6</sup> To date, the Secretary has not specified any additional duties.

claims process; (3) clarifying/explaining documents; (4) offering suggestions on where to look for evidence; (5) obtaining information from DEEOIC, or from one of the other agencies involved with EEOICPA; and (6) providing individuals with the status of their claim.<sup>7</sup>

To better understand the assistance that people seek, we outlined a sample of the e-mails<sup>8</sup> received by the Office for the period of June 16, 2013 through June 29, 2013:

1. DEEOIC asked claimant to submit additional evidence. Claimant wanted clarification as to what he needed to submit.
2. A claimant contacted us with a variety of issues:
  - He found a decision issued by DEEOIC that referred to medical literature addressing the same condition from which he suffers. He wanted the title of these articles.
  - The recent change in claims examiners concerned this claimant.
  - As of June 7, 2013, the claimant had not received a response from DEEOIC to a fax he forwarded on May 16, 2013.
  - He had questions concerning the issue of subrogation.
3. Since the treating physician opined that exposures on the job contributed to the illness, claimant questioned the denial of his claim.
4. Claimant informed us that DEEOIC finally received the response from the Social Security Administration (SSA) confirming his covered employment. Since the claim was denied prior to receipt of SSA's confirmation, claimant must now request reopening of his claim. Claimant thanked the claims examiner and the Office for their assistance.
5. Claimant complained of difficulties using the web bill processing portal maintained by Affiliated Computer Services (ACS), the company contracted by DEEOIC to handle all medical authorizations and bill processing. Claimant noted that he continued to encounter difficulties even after obtaining assistance from ACS.
6. Claimant filed EN-16 forms for two unrelated illnesses.<sup>9</sup> Since these forms did not identify the illness, claimant found it difficult to determine which EN-16 form related to each of his two claims.

<sup>7</sup> The assistance provided by this Office includes tasks that, at first glance, would appear to be tasks claimants could perform for themselves. In our experience there are a number of reasons some claimants seek assistance with these tasks. Two major reasons are: (1) individuals are not aware of the potential resources available to them, and (2) individuals do not have access to these resources. For instance, there is a link on DEEOIC's website that allows claimants to check the status of their claim. Some claimants are not aware of this link, while others contact us because they do not have access to the internet.

<sup>8</sup> The examples are only e-mails, and do not include telephone calls, letters, faxes, or personal contacts. Moreover, please note that in some instances, one entry reflects a series of e-mail exchanges.

<sup>9</sup> Form EN-16 contains questions seeking a definitive response from a claimant regarding whether they ever filed a state workers' compensation claim or tort claim (lawsuit) for the accepted medical condition(s). This form must be completed and signed by the claimant prior to the payment of benefits under EEOICPA.

7. Letter from DEEOIC notified claimant that his claim was under reconsideration. Subsequently, DEEOIC informed claimant that it sent a letter to his treating physician. Claimant wanted clarification of what was transpiring with his claim.
8. The claimant had questions concerning a new Special Exposure Cohort class.
  - This claimant also asked how to locate DEEOIC bulletins and other relevant publications.
  - Finally, the claimant discussed problems he encountered while trying to locate employment records.
9. Inquiry into the status of a claim.
10. Claim was approved. Claimant asked how long before compensation is received.
11. Claimant questioned why EEOICPA compensation was awarded to the estranged spouse of a worker.
12. The spouse of a claimant contacted us with the following concerns:
  - Every two years she accompanies her husband (the former worker) when he travels for pulmonary testing. Spouse contends that DEEOIC's reimbursement does not fully cover the expenses related to this travel.
  - Correspondence from DEEOIC referred to "remittance voucher." Spouse and claimant asked us to define the term "remittance voucher" and to explain what actions needed to be taken.
13. In a prior conversation, the Office referred the claimant to the Resource Center. The claimant now called to say that the Resource Center had been very helpful. Nevertheless, the claimant had additional questions concerning his claim.
14. Claimant not sure why claim was closed. Claimant believed she submitted the requested information to DEEOIC. Claimant sought the status of the claim and wanted to know if she needed to provide additional documentation.
15. Claimant wanted to provide the Office with a copy of his request to Reopen his claim.

While claimants contact the Office via telephone, fax, e-mail, or letter, attendance at outreach events continues to be a valuable vehicle for interacting with individuals. Outreach events are especially effective in interacting with claimants who are not otherwise familiar with the Office and/or our mission. Accordingly, as one of our 2013 goals, the Office tasked itself with identifying new avenues for outreach. In 2013 we expanded our outreach to include attendance at two (2) health fairs.<sup>10</sup>

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<sup>10</sup> The two health fairs drew attendance from a wider population than we generally encounter at other events.

Here is a full list of the outreach events the Office attended in 2013:

<b>Site of Meeting</b>	<b>Date</b>	<b>Event</b>
Oak Ridge, TN	02/13/2013	DEEOIC Medical Benefits Town Hall Meeting
Espanola, NM	02/20/2013	DEEOIC town hall meetings and Traveling Resource Center
Augusta, GA	03/12/2013	Meeting of the Advisory Board on Radiation and Worker Health
Knoxville, TN	05/21 and 05/22/2013	DEEOIC Medical Benefits Roundtable Discussion
Wellpinit, WA	05/23/2013	Health Fair and Town Hall Meeting
Pasco, WA	06/05 and 06/06/2013	DEEOIC Medical Benefits Roundtable Discussion and DEEOIC Town Hall Meetings
Santa Fe, NM	06/18/2013	DEEOIC Medical Benefits Town Hall Meeting
Albuquerque, NM	06/19/2013	DEEOIC Medical Benefits Town Hall Meeting
Grants, NM	06/20/2013	DEEOIC Medical Benefits Town Hall Meeting
Bolingbrook, IL	06/19/2013	JOTG Town Hall Meeting
Portsmouth, OH	07/17/2013	DEEOIC Medical Benefits Town Hall Meeting
Burlington, IA	09/05/2013	Meeting Sponsored by the Iowa Former Worker Medical Screening Program
Ames, IA	09/13/2013	Meeting Sponsored by the Iowa Former Worker Medical Screening Program
Livermore, CA	09/17/2013	JOTG Town Hall Meeting
Emeryville, CA	09/17/2013	JOTG Town Hall Meeting
Oak Ridge, TN	09/27/2013	Resource Fair
Farmington, NM	12/10/2013	DEEOIC Medical Benefits Town Hall Meeting

## Outlook for Calendar Year 2014

In 2014 we intend to continue our efforts to provide claimants with relevant information concerning the benefits available under EEOICPA, as well as prepare an annual report that accurately sets forth the numbers and types of complaints received, and provides an insightful assessment of the most common difficulties encountered by claimants. In furtherance of these goals, two areas that we will emphasize in 2014 are:

- 1. Continuing to expand the Office's outreach.** In terms of expanding our outreach, we believe that we start 2014 with a lot of momentum. In addition to the outreach events that we will host (or co-host) this year, plans are underway to increase our participation at other outreach events. Thus, in addition to once again having a presence at the health fairs and former worker programs that we attended in 2013, we look forward to attending two other events that we identified but were unable to attend in 2013. We also look forward to another productive year of outreach working with the Joint Outreach Task Group (JOTG) and we are appreciative that DEEOIC invites us to attend the outreach events that they sponsor.<sup>11</sup>
- 2. Developing the complaints that we receive.** It can sometimes be a challenge to fully appreciate all of the issues that arise in some of the concerns brought to our attention. In some instances claimants are unable to provide us with the answers that we need to gain a full grasp of the nature and extent of their concerns/complaints. In addition, due to the scientific, medical, and/or legal nature of some claims, claimants can find it difficult to concisely articulate their concerns. Therefore, when assisting a claimant, it generally helps if we can review the relevant documents. However, some claimants are unable to provide us with these documents – either because they do not have (or no longer have) these documents, or because they do not have access to the resources to forward these documents to us.<sup>12</sup> This Office continues to explore ways to make the process of obtaining relevant documents as easy for claimants as possible. Moreover, in our experience we generally gain a broader understanding of an issue when we have the opportunity to discuss the matter with multiple claimants. In fact, many of the issues discussed in this year's report are the result of the opportunities we had to discuss similar issues with multiple claimants. Therefore, in 2014 we intend to enhance our abilities to identify instances where individuals contact us raising similar issues.<sup>13</sup>

<sup>11</sup> In 2009, DOE teamed with DOL, this Office, NIOSH, the Ombudsman to NIOSH and the DOE funded Former Worker Program to create the JOTG. The premise of the JOTG is that agencies/programs with common goals can work together by combining resources and coordinating outreach efforts for EEOICPA and the Former Worker Medical Screening Program to better serve the current and former DOE workforce.

<sup>12</sup> Some claimants find it difficult to forward documents, especially lengthy documents. Moreover, while claimants can provide us with written authorization to obtain documents from DEEOIC, some claimants view this as another unnecessary bureaucratic hurdle. Thus, some claimants never respond when asked to provide written authorization for our Office to contact DEEOIC to obtain documents.

<sup>13</sup> As necessary, we will also continue to develop documents and other tools that provide claimants with simplified information.

## Preface to the report

As required by EEOICPA, this report sets forth the number and types of complaints, grievances, and requests for assistance received by the Office, as well as an assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year. However, because of our interactions with claimants and potential claimants we are also aware of the positive efforts to assist claimants and to improve EEOICPA undertaken by DEEOIC and the other agencies involved in the administration of the EEOICPA. We would like to take a moment to acknowledge some of the positive actions that we observed in 2013.

We start by recognizing DEEOIC's efforts processing claims:

### Combined Part B and Part E Summary

		Cases as of 12/31/2010	Cases as of 12/30/2012	Cases as of 12/29/2013
Applications filed		140,256*	159,585**	168,174***
Covered Applications Filed		113,840	131,662	
Total Compensation Paid	Payments	49,019	60,725	66,459
	Total Dollars	\$5,915,139,362	\$7,546,725,245	\$8,333,937,263
Total Medical Bills Paid	Total Dollars	\$625,674,597	\$1,344,088,687	\$1,745,136,681
Total Compensation plus Medical Bills Paid		\$6,574,813,959	\$8,890,813,932	\$10,079,073,944

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

\*\*A total of 94,211 unique individual workers are represented by the 159,585 cases reported.

\*\*\*A total of 99,831 unique individual workers are represented by the 168,174 cases reported.

See Appendix 2 for DEEOIC's Combined Program Statistics as of December 30, 2013.

Moreover, in June 2013, DEEOIC began piloting a new imaging system, the OWCP Imaging System (OIS), in the Cleveland district office and the Cleveland Final Adjudication Branch (FAB). The ultimate goal is to implement a program-wide imaging program to facilitate administrative efficiencies and lessen administrative costs. In addition to other advantages, DEEOIC anticipates that OIS will reduce the need to physically handle paper case files and will allow DEEOIC employees remote access to electronic case records.

Responding to concerns regarding the approval and payment of medical benefits, DEEOIC sponsored medical benefits meetings (roundtables) in Denver, Colorado and Knoxville, Tennessee and sponsored combined town hall meetings/medical benefits roundtables in Pasco, Washington, as well as Santa Fe, Albuquerque and Grants, New Mexico. These events provided attendees with a vast amount of useful information.

Turning to the other agencies involved in the administration of EEOICPA, in January 2013, HHS issued final rules allowing chronic lymphocytic leukemia (CLL) to be treated as potentially caused by radiation under EEOICPA. Prior to the issuance of these rules, claims for CLL were not forwarded to NIOSH for completion of a dose reconstruction, and were automatically assigned a 0% dose resulting in a denial of the claim under Part B.

Working with its site contractors and site offices, DOE continues to obtain updated rosters of former employees. Utilizing one such updated roster, the JOTG sponsored very successful town hall meetings in Emeryville and Livermore, California.

# **2013 ANNUAL REPORT TO CONGRESS**

The Office of the Ombudsman  
for the  
Energy Employees Occupational Illness Compensation Program

## I. Tables

Consistent with our statutory mandate Tables 1 and 2 set forth the number and types of complaints, grievances, and requests for assistance received during calendar year 2013.

In reviewing these lists, one should be mindful that:

1. Claimants do not necessarily characterize their concerns in a manner that is easy to categorize. Thus, many complaints simply do not neatly fit into a specific category. This helps to explain why many complaints are simply included in the miscellaneous category under “other.”
2. One claimant may have multiple complaints, or one complaint may address several issues. Each complaint and each issue is separately counted.
3. In most instances, our assistance with a matter requires multiple contacts with a claimant. To the extent that these contacts involve the same matter, multiple contacts count as one complaint.
4. Only inquiries related to EEOICPA are included in these tables.<sup>14</sup>
5. When reviewing the number of complaints received, it is important to remember that some issues could potentially impact many other claimants.
6. There are instances where we find it impossible to effectively collect data. For instance:
  - a. At outreach events people are sometimes lined up to talk to us. In an effort to talk to everybody, we often find that it is not possible to fully record each contact.
  - b. Some individuals contact us because they want an answer to a specific question. Often in these situations, the individual sees no need to share a lot of information (especially if they feel that the information is not germane to their question). This helps to explain why in many instances, we cannot identify the site where the employee worked.

<sup>14</sup> Throughout the year individuals seeking assistance with programs other than EEOICPA routinely contact this Office. These contacts are not included in these tables.

**Table 1 – Complaints by Nature**

	<b>CONCERN</b>	<b>NUMBER</b>
1	Covered Employment	56
2	Covered Facility	7
3	Covered Illness	30
4	Eligibility of Survivors	16
5	Exposure to Toxins	47
6	Dose Reconstruction	22
7	Special Exposure Cohort	30
8	Causation	45
9	Impairment	14
10	Wage Loss	9
11	Medical Benefits	120*
12	Home Health Care	119*
13	Status	29
14	Issues Involving Authorized Representative	15
15	Issues Involving Attorney Fees	13
16	Issues Involving a RECA Claim	8
17	Issues Involving Interactions with DEEOIC	
	• Bothered by change of CEs	7
	• Staff Rude	25
	• Calls not answered	21
	• Other	9
18	Processing of Claim Takes Too Long	31
19	Wanted To File A Claim/Did Not Know Who To Call	26
20	General Requests For Assistance	338**
21	Issues Related to Reopening/Reconsideration	18
22	Requests For DEEOIC Statistics	5
	<b>TOTAL</b>	<b>1060</b>

\* This includes claimants and potential claimants we encountered at the various medical benefits town hall meetings hosted by DEEOIC.

\*\* This includes claimants and potential claimants we encountered at the various town hall meetings and health fairs.

## Table 2 – Complaints by Facility

Table 2 provides the number of complaints, grievances, and requests for assistance received from various facilities. This table only reflects those instances where the complaint identified the work site. However, there were many instances when the work site was not identified. For example, where the complaint involves home health care, complainants generally do not see a need to discuss the worker's place of employment.

FACILITY	LOCATION	# OF COMPLAINTS
Albany Research Center	Albany, OR	1
Allied Chemical Corporation Plant	Metropolis, IL	3
Amchitka Island Nuclear Explosion Site	Amchitka, Island, AL	3
Ames Laboratory	Ames, IA	9
Argonne National Laboratory – East	Argonne, IL	1
Bendix Aviation (Pioneer Division)	Davenport, IA	4
Bethlehem Steel	Lackawanna, NY	2
Blockson Chemical Company	Joliet, IL	1
Brookhaven National Laboratories	Upton, NY	5
Clarksville Modification Center	Clarksville, TN	4
Dow Chemical Company	Pittsburg, CA or Madison, IL	1
Feed Materials Production Center	Fernald, OH	4
Fermi National Accelerator Laboratory	Batavia, IL	1
Hanford	Richland, WA	37
Idaho National Engineering Laboratory	Scoville, ID	2
Iowa Ordnance Plant	Burlington, IA	23
Kansas City Plant	Kansas City, MO	8
Lawrence Livermore National Laboratory	Livermore, CA	19
Los Alamos National Laboratory	Los Alamos, NM	8
Mound Plant	Miamisburg, OH	4
National Bureau of Standards, Van Ness Street	Washington, DC	1
Nevada Test Site	Mercury, NV	4
Oak Ridge Gaseous Diffusion Plant (K-25)	Oak Ridge, TN	5
Oak Ridge National Laboratory (X-10)	Oak Ridge, TN	8
Oak Ridge (Y-12)	Oak Ridge, TN	15
Oak Ridge (did not specify location)	Oak Ridge, TN	36
Pacific Northwest National Laboratory	Richland, WA	2
Pacific Proving Ground	Republic of the Marshall Island	2
Paducah Gaseous Diffusion Plant	Paducah, KY	11

<b>FACILITY</b>	<b>LOCATION</b>	<b># OF COMPLAINTS</b>
Pantex Plant	Amarillo, TX	9
Pinellas Plant	Clearwater, FL	6
Portsmouth Gaseous Diffusion Plant	Piketon, OH	11
Rocky Flats Plant	Golden, CO	9
Sandia National Laboratory	Albuquerque, NM	1
Savannah River Site	Aiken, SC	14
Texas City Chemical	Texas City, TX	1
Uranium Miners	Various Sites	31
Wah Chang	Albany, OR	1
Weldon Spring Plant	Weldon Spring, MO	1

## II. Potential claimants are not aware of the program

*I just found out about EEOICPA today...I'm not sure how to apply.*

Although EEOICPA was created in 2000, individuals routinely contact us asserting that they only recently learned of the program. While these individuals are appreciative to finally know about EEOICPA, some question why it took so long to hear of this program. One frequent question asks why the government never mailed notices announcing this program directly to all former workers.

As part of its efforts to notify former workers and their families about this program, DEEOIC routinely sponsors town hall meetings and traveling resource centers. In 2013, DEEOIC sponsored a total of ten town hall meetings and/or roundtable discussions in various locations around the country. While these efforts are commendable, some claimants believe that more can and needs to be done. For instance:

- Town hall meetings, traveling resource centers and roundtable discussions are often held in localities close to the covered facility (or close to where a covered facility once existed). We encounter individuals, especially those who subsequently moved further away from these facilities, who tell us that they were never notified of these events, or that the distance to these events was too far to travel. Some claimants suggest that more needs to be done to disseminate information to those who no longer live near these covered facilities.
- When announcing outreach events, DEEOIC generally mails letters, updates its website, and issues a press release. However, DEEOIC's mailing list is comprised of individuals who have already filed claims.<sup>15</sup> Some individuals suggest that more effort needs to be directed towards disseminating information about this program to those who have not filed claims.

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**DOE, working with the Former Worker Medical Screening Program (FWP) continues to update the employee rosters for many of the covered DOE facilities. In 2013, DOE/FWP, working with the JOTG utilized updated rosters with great success to notify claimants of two events held in California, and it appears that discussions are underway to explore other opportunities to utilize these updated rosters. However, while DOE has experienced success obtaining updated rosters of contractor employees, it has not experienced the same level of success locating rosters for subcontractor employees. Consequently, it is not surprising that many of the complaints that we receive concerning difficulties locating employment records involved subcontractor employment.**

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<sup>15</sup> While DEEOIC's mailing list only contains individuals who already filed an EEOICPA claim, it is not unusual at these outreach events to encounter individuals who never filed a claim but who heard of the event through the media or from someone who received a letter.

- Some claimants assert that it can be very difficult to locate information about EEOICPA. We especially hear this concern from individuals who note that when they first heard about EEOICPA, they knew very little about this program and thus, had little, if any idea of where to even begin a search for more information. For instance, we encounter individuals who generally know that a compensation program exists, yet do not know the name of the program, and/or that the program is administered by DOL. In fact, it is common to encounter individuals who tell us that as they searched for more information, it was only by coincidence that someone provided them with the contact information for this Office.

Nevertheless, in our experience, claimants do not contact us simply to report that there was a delay in their becoming aware of this program. Rather, claimants generally contact us when they believe that the processing of their claim was impacted by the lack of prompt notice. Some of the concerns that we hear include:

**Passage of time makes it difficult to locate evidence:** Claimants frequently contend that the passage of time makes it more difficult to locate the evidence needed to establish eligibility for compensation and benefits. Claimants believe that it is unfair to create a program where they bear the burden of proof and for years to go by before they are informed of the program. Some of the more vocal comments arise when claimants believe that relevant evidence was destroyed in the time that lapsed between the creation of the program and when they first learned of the program.

*In speaking with XXX she wants medical records- as I have advised her I am not able to obtain those due to the time that has past. I have obtained a letter from my physician at that time attesting to the fact... I am sure I am not the only one that is unable to get medical records due to the time frame.*

**Medical expenses will not be reimbursed:** Another concern brought to our attention suggests that due to the lapse of time claimants may not be able to recoup certain expenses. Prior to learning of EEOICPA, some claimants paid medical expenses out of their own pocket. If the claim is ultimately approved, DEEOIC only reimburses the claimant for the medical bills associated with the covered illness that accrued since the filing of the claim. Consequently, some claimants view it as unfair to delay notifying them of this program and to then refuse to reimburse them for medical expenses that incurred prior to the time they became aware of the program and filed a claim for benefits.

Since they encounter such difficulties simply trying to obtain information on how to file a claim, when they contact our Office for assistance, some claimants are already experiencing a significant level of frustration.

### III. Concerns regarding the scope of the program

*My Father died XX years ago from Mesothelioma, it is on his death certificate that way. He worked at [an AWE] for over 30 years...<sup>16</sup>*

There are individuals who firmly believe that the purpose of EEOICPA is to compensate every employee who worked at a facility associated with the U.S. nuclear program who now suffers (or suffered) from an illness related to toxic exposures arising from that employment. However, as written, EEOICPA is not as broad as these individuals believe. The program clearly identifies those employees who are covered. When they discover that coverage under EEOICPA is not as broad as they thought, some individuals contact us to express their disappointment. The comments that we receive concerning the scope of EEOICPA tend to focus on who is covered and the illnesses covered under EEOICPA.

There are differences in terms of the illnesses covered and the employees covered under Part B and Part E. These differences are outlined in Charts 1 and 2:

**Chart 1**

Illnesses potentially covered under Part B	Illnesses potentially covered under Part E
<ul style="list-style-type: none"> <li>• Any cancer that is 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 the mining of atomic weapon test 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 2**

Employees potentially covered under Part B	Employees potentially covered under Part E
<ul style="list-style-type: none"> <li>• Department of Energy Contractors</li> <li>• Department of Energy Subcontractors</li> <li>• Employees of Beryllium Vendors</li> <li>• Employees of Atomic Weapons Employers</li> <li>• Department of Energy Employees</li> <li>• Approved RECA Section 5 claimants</li> </ul>	<ul style="list-style-type: none"> <li>• Department of Energy Contractors</li> <li>• Department of Energy Subcontractors</li> <li>• RECA Section 5 uranium miners, millers, and ore transporters</li> </ul>

<sup>16</sup> Employees of Atomic Weapons Employers (AWEs) are potentially eligible for coverage only under Part B of EEOICPA for radiogenic cancer. They are not eligible for coverage under Part E. Since this employee was a former AWE employee and mesothelioma is not a covered condition under Part B, this claimant does not have an eligible EEOICPA claim

- During the year, DOE federal employees questioned whether it was fair to create a program in which they were covered under Part B if they suffered from a cancer caused by radiation exposure, chronic beryllium disease, beryllium sensitivity, or possibly, chronic silicosis, but not cover them under Part E due to their status as DOE employees.
- Employees of Atomic Weapons Employers and Beryllium Vendors contacted us with concerns that went even further. In addition to questioning why they were covered under Part B, but not covered under Part E, these employees also question why their coverage under Part B is limited to some but not all of the Part B illnesses. (See Chart 3 below).

**Chart 3 - Part B coverage**

	<b>Cancer caused by radiation exposure</b>	<b>Chronic Beryllium Disease</b>	<b>Beryllium Sensitivity</b>	<b>Chronic Silicosis</b>
DOE Employee	Yes	Yes	Yes	Yes
DOE Contractor	Yes	Yes	Yes	Yes
DOE Subcontractor	Yes	Yes	Yes	Yes
Atomic Weapons Employer	Yes	No	No	No
Beryllium Vendor	No	Yes	Yes	No

Here are some of the specific issues brought to our attention by those who contacted us with concerns involving the scope of EEOICPA's coverage:

- **Fairness:** Some claimants argue that coverage under EEOICPA can be unfair. Claimants find it hard to understand why two employees exposed to the same toxins and possibly performing similar jobs should have their eligibility under EEOICPA based upon their employment. This is the precise argument we heard from employees of Allied Chemical Corporation Plant, a facility designated as an AWE facility. These former employees questioned why they were covered under Part B, but not covered under Part E, and further questioned why they were only covered under Part B for cancers caused by radiation exposure. A similar argument was raised by an employee of a Beryllium Vendor. This employee questioned why he was covered under Part B but not covered under Part E, and why his Part B coverage was limited to chronic beryllium disease and beryllium sensitivity, thus rendering him ineligible to seek compensation for his cancer that he believed was related to exposures at a covered facility.
- **No explanation for differences:** Those impacted by these differences in coverage often find it troubling that no one can provide them with a rationale for these differences.
- **Differences are not easily discernible:** We talk to individuals who assure us that before filing a claim, they make an effort to understand the basic rules concerning eligibility. Therefore, some of these individuals find it frustrating when they are suddenly made aware of basic rules well into the claims adjudication process. In one instance, a former AWE employee was very frustrated when he filed his claim only to later learn that employees of AWEs are only covered under Part B, and under Part B are only covered for cancers caused by radiation exposure. Since he did not have a claim for cancer caused by radiation exposure, this employee argued that it would have

saved him time and energy if he had known this basic fact up front. This employee, as well as others, question why basic facts/rules relating to eligibility are not more prominently posted by DEEOIC.

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**There is a brochure on DEEOIC’s website that explains that employees of AWEs are only covered under Part B for cancers caused by radiation exposure. To find this brochure, starting at DEEOIC’s webpage you click the link to “Brochures” where 12 options are presented. If you select, “Eligibility for Compensation and Benefits under EEOICPA” you find this brochure. Otherwise to locate this information one must review the EEOICPA statute, the EEOICP Procedure Manual, or the applicable regulations. Claimants who have utilized these other sources often tell us that these sources do not address AWE coverage in language that is clear and concise.**

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Some claimants suggest that in keeping with a “claimant-friendly” program, information outlining the basic eligibility requirements for Part B and Part E ought to be prominently posted and conveyed in language that is easily understood by all.

Many of the claimants we encounter are adamant that they only wish to pursue an EEOICPA claim if they earnestly believe they are entitled to compensation and/or benefits. These individuals emphasize that they have no desire to seek, or to be viewed as seeking, money or benefits from the government for which they are not entitled. Therefore, some claimants find it embarrassing to file a claim only to subsequently discover that they do not meet the basic eligibility requirements, and this is true even in instances where no one questions the claimant’s intent in filing the claim. Claimants suggest that these embarrassing situations could sometimes be avoided if the basic rules of eligibility were more prominently posted.

## IV. Issues related to establishing employment

To be eligible under EEOICPA, the worker must qualify as a covered employee and must have worked at a covered facility. To assist claimants in establishing employment when a claim is filed, in addition to the information provided by the claimant on the employment verification form, DEEOIC contacts DOE for employment verification. Moreover, as appropriate, DEEOIC verifies employment through the Oak Ridge Institute for Science and Education (ORISE) database, the Center for Construction Research and Training, Social Security Administration (SSA) wage data and corporate verifiers.

- **Difficulty Locating Evidence**

There are instances where the assistance offered by DEEOIC is sufficient to enable a claimant to verify employment. However, as with other aspects of EEOICPA, there are also instances where the assistance offered by DEEOIC is not sufficient. The following case illustrates some of the problems encountered by claimants attempting to verify covered employment.

*Claimant contacted the Office for assistance when he encountered difficulties verifying his employment at Amchitka Island, Alaska. In response to the inquiry from our Office, DEEOIC indicated that they could not locate any DOE records verifying this claimant's employment. We then contacted DOE who acknowledged that the employer was a known subcontractor at Amchitka. In their response, DOE indicated that there were no security clearance records for subcontractor employees at Amchitka.<sup>17</sup> DOE further indicated that while one of the primary means of verifying subcontractor employment at Amchitka was the presence of dosimeters issued to workers, in the year of this claimant's alleged employment, no dosimeters were issued.<sup>18</sup> When we informed the claimant of this response, he asked how to request a copy of the documents submitted in conjunction with his application for a Q clearance.<sup>19</sup> In response to this inquiry, DOE indicated that in the normal course of record retention, these documents had been destroyed. This claimant further reported that when he asked for other suggestions of where to look for relevant records, he was advised to contact his former employer, to which the claimant noted that he had already approached the employer and was informed that its records did not go back that far.*

- **Hard to believe that no one can locate records:** In light of the emphasis placed on security at these facilities, claimants find it difficult to accept that, in some instances, the government cannot locate a single record verifying their employment. The case discussed above highlights this concern. Amchitka Island is located about 1300 miles from Anchorage, Alaska. Access to the island was by boat or airplane. In addition to the security one had to undergo to work at this facility, there is a good chance the government or the employer provided transportation to and

<sup>17</sup> It is not clear whether there were no security clearance records for any subcontractor employees at Amchitka or simply no security clearance records for subcontractor employees who worked during the years alleged by this claimant.

<sup>18</sup> Amchitka was a DOE facility during the year that this claimant alleged employment.

<sup>19</sup> In the experience of this Office, the mere issuance of a Q clearance is not accepted as conclusive evidence of a worker's presence at a particular site. Nevertheless, this claimant hoped that information in his application would assist in verifying his employment at Amchitka.

from this work site, as well as housing and meals at the site. It is hard for this claimant to accept that no one can locate any of these records. While most work sites were not nearly as remote as Amchitka, claimants firmly believe that wherever they worked, there were abundant records documenting their presence at these sites. Thus, they find it hard to accept that no one can locate any of these records.

- **Unreasonable and unfair to keep the burden on claimants where the government cannot locate or destroyed relevant records:** Claimants stress that it is important to remember that the government or the employer usually maintained employment records. Thus, where the government or the employer cannot locate the relevant employment records, claimants argue that it is unreasonable to expect them to locate these records. We frequently hear this assertion where relevant records were lost or destroyed, and especially where the government or the employer is responsible for the destruction/loss of these records. Claimants contend that it is fundamentally unfair to place the burden of proof on them when, unbeknown to them, someone else destroyed the relevant records.
- **Assistance offered to claimants not always sufficient:**

*The President shall, upon the receipt of a request for assistance from a claimant... provide assistance to the claimant in connection with the claim, including...*

*(2) such other assistance as may be required to develop facts pertinent to the claim.<sup>20</sup>*

While claimants acknowledge that assistance is provided, some question whether this assistance measures up to what Congress intended. Claimants argue that when Congress drafted Section 7384v, it was well aware that some records were lost or destroyed. Thus some claimants believe that Congress intended the government to take a very active role in assisting claimants. In the opinion of these claimants an active role in assisting claimants would include, (1) in individual claims, directly contacting employers to request documents<sup>21</sup>, (2) assisting claimants in locating former colleagues; and (3) other assistance as the case may require. In furtherance of this contention some claimants believe that employers are more apt to respond to requests from the government (than to respond to requests from claimants) and contend that the government has better resources to track down former colleagues.<sup>22</sup>

- **DEEOIC Can Be Unrealistic In Terms of the Evidence That It Requires**

We continually hear comments suggesting that DEEOIC can be unrealistic in terms of the evidence required to verify employment. This next example illustrates this concern.

*The claimant worked at the multi-agency Iowa Ordnance Plant, (IOP) in Burlington, Iowa. During the relevant time period, the U.S. Army operated part of this facility and the U.S. Atomic Energy Commission (AEC), a predecessor of DOE, operated part of this*

<sup>20</sup> 42 U.S.C. §7384v(a)(2).

<sup>21</sup> We must often hear these complaints in instances where claimants need assistance verifying DOE subcontractor employment.

<sup>22</sup> Claimants believe that an employer is more apt to respond to the government than to respond to a request from a former employee, especially where that former employee last worked for the employer 20 to 40 years ago.

facility. One part of the facility operated by the AEC is known as Line 1. The claimant worked in a building outside of the boundaries of what is generally considered Line 1. Accordingly, the challenge for this claimant was to establish that she worked at a “Department of Energy facility” which EEOICPA defines as:

*Any building, structure, or premise, including the grounds upon which such building, structure, or premise is located –*

- (A) *In which operations are, or have been conducted by, or on behalf of, the Department of Energy...; and*
- (B) *With regard to which the Department of Energy has or had –*
  - (i) *a proprietary interest; or*
  - (ii) *entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction or maintenance services.*<sup>23</sup>

*The DEEOIC Notice of Final Decision discussed the evidence addressing the claimant’s employment. According to this final decision, one employment verification form indicated that the claimant’s job was specific to DOD, while a second employment verification form indicated that the job code was “inconclusive.” The decision further noted that claimant submitted a narrative in which she identified the building where she worked and in which she asserted that a majority of her work was for Line 1, as well as Line 6. The decision also recognized that the claimant submitted a copy of a contract between the AEC and the Army’s Ammunition Procurement and Supply Agency (the Agreement). The Agreement identified claimant’s work site as a “Joint-Use Facility,” which the Agreement defined as, “...facilities at the IOP which are utilized jointly for [Army] and [AEC] activities.”<sup>24</sup> In addition, claimant submitted “Personal and Medical Records” along with a copy of the site profile for the Iowa Ordnance Plant. At least one of the claimant’s medical records is on stationary with the letterhead “Burlington AEC Plant.”*

*According to the final decision, DOL’s Office of the Solicitor reviewed the Agreement and found that:*

- 1. The Agreement did not establish that the AEC in fact performed operations in Building 300-148 or that the Army performed operations at the site on behalf of the AEC.*
- 2. There was insufficient evidence to determine whether the DOE had a “proprietary interest” in Building 300-148. The final decision states that the*

<sup>23</sup> 42 U.S.C. §7384(12).

<sup>24</sup> See Agreement, Albuquerque Operations, U.S. Atomic Energy Commission and Ammunition Procurement And Supply Agency, Department Of The Army For The Operation Of The Burlington AEC Plant And the Iowa Ordnance Plant, effective October 1, 1963.

*solicitor determined that, “[t]he Agreement allows the AEC to use the building, but its use was shared with the Army. The Use Permit does not allow the AEC to use, occupy, and control Building 300-148.”*

3. *There is no evidence of a contract between the AEC and the Army to provide services for the AEC in Building 300-148 or evidence of a contract between [the employer] and the AEC to provide services for the AEC in Building 300-148.*

*Thus, the final decision informed the claimant that the Solicitor concluded that due to the lack of available documentation, the Solicitor’s Office was unable to “advise” as to whether the building where the claimant worked [met] the definition of a DOE facility. Thus, the district office was directed to determine if claimant worked under her employer’s contract with the AEC or the Army.*

*In its conclusions of law, the final decision recognized that, pursuant to medical and personnel records claimant’s supervisor was classified as employed in the production of weapons for both the AEC and the Army. However, the final decision concluded that these records were not sufficient to classify the claimant as an AEC employee. The final decision further determined that the claimant’s medical record on “Burlington AEC Plant” stationary was not proof of a contract between the AEC and the claimant’s employer. Lastly, the final decision found that the site profile did not address whether the AEC operated at the building where claimant worked.<sup>25</sup> Consequently, DEEOIC denied the claim on the ground that the evidence did not establish that claimant was a “covered employee” as defined in EEOICPA.<sup>26</sup>*

The second to last paragraph of the final decision denying the claim contains the following passage,

*“To establish a claim under the Act, the claimant bears the burden of proving by a preponderance of the evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category...”*

In our conversation with this claimant she asked a question that we frequently hear when individuals find themselves in similar circumstances. This claimant asked “what else can I produce?” Other claimants have similarly remarked that since they were not parties to these contracts between their employer and DOE, it is unrealistic to expect them to have a copy of these contracts or to know where to look for these contracts.

Due to the passage of time and the destruction/loss of records, claimants often feel fortunate if they locate any evidence addressing employment that occurred years ago. Therefore, claimants find it very disheartening when they locate evidence, only to have that evidence deemed insufficient. It often only adds to the frustration when evidence is deemed insufficient, yet no one can offer any realistic suggestions of where to look for other evidence and/or no one can suggest evidence that actually exists, that might be deemed sufficient. For instance, claimants note that when

<sup>25</sup> Claimant also submitted a Use Permit. DEEOIC determined that this permit did not include claimant’s work site as an area that the AEC was permitted to use, occupy and control.

<sup>26</sup> See 42 U.S.C. §7384l(11).

they encounter difficulties verifying employment they are often advised to obtain affidavits from colleagues. Claimants frequently suggest that this advice is not very realistic, noting that in the ensuing years they lost track of colleagues, other colleagues passed away; and those they can locate do not have the capacity to complete an affidavit.

Where relevant evidence was lost or destroyed, or where the parties to the contract are unable to produce the contract, it is suggested that DEEOIC can be too demanding in terms of the evidence that it demands as proof. Some attorneys suggest that when it comes to the evidence that it will accept, DEEOIC sometimes imposes higher requirements than those encountered in many courts. The case discussed above underscores this belief. Since the parties to the contract were unable to produce the contract, this claimant believes that there is sufficient evidence to suggest a contract – this claimant questions whether DEEOIC is requiring absolute proof of a contract.<sup>27</sup>

- **Does DEEOIC Employ The Correct Standard?**

Claimants contend that they are not required to establish their employment with absolute certainty. Rather, it is noted that claimants are only required to establish each criterion by a preponderance of the evidence. Throughout the year we received inquiries asking if DEEOIC applied the proper standard of proof in weighing evidence to determine if covered employment is established. These inquiries usually arise where, contrary to the findings of DEEOIC, claimants believe that a preponderance of the evidence in the record establishes employment.<sup>28</sup>

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**While claimants have the right to appeal a final decision issued by DEEOIC to Federal District Court, some claimants believe that this option is beyond their (legal) capabilities, and/or is too expensive (especially if they have to retain counsel). Moreover, some former workers have real reservations about going to court, especially if it means going to court in a claim against the government. Therefore, some claimants believe that there needs to be a procedure, short of an appeal to Federal Court that offers an opportunity for an independent review of decisions issued by DEEOIC. Claimants believe that such a review would help ensure consistency among decisions and ensure that decisions are consistent with the Act.**

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<sup>27</sup> During the course of this year we also met claimants who encountered difficulties attempting to establish a contractual relationship involving contractors at the Brookhaven Laboratory.

<sup>28</sup> Some claimants and ARs have noted that the DEEOIC Procedure Manual provides that, “[a]s the statute allows latitude in the assessment of evidence, it is not necessary for the claims examiner to collect evidence that establishes that the claimed employment is proven beyond a reasonable doubt, but merely that a reasoned basis exists to conclude that the employment occurred as alleged. This ensures that the claimant receives favorable treatment during the employment verification process.” See DEEOIC Procedure Manual, Chapter 2-0500.6 (January 2010).

- **Locating SSA Records**

Another problem encountered by claimants this year involved issues that arose in light of delays in obtaining SSA records. DEEOIC utilizes SSA records to verify employment and to determine wage loss. The Ombudsman's 2009 Annual Report addressed concerns by claimants who experienced delays in the processing of their claims when DEEOIC did not promptly receive copies of their SSA records. In that annual report, we further noted that DEEOIC issued policy guidance designed to allow for more expeditious interactions with SSA to obtain vital employment verification and wage-loss information. See 2009 Annual Report to Congress, March 4, 2010, page 20, n. 12. In spite of this action by DEEOIC, claimants continue to experience delays in the receipt of SSA records. Claimants ask why more is not done to ensure that SSA records are promptly forwarded to DEEOIC.

In a couple of the instances brought to our attention, the concern voiced by claimants went beyond the fact that the processing of the claim was delayed. In these instances claimants found it troubling that DEEOIC issued recommended and sometimes final decisions, finding that the worker did not have covered employment, without receipt (and thus without the opportunity to review) the SSA records. These claimants questioned the fairness of issuing a decision knowing that potentially relevant evidence was not in the file.

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**If a claim is denied prior to the receipt of the SSA records, once the records are received, the claimant can, as appropriate, seek reconsideration or re-opening. Some find these options less than optimal. Some claimants believe that once a decision issues, they face a tough uphill battle to overturn that decision. Accordingly some claimants believe that it is preferable to delay the issuance of a decision as opposed to receiving a denial and then trying to obtain reconsideration or a re-opening. This also explains why some claimants are suspicious whenever it appears that issuing a decision within a prescribed amount of time takes precedence over a review of all of the relevant evidence.**

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## V. Covered illness

To pursue a claim under EEOICPA, there must also be a diagnosed medical condition/illness. With respect to establishing a covered illness, a majority of the concerns that we encountered this year involved one of the following issues: (1) did the physician provide a diagnosis; (2) verifying a diagnosis of cancer; and (3) verifying the existence of CBD.

### 1. Did the physician provide a diagnosis

Disagreements sometimes arise over whether an entry by a physician is actually a diagnosis of a condition. These disputes generally involve situations where DEEOIC interprets the entry as a symptom rather than the diagnosis of a condition. In response to these disputes, some claimants question whether CEs and/or HRs have the medical expertise to make such distinctions.

### 2. Verifying a diagnosis of cancer

Pursuant to 20 C.F.R. §30.211, a diagnosis of cancer is established with medical evidence that sets forth a specific diagnosis of cancer and the date on which that diagnosis was first made. The requirements for establishing a diagnosis of cancer are further addressed in the EEOICP Procedure Manual (PM) which, as a general rule, requires a medical report of tissue sample in order to accept a diagnosis of cancer under EEOICPA.<sup>29</sup> Claimants contact our Office to tell of the struggles they endure endeavoring to locate tissue sample reports. These contacts often involve instances where the initial diagnosis of cancer was made more than 10 years ago. In some of these situations problems arise since hospitals and physicians are only required to retain medical records for a length of time that typically is no more than 10 years. While claimants appreciate the need to verify the diagnosis of cancer, they contend that it is unfair and unrealistic to condition eligibility on the submission of evidence that does not exist, and sometimes was destroyed long before the program was created. Claimants point to this as another instance where it is frustrating to submit evidence that DEEOIC subsequently deems as insufficient, yet DEEOIC cannot realistically point to other evidence (still in existence) that could establish the necessary fact (here, establish the diagnosis of cancer).

DEEOIC regulations further provide that if a person with knowledge of the fact submits a certified statement indicating that the medical records containing a diagnosis and the date of that diagnosis do not exist, OWCP may consider other evidence to establish a diagnosis and the date of the diagnosis. See 20 C.F.R. § 30.113(c). Nevertheless, we encounter claimants who question the extent to which DEEOIC adheres to this policy and/or believe that DEEOIC is too demanding when it comes to the other evidence that it is willing to accept to establish a diagnosis and the date of that diagnosis.

<sup>29</sup> A report of tissue sample includes a pathology report, a surgical pathology report, an autopsy report, or a post-mortem examination report. The PM further provides that in certain instances a diagnosis of cancer can be accepted based on a cytology report, or imaging report (x-ray, CAT scan, or MRI). If the worker is deceased and none of the other listed reports are available, the PM states that a diagnosis of cancer based on hospital admission/discharge reports describing the tumor; hospice records, or a death certificate signed by a physician. DEEOIC Procedure Manual, Chapter 2-0900.3 (January 2010).

### 3. Verifying the existence of CBD

The bulk of the comments that we receive addressing covered illnesses concern efforts to establish the existence of CBD. The three primary issues brought to our attention are: (a) whether the standard used by DEEOIC for establishing CBD under Part E is consistent with the Act; (b) whether specific evidence satisfies the Part B criteria for CBD; and (c) whether DEEOIC is consistent in its application of its policies involving CBD claims.

**(a) Is the standard used by DEEOIC for establishing CBD under Part E consistent with the Act?**

EEOICPA specifically outlines the criteria needed to establish CBD under Part B. See 42 U.S.C. §7384l(13). However, EEOICPA does not contain specific criteria for establishing CBD under Part E. In 2011, DEEOIC indicated that a positive or abnormal beryllium lymphocytic proliferation test (BeLPT) was necessary to prevail in a claim for CBD under Part E.

- Claimants argue that since Congress had the opportunity but did not establish criteria for diagnosing CBD under Part E, this shows that Congress did not intend specific criteria for establishing CBD under Part E. Accordingly, claimants question DEEOIC's authority to establish specific criteria for diagnosing CBD under Part E.
- Some claimants also find it troubling that it is difficult to locate a concise statement of DEEOIC's policy requiring a positive or abnormal BeLPT in order to prevail in CBD claims under Part E.
- Where they have little, if any, access to information regarding this policy, claimants contend that it is difficult, if not impossible, to develop a credible challenge to this policy. Some claimants suggest that their full understanding of this policy is based on what they read in the decision that DEEOIC issued on their claim, and further contend that the discussion of the policy contained in that decision was often limited to a statement of the policy without any explanation of the policy and without any citation as to where to find the policy.<sup>30</sup> Claimants believe that in order to determine if they wish to challenge a policy, they need an opportunity to review the policy, and to review the documentation relied upon in creating the policy. As we discuss in more detail at Chapter XI, subchapter B, some claimants believe that their ability to review and/or challenge policies announced by DEEOIC was severely hampered by a lack of information.

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**With respect to the criteria for establishing CBD under Part E, the Office is aware of decisions that provided an explanation for why a positive or abnormal BeLPT was necessary. However, this Office is also aware of other decisions that did not include such an explanation. These latter cases often simply announced and then applied the policy to the facts of that particular case.**

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<sup>30</sup> We also encountered claimants who indicated that certain policy changes were announced with a reference to Policy Teleconference Notes. Some of these claimants contend that their requests for copies of these Policy Teleconference Notes were denied on the ground that these documents were "pre-decisional."

**(b) Whether specific evidence satisfies the Part B criteria for CBD:** As noted above, EEOICPA outlines the criteria needed under Part B to establish CBD. See 42 U.S.C. §7384l(13). The DEEOIC PM further describes the evidence necessary to establish CBD under Part B. A continuing source of controversy concerns whether evidence submitted by claimants satisfies the criteria for establishing CBD outlined by the statute and further defined by DEEOIC.

Many of the inquiries that we received this year involved x-ray results submitted by claimants to establish a diagnosis of CBD prior to January 1, 1993.<sup>31</sup> With respect to diagnoses made prior to January 1, 1993 (pre-1993 CBD), CBD is established if there was an occupational or environmental history, or epidemiologic evidence of beryllium exposure and any three of five criteria outlined in EEOICPA are met. See 42 U.S.C. §7384l(13)(B). One of the five criteria for pre-1993 CBD is characteristic chest radiographic (or computed tomography (CT)) abnormalities. See 42 U.S.C. §7384l(13)(B)(ii).<sup>32</sup>

Throughout the year, claimants took exception with DEEOIC's determination that an x-ray was not characteristic of CBD. In raising their concerns, claimants question whether CEs and/or HRs have the medical background to evaluate x-rays reports. Questions also arise concerning the use of the PM and specifically whether undue credence is given to the PM. Since the PM is not a statute or a regulation, claimants believe that it should only be used as guidance, and not used as an absolute authority. Some claimants contend that there are instances where, in evaluating evidence for CBD, the CE or HR rejected evidence simply because it was not entirely consistent with statements in the PM. Claimants ask whether this is appropriate. Similar concerns were brought to our attention involving another of the criteria for pre-1993 CBD – namely, restrictive or obstructive lung physiology testing or diffusing lung capacity defect. Again claimants question whether CEs or HRs have the expertise to evaluate these test reports.

**(c) Is DEEOIC consistent in its application of the policies governing CBD claims:** There are those who contend that DEEOIC is not consistent in its application of the policies governing the adjudication of claims for CBD. Throughout the year, individuals presented us with examples that they believe demonstrated an inconsistent application of various rules concerning pre-1993 CBD.

*In one instance, an authorized representative (AR) contacted the Office when, in an effort to establish CBD, he submitted an x-ray report finding "dense left basilar opacification probably left lower lobe infiltrate or consolidation," as well as a medical report stating that these findings were consistent with CBD. In spite of this evidence, DEEOIC forwarded the claim to a CMC for review. The claim was subsequently denied on the ground that the physician did not provide a well rationalized discussion for concluding that the findings were consistent with CBD,*

<sup>31</sup> EEOICPA specifically outlines the criteria under Part B for establishing CBD diagnosed before January 1, 1993, as well as, on or after January 1, 1993.

<sup>32</sup> A characteristic chest radiograph is further defined in PM Chapter 2-1000. 6.

*as well as on the determination of the CMC who concluded that the findings were not characteristic of CBD.<sup>33</sup>*

This AR suggested that he was aware of other instances when he was not required to submit a well-rationalized discussion that objective test findings were consistent with CBD. The AR suggested that in those other cases, a statement by the physician indicating that the findings were consistent with CBD was sufficient. In light of situations such as the case discussed above, claimants contend that they simply want a clear understanding of what they need to submit in order to prove their claims. For example, as highlighted in the case discussed above, claimants want to know if it is sufficient if the physician states that the x-ray findings are characteristic of CBD or whether the physician needs to provide a well rationalized discussion of why the x-ray findings are characteristic of CBD.

Claimants also indicate that when they question DEEOIC's consistency in the application of its rules and procedures, in response they are often told that every decision is decided on its own facts. Yet, some claimants believe that this does not fully explain many of the perceived inconsistencies that they encounter. However, since DEEOIC does not publish most of its decisions, claimants contend that it is difficult to identify possible inconsistencies. Some claimants firmly believe that inconsistencies exist and further believe that if there was a general review of DEEOIC decisions, many of these inconsistencies would come to light.<sup>34</sup>

<sup>33</sup> The final decision indicated that DEEOIC forwarded the claim to the CMC because it was unclear whether the x-ray evidence met the criteria for a characteristic chest x-ray. However, this decision did not explain why the evidence was unclear. In addition, even the CMC recognized that "consolidation" is mentioned as a radiographic pattern characteristic of CBD. See generally PM Chapter 2-1000.6 (under Alveolar Patterns on chest x-rays).

<sup>34</sup> For instance, claimants note that before DEEOIC announced that a positive or abnormal BelPT was necessary to prevail in a claim for CBD under Part E, there was a period when decisions did not apply this policy.

## VI. Exposure

Another criterion for eligibility under EEOICPA requires that the covered employee have been exposed to toxins while working at a covered facility. Issues involving exposure continue to be a source of concern for many claimants. Our discussion of issues related to exposure will first explore some of the general concerns that we received involving exposure. Following that discussion, we will discuss the study of SEM issued by the National Institute of Medicine (IOM) of the National Academies.

In general, there are two primary problems that claimants encounter while attempting to verify exposure: (1) the inability to locate exposure records; and (2) concerns with the accuracy of the records that are available. Some of the specific problems encountered by claimants include:

**Records not available:** As with employment records, claimants often find that due to the passage of time, exposure records are lost or destroyed. Moreover, as with employment records, claimants contend that these records were almost always in the sole control of the government or their employer, and thus question why the burden of proof remains on them even when the government and/or the employer cannot locate these records.

**Information never disclosed to workers:** Claimants frequently suggest that these facilities generally operated on a “need to know basis.” Therefore, claimants often assure us that no one ever informed them of, and they knew better than to ask for, the names of the various toxins to which they were exposed. In fact, we routinely encounter claimants who are truly surprised when they finally realize all of the toxins to which they were exposed.

**Existing records not accurate:** Although claimants may not know the name of every toxin to which they were exposed, when they review existing records they can often recognize that these records are not accurate, or do not provide a full account of certain accidents/incidents. A common inquiry that we encounter questions the sources relied upon when preparing these lists of toxins. Claimants strongly believe that DEEOIC should seek more input from former workers in developing these lists.

In light of the problems that they encounter attempting to establish sufficient exposure, there are certain grievances that we routinely hear. These grievances include:

- **Concerns with the system for updating exposure information:** Some claimants not only question the accuracy of existing exposure records, they also have information that they believe could be relevant to these discussions. We continue to hear from claimants who contend that when they submit documents addressing additional exposures, they receive little, if any feedback from DEEOIC concerning these submissions. We especially hear these concerns from claimants who submit evidence in an effort to update the SEM database. The SEM website provides a link with which claimants can submit additional (unclassified) site-related or illness-related information. It concerns claimants when they submit additional information for review and DEEOIC does not acknowledge receipt of the information, and does not inform the claimant

whether the information proved useful.<sup>35</sup> The webpage for SEM states that, “[i]ndividuals submitting information for review will only be contacted in the event additional documentation is required.”<sup>36</sup> In response some claimants argue that if they are never advised of the results of their first submissions (and if their first submissions are never acknowledged), they are less likely to submit information in the future.

- **Not utilizing the best sources:** Some claimants question whether in determining the toxins used at a work site, the government gives too much credence to manuals and other official documents and not enough credence to (and devotes too little time in trying to obtain the input of) the people who actually performed the work. A frequent comment suggests that in many instances, the procedures outlined in these manuals and other official documents bears little resemblance to what actually occurred at the facility on a daily basis. It is further suggested that even where the manual or document is accurate, there were often widely accepted exceptions/ deviations that routinely occurred, yet no one ever took the time to record these exceptions/ deviations. Accordingly, claimants argue that there needs to be more input from the workers in determining the toxins used at various facilities, and in identifying the job categories that came into contact with various toxins.

The discussion below highlights many of the concerns that arise when endeavoring to verify exposure. In this case, some former workers take exception with the determination that guards at Line 1 of the Burlington Plant were not exposed to any known toxins.

*At one time the SEM for the Iowa Ordnance Plant (Line 1) listed certain toxins to which security guards were exposed.<sup>37</sup> However, a subsequent determination that the correct job title was “Guard,” not “Security Guard” resulted in the conclusion by DEEOIC that there were no known toxins to which a “Guard” at Line 1 was exposed. At least five former guards contacted the Office to question the information relied upon in reaching this determination. These former guards assure us that based on their conversations with other former colleagues it does not appear that DEEOIC sought the input of these former workers prior to instituting this change. Thus, these former guards question whether DEEOIC is giving too much weight to the mere title attached to the job – and not fully exploring what was required to perform this job.*

*These former workers also find it troubling that they have encountered so much difficulty attempting to locate the documentation DEEOIC relied upon in making this change. A couple of former workers initially submitted Freedom of Information Act [FOIA] requests to DEEOIC for the documents relied upon in making this change. In response, DEEOIC informed these workers that DOE had primary interest in maintaining control over these records and the information*

35 In the specific instances brought to our attention, it is not clear if claimants received confirmation that DEEOIC received the submission.

36 While this statement is now on the webpage, it is not clear if this statement was always on the webpage.

37 SEM is updated from time to time. However, once SEM is updated, the public does not have access to the older version of SEM. With respect to the issue of “guards” at Line 1, more than one claimant has assured us that there was a time when SEM listed certain toxins to which security guards were exposed. This Office does not have the ability to independently verify this assertion.

*contained therein. In one instance DEEOIC then forwarded the FOIA request to DOE. In the other instance, the claimant was advised to contact DOE. In both instances, DOE subsequently responded indicating that they could not locate any relevant documents. In one instant, the claimant was then advised to contact NIOSH. This claimant is still awaiting a final response from NIOSH.*

As one might imagine, on top of the fact that they disagree with the determination that in the course of their jobs they were not exposed to any toxins, these employees also find it troubling that they have encountered such difficulties obtaining copies of the documents relied upon by DEEOIC to make this change in the SEM database. These employees believe that the difficulty locating documents has already hampered their ability to adequately respond to the denials of their claims, and some are starting to question whether they will ever receive sufficient documentation to fully review this determination.<sup>38</sup>

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<sup>38</sup> These claimants recognize that they could challenge this decision without the documentation that they are awaiting. However, these claimants believe that challenging this determination without the opportunity to review the documentation relied upon in making this change would be futile.

## VII. Issues related to establishing exposure to toxins

**SEM DATABASE** – Under Part E, in order to establish eligibility, among other requirements, a DOE contractor or subcontractor employee must submit evidence establishing that it is at least as likely as not that exposure to a toxic substance at a covered DOE facility was a significant factor in causing, contributing to, or aggravating their illness; and it is at least as likely as not that exposure to such toxic substance was related to employment at a DOE facility. See 42 U.S.C. § 7385s-4(c). DEEOIC created the SEM database as a tool to assist claims examiners in the development and adjudication of claims for benefits under Part E. In 2010 DEEOIC released an expanded version of the SEM database to the public, which, according to DEEOIC, substantively mirrors the internal SEM database available to claims examiners.

As in years past, during 2013 claimants and their authorized representatives (ARs) contacted the Office with questions such as (a) what is the source(s) for the information in SEM; (b) whether the information in SEM is accurate; (c) how to use SEM; (d) whether the information claimants submit to DEEOIC is ever included in SEM; and (e) whether DEEOIC properly utilizes (applies) the SEM database during the claim adjudication process. In fact, for years this Office received very specific and sometimes very technical questions and complaints addressing the scientific basis for SEM, to which we could not locate any clear and precise answer. However, on March 27, 2013, the Institute of Medicine (IOM) of the National Academies published a *Review of the Department of Labor's Site Exposure Matrices Database* which addressed many of the questions and complaints that we had received over the years. <http://www.iom.edu/Reports/2013/Review-of-the-Department-of-Labor-Site-Exposure-Matrix-Database.aspx>.

In June 2010, DEEOIC approached the National Academy of Sciences' IOM to conduct a study of the scientific rigor of the relationships between exposure to toxic substances and occupational diseases cited in SEM and to make recommendations on ways in which the SEM database can be improved. See IOM Report, page 20. To complete its task, the IOM formed an ad hoc committee of experts from a range of disciplines to conduct an 18-month study to review the scientific rigor of the SEM database. See IOM Report, page 20. As the IOM makes clear in the discussion of its charge, the focus of its study was to review the SEM database and the HAZ-MAP database as the source of toxic substance-occupational disease links in SEM. The report concludes with specific recommendations for addressing weaknesses in SEM and Haz-Map, and answers the eight (8) questions which are identified as Tasks. The DEEOIC issued a response to the IOM Report, which can be found on the homepage of the DEEOIC website. <http://www.dol.gov/owcp/energy/regs/compliance/pressreleases/esa20130328.htm>.

When it comes to SEM, one of the most frequent inquiries we receive questions the scientific basis for the links in SEM between toxic substances and diseases. According to the IOM Report, SEM imports information solely from the Haz-Map "Disease" database into the toxic substance-occupational disease links in SEM. See IOM Report, page 5, 11, 97. The Haz-Map database was developed in 1991 by Jay Brown, M.D., a physician board certified in occupational medicine. See IOM Report, pages 25 and 26. Haz-Map was not designed for compensation purposes, and was privately developed and maintained by Dr. Brown from 1991 to 2002. See IOM Report, page 4.

Since 2002, the National Library of Medicine (NLM) has published Haz-Map on its website, where its content is periodically updated with revisions provided by Dr. Brown. See IOM Report, page 4.<sup>39</sup>

The IOM Committee first reviewed the Haz-Map “Disease” database and reported the following limitations:

- Lack of transparency as to the information reviewed, the source of this information, and how this information is evaluated for each toxic substance- occupational disease link<sup>40</sup>;
- Lack of formal criteria for determining the hazardous agent-occupational disease links;
- Lack of a clear weight-of-evidence approach;
- Haz-Map lacks adequate oversight or content review by external, independent experts. (The IOM Report also noted that there was no disclaimer on the Haz-Map home page at the NLM website indicating that it is not peer-reviewed or that NLM is not responsible for its content);
- Many of the references used for Haz-Map are not easily accessible to the general public which makes it difficult to verify the information;
- Lack of clarity on what toxic substances and data fields have been updated by the Haz-Map developer; and
- The “Diseases” field of Haz-Map, which contains the toxic substance-occupational diseases links used in SEM, does not capture information on exposures that aggravate or contribute to disease. Rather this field only contains links the developer determined establish a causal connection between a toxic substance and disease. See IOM Report, pages 26, 43, 75.

Consistent with the concerns expressed to this Office, the IOM Committee noted that not all of the Haz-Map information sources are available online to the general public, which makes it difficult to determine whether the most current information has been used for a database record, when a record was last updated, and what changes were made to the record. The Committee also noted that most of the textbooks cited in Haz-Map are not available online or in many libraries and reference collections, including DOLs and many university medical libraries.

While DEEOIC recognizes that the toxic substance-disease links in SEM only analyze whether toxic exposure caused an illness, and that SEM cannot be used to analyze whether toxic substance exposure aggravated or contributed to an illness, this fact is not readily available or explained to users of SEM. The IOM Committee further noted that the Haz-Map database uses strict criteria for identifying toxic substances that cause cancer, but has ambiguous criteria for identifying toxic substances that cause diseases other than cancer. See IOM Report, page 4.

<sup>39</sup> The IOM Report notes that concerns by claimants regarding SEM have, over time, prompted investigative reports, congressional inquiries, a report by the Government Accounting Office, and several reports on the EEOICPA claims process from this Office, ultimately prompting DOL to seek an assessment of SEM. See IOM Report, page 20

<sup>40</sup> The IOM Report found the exception to be the International Agency for Research on Cancer (IARC) classifications for carcinogens.

These findings by the IOM appear to offer some credence to concerns raised by claimants who often contacted us to question a CE's application of SEM. A common scenario that we encountered involved situations where DEEOIC did not accept the evidence submitted by a claimant concluding that toxic substance exposure was a significant factor in the worker's illness. Claimants often note that in rejecting this evidence, the decision issued by DEEOIC merely refers to SEM (and sometimes to other unidentified evidence). However, since SEM only addresses causation, claimants often question whether SEM was erroneously relied upon by the CE to conclude that their toxic exposure had not aggravated or contributed to their illness.<sup>41</sup>

The IOM Report further states that when claimants access the Haz-Map database from the SEM database they are directed to the Haz-Map website found on the National Library of Medicine (NLM) website at <http://hazmap.nlm.nih.gov>. Moreover, once Haz-Map is accessed from the NLM website, it is possible to then access the developer's separate Haz-Map website at [www.haz-map.com](http://www.haz-map.com). The matter of two separate Haz-Map websites further illustrates the consistent complaints that this Office receives from claimants regarding their inability to determine where to look for the basic information that DEEOIC uses to adjudicate their claims; and the lack of transparency regarding the underlying scientific basis for the contents of SEM.

The IOM Committee specifically recommended that DEEOIC document the scientific evidence used for the toxic substance-disease links so that the user can verify the information and determine its accuracy, validity, and credibility, and its use of the most comprehensive and current information. Without identification of all sources of the underlying information, the accuracy and timeliness of the links cannot be determined. See IOM Report, page 96.

Overall, the IOM Report identified the following Major Weaknesses in SEM: See IOM page 5 and 65:

- Difficulties in accessing information, for example, the SEM database is not directly accessible from the DEEOIC homepage, See also IOM Report, page 66;
- Lack of exposure information for toxic substances;
- Inability to handle complex exposures, including exposures to mixtures;
- Lack of clarity regarding why certain links are missing – links may be missing because there is (1) ambiguous criteria for establishing the links in Haz-Map, (2) lack of consistency between the Haz-Map "Diseases" field and the SEM "Special Health Effects" field for some substances, and (3) delays in updating links in Haz-Map and thus in SEM;
- Incomplete or inconsistent exposure profiles for particular locations and jobs;
- Failure to consider epidemiological studies of DOE workers;

<sup>41</sup> We especially encounter this concern where the recommended and or final decision does not specifically address other evidence that concludes that toxic substance exposure was not a significant factor in aggravating or contributing to the illness.

- The sole use of Haz-Map for toxic substance-occupational disease links, which is problematic because Haz-Map lacks external peer review; lacks transparent references and supporting documentation; lacks explicit causal criteria for non-cancer diseases; and does not indicate the use of weight-of-evidence evaluations. See also IOM Report, page 75.

The IOM Report also acknowledges the existence of a private, internal DEEOIC version of SEM used by claims examiners and a separate version of SEM available online to the general public. The IOM Committee only used the public version of SEM for its review. See IOM Report, pages 52 and 55. According to DEEOIC, there are no longer differences between the content of the public and the internal SEM databases. See IOM Report, page 52. However, DEEOIC acknowledges a six-month lag time exists before data from the internal DEEOIC SEM is updated to the public SEM. Nevertheless, it has been brought to the attention of this Office that EEOICPA Bulletin 08-38, Rescinding Bulletins 6-10 and 6-14 (June 25, 2008) may address another potential distinction in the two versions of SEM. Bulletin 08-38 states that programmatic changes to SEM may or may not require the issuance of a Final Bulletin, but in either case,

*...SEM updates with policy implications will be evident by the appearance of the small DOL icon in the "References" column in the SEM search result page. The appearance of the DOL icon will inform the CE [claims examiner] that policy guidance is present regarding a given subject in SEM and the CE must review the policy statement before proceeding further.*

The current public version of SEM does not appear to include the DOL icon in the References column of data searches. Therefore, it is unclear if claimants have access to the policy guidance regarding SEM data that informs the CEs adjudicating their claims for benefits.

In addition, claimants complain that their suggestions and submissions of new evidence to DEEOIC regarding SEM sometimes are not addressed. The IOM committee reported that DEEOIC has a structured internal process for reviewing submitted information, but no formal external review process. See IOM Report, page 61. Therefore, claimants remain unaware and are not made part of the process by which their evidence is considered for use in SEM.<sup>42</sup>

The Report further noted that according to DEEOIC, before a toxic substance-disease link is added to SEM it is reviewed by the Haz-Map developer for inclusion in Haz-Map, and if the Haz-Map developer accepts the link, the occupational disease is added to Haz-Map, and then, only after review and approval by DOE is it added to SEM. See IOM Report, page 61 and 62. Yet, as the Report found, although the DEEOIC SEM contractor is to ensure that the Haz-Map information used in SEM is properly managed, evaluated, and input into the system in a timely manner, there are no contractual specifications as to what is meant by "evaluated" nor is there any requirement that any of the information be formally or informally peer reviewed at any point in the update process. See IOM Report, page 63.

<sup>42</sup> The SEM website informs individuals that, "[i]ndividuals submitting information for review will only be contacted in the event additional documentation is required."

Thus, the IOM Report contains three primary recommendations for improving the Toxic Substance-Disease links in SEM, each of which contains numerous specific recommendations. The primary recommendations are as follows:

- 1) Add supplemental information sources to the health effects information imported from Haz-Map.

Supplemental data sources are necessary to provide a more comprehensive picture of the adverse effects that may be associated with exposure to the toxic substances found at DOE sites. The Report then identifies two types of information that might be used to supplement the health effects data field imported from Haz-Map: (1) bibliographic information; and (2) evaluative information. The IOM committee acknowledges that some sources of evaluative information are already used to make the Haz-Map reference list, but the use of this information does not appear to be systematic or comprehensive. In the opinion of the IOM Committee, the advantage of evaluative databases and documents is that they typically use a weight-of-evidence approach to draw conclusions about the strength of an association between exposure to a toxic substance and a disease. They also typically have a defined method, describe the evidence based of their conclusions, and, for the most part, are periodically updated with new evidence and documentation of whatever changes have been made in the conclusions. See IOM Report, pages 99 to 101.

- 2) Improve the structure and function of SEM, including the addition of available exposure information.

First, the IOM Committee believes that the current links between a toxic substance and an occupational disease must be appropriately referenced whether in SEM, Haz-Map, or preferably both databases. The committee found several statements addressing NLM involvement in SEM to be misleading and recommends that they be corrected. See IOM Report, page 101. Second, in order to link to the expanded SEM the user must first choose a specific DOE site. The committee suggests that the SEM search capabilities could be improved by providing a direct link on DEEOIC's homepage to the expanded database without first requiring the user to choose a specific DOE site. In addition, while SEM generally indicates when a record was last updated, users cannot discern the specific information or field that was updated. This lack of information makes it extremely difficult for the user to know if and when the most current information was incorporated into the database. Finally, the IOM Committee noted that information on the nature of possible exposures to toxic substances at each DOE site is absent. For example, to help evaluate whether an individual's disease might result from occupational exposures requires information on the duration, intensity, frequency, and route of exposure. The IOM Committee found that none of this exposure information, such as monitoring data, is currently in SEM, and suggested that inclusion of such information, if available, would enhance the utility of the database for both claimants and claims examiners. See IOM Report, pages 101 to 103.

- 3) Use an external advisory panel to review the health effects information in SEM.

In order to accomplish the two major recommendations previously discussed, the IOM Committee recommended that DEEOIC establish an expert advisory panel. The IOM Committee noted that this is not the first time that such a panel was suggested (e.g., 2010 GAO report; H.R. 1030).

Moreover, citing to the Advisory Board for Radiation Worker Health, the Committee noted that there is precedent under Part B for such a panel. According to the Committee, the primary function of the advisory panel would be to peer review the toxic substance-occupational disease links. The Report further suggested that the panel be broad-based, external to DEEOIC and its current SEM contractor, with membership including such expertise as epidemiology, occupational medicine, toxicology, and industrial hygiene. The IOM Committee also recommended inclusion of claimants and advocacy organization representation on this panel. The report discusses, in detail, the four immediate tasks for such an expert advisory panel, See IOM Report, page 103; and five ongoing responsibilities for such a panel in support of Part E of the EEOICPA. See IOM Report, page 104. Finally, the IOM Committee explained that DEEOIC need not develop its peer review process de novo, and outlined three approaches to institute a peer review process for SEM, noting that a major feature of each option is that all information and actions would be documented so that the evidence base used to make decisions on toxic substances-occupational disease links could be reviewed by others and would be easy to understand. See IOM Report, page 105.

The Tasks outlined in the IOM Report add further information that this Office can share with claimants in response to questions they pose during the year. For instance,

- a) What are the strengths and weaknesses of the NIH/NLM peer review process with regard to Haz-Map? How might this process be improved? There is no NIH or NLM peer review process for Haz-Map. The IOM finds that this is a critical weakness for the database. The NLM is merely a platform for Haz-Map, and has little involvement in content. There are several options for a peer review process for both Haz-Map and SEM. See IOM Report, page 109.
- b) What consistent process or approach could be used to consider a disease or cancer established when studies are inconclusive, inconsistent, or conflicted? The IOM Committee strongly recommends that an expert advisory panel be established to review the evidence on any potential toxic substance-disease link. Such a panel, using a weight-of-evidence approach, could determine how to assess inconclusive, inconsistent, or conflicted studies for purposes of evaluating whether there is a causal link. The panel may wish to develop its own criteria for weighing evidence or use criteria established by other authoritative organizations, such as IARC, NTP, and IOM. See IOM Report, pages 109 to 110.

Furthermore, on February 21, 2013, DEEOIC issued EEOICPA Bulletin 13-02, Systematic Review of Denied Part E Cases. Thereafter, on February 21, 2013 and August 29, 2013, DEEOIC issued EEOICPA Circulars 13-06 and 13-12, Review of Denied Bladder Cancer Cases under Part E, and Review of Denied Ovarian Cancer Cases under Part E, respectively. Claimants question how long it will take DEEOIC to review all the denied bladder and ovarian cancer claims. Claimants also question how long it will take DEEOIC to review other previously denied illnesses after SEM data has been updated. The fear is that if this review is conducted one illness at a time the review process could take years to complete. In addition, claimants question whether DEEOIC intends to contact them to let them know when their case is under review and if DEEOIC intends to notify them of the results of this review.<sup>43</sup>

<sup>43</sup> As discussed earlier, when a new SEC is announced, DEEOIC conducts a review of all previously denied claims that are potentially impacted by the new SEC. However, claimants are only notified if DEEOIC determines that the new SEC impacts the previous decision.

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**Per EEOICP Bulletin 13-02, Systematic Review of Denied Part E Cases, it appears that claimants will be contacted if DEEOIC's review determines that there is something new that affects the claim, thus necessitating a reopening of the claim.**

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While claimants believe that, in light of the IOM Report, DEEOIC will make changes, there is a concern that without oversight it will be difficult to determine if these changes fully address the issues outlined in the IOM Report.

The Office of the Ombudsman commends DEEOIC for authorizing this Report and we appreciate the detail and specificity of the IOM Report. More importantly, claimants believe that this Report supports the concerns that they have raised for years regarding the scientific basis for SEM, and the use of SEM by DEEOIC in the claims adjudication process. Claimants hope that DEEOIC takes meaningful actions consistent with the recommendations outlined in the Report.

## VIII. Causation

To establish eligibility under Part E, the evidence must establish a link between the worker's exposure to a toxic substance and the worker's illness or death. In order to satisfy the burden of establishing this link, the evidence must demonstrate that it is "at least as likely as not" that exposure to a toxic substance 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. The burden of proof under Part E continues to be a source of confusion.

- **Not what claimants expected:** When they first hear of EEOICPA, many individuals come away with the belief that this program compensates any worker ever employed at a covered facility who now suffers from an occupational illness. It often comes as a surprise when these individuals discover that, among other requirements, they must establish a link between the illness and a toxic substance to which the worker was exposed while working at the covered facility.
- **An unrealistic burden:** When informed that they must establish a link between the illness and a work-related toxic substance, some claimants respond citing to the enormity of this task. Claimants argue that it is not realistic to expect them to develop/locate the technical medical and scientific evidence needed to establish these links.<sup>44</sup> They also suggest that with so many potential toxic substances and illnesses it is unrealistic to believe that there is medical literature addressing the potential link between every conceivable toxic substance and every possible illness. In fact, in support of this suggestion one claimant this year cited to DEEOIC Bulletin 08-38 wherein it states that, "[s]ome chemicals used in the production of nuclear weapons are so unique and exotic that no broad-based studies of their health effects exists..."
- **More assistance:** While the SEM database contains information addressing scientifically established links between toxic substances and recognized occupational illnesses, claimants routinely suggest that more assistance is needed. These comments often come from individuals who question the accuracy of the information contained in SEM. These individuals generally believe that the information included in SEM needs to be more thoroughly vetted to ensure accuracy.

However, concerns with SEM are not the only issues that we hear from those who encounter difficulties establishing causation. Claimants also contend that it can be difficult to locate the technical and scientific evidence needed to link a particular illness to a specific toxic substance. Some claimants suggest that Section 7384v(a)(2) specifically mandates the government to make efforts to obtain information addressing the link between toxic substances and recognized occupational illnesses and thus question whether the current version of SEM fully meets the intent of this provision.<sup>45</sup>

<sup>44</sup> Claimants further contend that obtaining such reports can sometimes be cost prohibitive. Some claimants assure us that even though they may be reimbursed if they eventually prevail, they do not have the resources to incur such expenses.

<sup>45</sup> Pursuant to 42 U.S.C. §7384v(a)(2), the President shall provide assistance to the claimant in connection with the claim, including, such other assistance as may be required to develop facts pertinent to the claim.

- **Claimants do not understand the causation standard:** By far the most common issue that we encounter involving causation concerns the lack of understanding by claimants as to what evidence is required to satisfy their burden of proof.
- **Information addressing causation difficult to locate:** As mentioned earlier, some claimants start the EEOICPA claims process with a limited understanding of this program and how it operates. When they attempt to learn more about the program, some claimants find it difficult to locate the information they need, and others tell us that the information that they find is sometimes difficult to understand. Claimants fully appreciate that with so many rules, it is impossible to prominently display every rule that could impact a claim. Nevertheless, they believe that there are certain basic rules concerning EEOICPA that ought to be prominently posted and worded so that claimants can understand. A discussion of the evidence needed to establish a link between an employee's toxic exposure and his illness is one example of that basic information that some claimants believe ought to be more readily available. In addition, claimants believe that this information ought to be explained using language that can be easily understood. Other feedback suggested that the evidence needed to establish causation be given more emphasis at outreach events. The people expressing these comments felt that the importance of this causal link was sometimes minimized in discussions of EEOICPA.
- **Apprised of the burden of causation far too late in the claims process.** As discussed on page 20, some prospective claimants only wish to file an EEOICPA claim if they earnestly believe they are entitled to compensation and/or benefits. Therefore, some prospective claimants first seek a medical opinion and only file a claim if that medical opinion concludes that their illness is related to toxic exposures at work. This approach can lead to problems if DEEOIC subsequently determines that this report is insufficient to establish causation. Often when DEEOIC determines that medical evidence is insufficient, it provides the claimant with a letter outlining what is needed to establish causation. In response to these letters claimants frequently ask why the information outlined in these letters was not made available sooner. Claimants maintain that with earlier access to this information, they could have provided it to the physician when they sought the initial report, thereby expediting their claim and avoiding the need for a second/ revised opinion.<sup>46</sup>
- **Claimants do not know how to interpret the data in SEM.** We continue to encounter claimants who believe that if SEM demonstrates a link between a toxin and their illness, then causation is established. Unfortunately, this is not the case. In response claimants assert that it would be helpful if DEEOIC provided a clear and concise explanation of how to use (and interpret) the information found in SEM.
- **Is evidence properly evaluated under SEM:** As discussed in more detail in the discussion of the IOM review of SEM found at Chapter VII, claimants question the evidence relied upon to find that there is no causal link between an illness and a toxic substance. Claimants suggest that there are instances where the evidence that DEEOIC relies upon to discredit the evidence finding

<sup>46</sup> Claimants note that while DOL may reimburse them for the second medical report if the claim prevails, they will pay for two medical reports if the claim is not successful.

a link only address direct causation – i.e., whether exposure to the toxic substance caused the illness. Claimants note that causation under Part E is established if exposure caused, aggravated, or contributed to an illness. Thus, evidence that only addresses whether exposure caused the illness does not fully address the causation standard and as a result claimants question whether DEEOIC's evidence fully rebuts the medical evidence finding such a link via contribution or aggravation. Even before the issuance of the IOM report some claimants believed that an independent oversight (or advisory board) was necessary to determine whether DEEOIC properly evaluated evidence under the Part E causation standard. These claimants believe that the IOM report verifies many, if not all of their concerns and bolsters the need for independent oversight via an advisory board.

- **Relevance of animal and environmental studies.** We occasionally are approached by claimants who contend that in determining whether the evidence establishes a link between exposure to a toxic substance and an illness, DEEOIC summarily dismisses animal or environmental studies. In this regard, claimants note that EEOICP Bulletin NO. 08-38 provides in relevant part,

*...Animal and environmental studies may also be useful in certain circumstances. Some chemicals used in the production of nuclear weapons are so unique and exotic that no broad-based studies of their health effects exist; therefore, animal and environmental studies must be assessed for possible program-wide applications.*

There are claimants who believe that in spite of Bulletin 08-30, animal or environmental studies were summarily rejected simply because it was an animal or environmental study, or were rejected without an explanation.<sup>47</sup>

<sup>47</sup> The IOM Report also questions DEEOIC's failure to incorporate epidemiological studies of DOE workers into SEM, with the exception of studies regarding the toxic substance, mercury. See IOM Report, page 74.

## IX. Special Exposure Cohort (SEC)

Generally a dose reconstruction is conducted on all cancer claims filed under EEOICPA.<sup>48</sup> The exception is when the employee qualifies for inclusion in a SEC class. Where an employee qualifies for inclusion in a SEC class, he can be compensated without the completion of a dose reconstruction and without a determination of the probability of causation (PoC). In order to qualify for inclusion in a SEC class, the employee must have worked at SEC facilities for a specified period of time and in some instances, must meet certain employment criteria.

EEOICPA originally established four (4) SEC classes.<sup>49</sup> However, EEOICPA also authorized the Secretary of Health and Human Services (HHS) to add other classes of employees to the SEC. Since the inception of this program HHS has added close to 80 additional classes. In calendar year 2013, nine (9) additional classes were added:

Site	Petition Filed	Effective Date of SEC
Oak Ridge National Laboratory (X-10)	July 18, 2011	January 6, 2013
Los Alamos National Laboratory	April 3, 2008	January 6, 2013
Mound Plant	August 15, 2012	January 6, 2013
Nuclear Metal, Inc.,	October 20, 2011	January 6, 2013
Joslyn Manufacturing and Supply Co.	March 15, 2012	April 5, 2013
Baker Brothers	June 5, 2012	April 5, 2013
Battelle Laboratories, King Avenue	October 26, 2012	April 5, 2013
Feed Materials Production Center	December 12, 2005	October 30, 2013
Pantex Plant	September 8, 2006	October 30, 2013

SEC process takes too long: In our 2012 annual report, we addressed complaints alleging that the SEC process sometimes took too long. At that time, we noted that claimants contacted us with concerns regarding three sites. Here is an update of those sites:

Site	Petition Filed	Final Action	Effective Date
Weldon Spring Plant, MO	April 29, 2009	Denied	December 28, 2012
United Nuclear Corporation, MO	June 19, 2008	Denied	January 2, 2013
General Steel Industries, IL	February 25, 2008	Denied	March 26, 2013

<sup>48</sup> A dose reconstruction is conducted on a claim for cancer provided that covered employment is established. The exception arises when the claim qualifies for inclusion in a SEC class.

<sup>49</sup> DOE employees, as well as DOE contractors and subcontractors employed prior to January 1, 1974 on Amchitka Island, Alaska; and DOE contractor and subcontractor employees employed for an aggregate of at least 250 work days prior to February 1, 1992, at the gaseous diffusion plants in Paducah, Kentucky, Portsmouth, Ohio, or Oak Ridge, Tennessee.

As we prepare this report, there are three outstanding SEC petitions that qualified for evaluation and are currently active in the SEC petition process:

Site	Petition Filed	Petition Qualified for Evaluation
Rocky Flats Plant	August 23, 2011	February 9, 2012
Kansas City Plant	March 12, 2013	July 1, 2013
Sandia National Laboratories (Livermore California)	August 22, 2013	August 28, 2013

**Establishing 250 days:** For inclusion in a SEC class, the employee must have worked at SEC sites for a specified period of time. In most instances this period of time is 250 work days. While this may not seem like a long period of time, some claimants encounter difficulties establishing the requisite period of time. While problems establishing the requisite period of time are not limited to certain employees, this Office tends to encounter this problem more often with employees who traveled to various sites and thus did not have a permanent presence at any one site (such as couriers), as well as those who did not work “normal” shifts. Laboratory workers are examples of this latter group. Lab workers often assert that they did not work eight (8) hour shifts, but rather came to the lab as often as needed and stayed as long as needed to complete a project. Therefore, lab workers argue that it is not fair to hold them to information recorded on time sheets, especially since some of the other employees who worked can attest that these records are not an accurate reflection of the actual time spent on these projects.

**Claimants not notified when new SECs are added:** When a new SEC class is added, a notice is posted in the Federal Register and an announcement is posted on DEEOIC’s website. On many, but not all occasions, DEEOIC also sponsors an outreach event to announce a new SEC. These events are usually held in a location near the facility. In addition, whenever a new SEC class is added, DEEOIC automatically identifies previously denied claims impacted by this change and re-reviews these claims for inclusion in the new SEC class.

Where DEEOIC’s re-review determines that a claim is not impacted by a new SEC class, the claimant is not notified. As a result, when some individuals finally learn of a new SEC, they contact our Office asking what, if any action was taken on their claim in light of the new SEC. When informed that a re-review by DEEOIC determined that their claim was not impacted by the new SEC, some inquirers then ask why they were never informed of DEEOIC’s determination. Some of these individuals also question why prior to DEEOIC’s re-review they were not provided an opportunity to submit additional evidence and comments. In support of these questions, some claimants note that where the prospect of prevailing on their earlier claim was dim, they may not have developed the claim as thoroughly as possible. These claimants argue that had they been aware that DEEOIC was going to re-review the case in light of a new SEC, there was additional relevant evidence they would have presented.

**How does DEEOIC handle SEC claim decisions:** As noted above, when a new SEC is announced, DEEOIC identifies previously denied claims potentially impacted by the new SEC and determines whether the new SEC class impacts the decision in these claims. In spite of these statements, claimants approached us this year asserting that when they inquired on the status of claims

potentially impacted by a new SEC class, they were informed that there was no procedure for expediting the review of pending or previously denied claims impacted by the new SEC. Note: the instances brought to our attention all involved claims awaiting a decision by FAB. Claimants would like to know if DEEOIC expedites the review of pending and previously denied claims potentially impacted by a new SEC, and if so, if this approach applies to claims pending at the district office level, as well as claims pending decisions by FAB.

**Why only 22 specified cancers:** In order to qualify as a covered employee with cancer, where the claimant has established inclusion in an SEC class, the claimant must also establish the diagnosis of at least one of 22 specified cancers. We are contacted by people asking why there are only 22 specified cancers. Our response to these claimants has consistently been that the specified cancers are defined in the EEOICPA. Most of the inquiries that we received this year focused on recent changes affecting chronic lymphocytic leukemia (CLL).

**Chronic lymphocytic leukemia.** While EEOICPA specifically excludes CLL from the list of specified cancers, see 42 U.S.C. §7384l(17), NIOSH also had its own regulation excluding CLL from dose reconstructions. As more literature challenging this notion was submitted, NIOSH conducted further studies. As a result of these studies in 2012 NIOSH announced a new rule designating CLL as potentially caused by radiation and therefore potentially compensable under EEOICPA. When claimants heard that NIOSH now recognized CLL as a radiogenic cancer, they assumed that this new rule would also add CLL to the list of specified cancers. Unfortunately this is not the case. The new rule simply means that claims for CLL are now forwarded to NIOSH for a dose reconstruction. Claimants believe that since CLL is now recognized as a radiogenic cancer, it ought to be added to the list of specified cancers for consideration in SEC cases. When told that in order to add CLL to this list the EEOICPA must be amended, claimants want to know whose job it is to initiate such action.

**The SEC process only assists those with one of the 22 specified cancers who have the requisite number of work days at covered facilities:**

The basis for creating a new SEC is that “it is not feasible to estimate with sufficient accuracy the radiation dose that workers included in the class received and, there is a reasonable likelihood that such radiation dose may have endangered the health of members of the class.” See 42 U.S.C. §7384q(b). Concerns arise when employees potentially covered by a SEC class are not eligible for inclusion in the class – often because they either were not diagnosed with one of the 22 specified cancers or did not work at SEC facilities for the specified period of time. Since these claims for cancer are not eligible for inclusion in the SEC class, they are forwarded to NIOSH for a dose reconstruction. Some claimants who find themselves in this situation argue that it is unfair to acknowledge that it is not feasible to estimate with sufficient accuracy the radiation dose that the employee received, and yet to forward the claim to NIOSH for a dose reconstruction.

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**Where an employee with cancer worked at SEC facilities during a covered time period, but does not qualify for inclusion in the SEC class, NIOSH conducts a partial dose reconstruction. A partial dose reconstruction is considered a complete and best estimate given the use of all reliable available data.**

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## X. Impairment/wage loss

In previous years claimants occasionally contacted us to ask why they never received any monetary compensation. When we looked into these matters, we sometimes found that these questions related to claims accepted under Part E where the claimant did not realize that in order to trigger a claim for impairment and/or wage loss he first had to submit a written request to DEEOIC.<sup>50</sup> To ensure that claimants were aware of this requirement, DEEOIC worked with its Resource Centers to notify claimants who were potentially eligible, but had never filed a claim for wage loss and/or impairment compensation. See 2009 Annual Report to Congress, March 4, 2010. At the same time DEEOIC redoubled its efforts to ensure that, where appropriate, claimants were advised of their right to apply for impairment and/or wage loss compensation. Thus, there has been a significant reduction in the claimants we encounter who are potentially eligible for impairment and/or wage loss compensation and are not aware that they first need to submit a written request.

However, there are three issues involving impairment evaluations that continue to generate concerns: (1) delays in the processing of impairment claims; (2) the inability to locate a physician to perform the evaluation; (3) instances where claimants were confused as to when and if they were eligible for increased impairment benefits.

### 1. Delays in the processing of impairment claims

When a claimant files an impairment claim, the claimant elects, in writing, whether he wants a physician of his choosing or a DEEOIC CMC to perform the impairment evaluation. In our 2012 annual report we discussed concerns from claimants and physicians alleging that where claimants elected to have a physician of their choosing perform the evaluation, it took an inordinate amount of time to obtain DEEOIC's "approval" to proceed with the evaluation. In response to these concerns, DEEOIC indicated that prior approval was not necessary to proceed with an impairment rating evaluation.

In spite of this response, claimants continued to tell us of inordinate delays in receiving "approval" for an impairment evaluation. This year, some light was finally shed on this matter when a claimant provided us with a copy of his recommended decision. The decision indicated that when a claimant files a claim for impairment and selects to have the impairment rating performed by his own physician, DEEOIC forwards a letter notifying the physician that he was selected to perform the claimant's impairment evaluation. This letter also explains to the physician the requirements for an impairment rating. See Chapter 2-1300, subchapter 5(c) of the PM. After reading this letter, we now believe that the "approval" referred to by some claimants and physicians is in fact the letter DEEOIC forwards to physicians selected to perform a claimant's impairment evaluation.<sup>51</sup>

<sup>50</sup> In claims filed by former workers under Part E, the first determination is whether to accept the claimed illness. If the claim is accepted, the former worker is entitled to medical benefits for the covered illness. Moreover, once the claim is accepted, the former workers can then file a claim for monetary compensation for impairment and/or wage loss related to the covered illness. Where a Part E claim is filed by a surviving family member, eligible survivors are entitled to a lump sum award that can vary depending upon the number of years of wage loss.

<sup>51</sup> The confusion may have been that some claimants referred to this action by DEEOIC as an "approval."

*On December . . . , 2011, the district office received your written request for an impairment evaluation. The letter stated that the impairment evaluation would be completed by . . .*

*On September . . . , 2012, the . . . District Office sent a letter to Dr. . . . authorizing the impairment evaluation for you. . . .”*

It is also worth noting that in the recommended decision that we reviewed, there was a nine month gap between when claimant submitted his request for an impairment evaluation and when DEEOIC finally forwarded the letter notifying the physician that claimant had selected him to perform the impairment evaluation. Some claimants view instances such as this as a manifestation of how the program can be unfair. These claimants contend that it is unfair that whenever they need more time, their requests are often rejected, yet when DEEOIC wants more time, the processing of the claim is delayed, and often delayed without notice, explanation, or any penalties attached.

- Claimants contend that this delay not only prolongs the processing of the claim, they also assert that it sometimes impacts their ability to utilize the physician of their choosing for the impairment evaluation. We are told of physicians who were willing to perform the impairment evaluation, but while awaiting notice from DEEOIC, either resigned or left the area. We also hear of instances where in spite of the reservations that they harbor, physicians initially agreed to perform the impairment evaluation, and later changed their mind when, consistent with their initial fears, the government was unable to expeditiously forward the necessary forms.

## **2. Inability to locate physicians**

Claimants who prefer to choose a physician to conduct the impairment evaluation sometimes contend that their efforts are hindered because they cannot locate a physician willing to perform the evaluation. In some instances, the inability to locate a physician is compounded by the fact that there simply are not a lot of physicians practicing in some areas of the country. Nevertheless, some claimants report that when they approach physicians, they are told that these physicians have no desire to provide an impairment evaluation for EEOICPA patients.<sup>52</sup>

DEEOIC is willing to discuss the program with physicians who have concerns and questions. However, this does not guarantee that a physician will ultimately agree to provide the impairment rating. In fact some claimants report that even after DEEOIC talked to the physician, the physician still refused to provide the impairment evaluation. See Chapter XIV, Section 1 for a further discussion of the problem encountered attempting to find DEEOIC’s list of enrolled physicians.

<sup>52</sup> To be clear, in many instances, the physician is unwilling to enroll in ACS. As a result, if this physician is utilized, the claimant is responsible for paying the physician. The claimant can subsequently seek reimbursement from DEEOIC. Claimants often assert that they do not have the ability to pay a physician and later seek reimbursement. In addition if the physician is not enrolled in ACS, the physician is not bound by the fee schedule outlined by DEEOIC. This means that even if the claimant directly pays the physician, the reimbursement that the claimant receives will be in accord with the fee schedule and may not fully cover what was paid to the physician.

### **3. Confused as to when and if they are eligible for increased impairment benefits**

Claimants can request a re-evaluation of their impairment every two years. In addition, a new impairment evaluation may be requested whenever DEEOIC accepts a new covered illness.

Some claimants call us because they are uncertain how to calculate two years for determining when they can request a re-evaluation. According to DEEOIC, it is two years from the previous impairment award. We encounter claimants who erroneously believe that it is two years from the date of the last impairment evaluation. We also encounter claimants who are not aware that they can request a new impairment evaluation if DEEOIC accepts a new covered illness and/or consequential illness.

## XI. The administration of the program - the evaluation of evidence

The administration of the program is at the center of a vast majority of the comments that we receive each year. These issues range from complaints contending that telephones calls were not answered to concerns with the decisions issued by DEEOIC. A major concern this year involved questions relating to the evaluation of evidence. As such we will separately address the concerns with the evaluation of evidence in this chapter and discuss the other issues concerning the administration of the program in the next chapter.

The following case illustrates many of the concerns we receive addressing the evaluation of evidence:

- o *October 2011 – claim filed for hearing loss due to organic solvent exposure. (When this case was filed, PM Chapter 2-1000.18d(2) provided that claims for hearing loss due to organic solvent exposure where the employee had less than 10 consecutive years of employment prior to 1990 must be forwarded to the National Office for specialist review).*
- o *November 2011 - recommended decision denied the claim. [Both the Remand Order dated March 2, 2012, as well as the Remand Order dated October 16, 2012, quoted the November 21, 2011 Recommended Decision as stating that “[t]he district office did not further ascertain the original date of diagnosis for the hearing loss, the solvents to which he could have been exposed, or the job category under which compensation is paid, as the employee was unable to qualify for hearing loss based upon the required criteria of 10 consecutive years of exposure”].*
- o *March 2012 – Citing Chapter 2-1000.18d(2) of the PM and it’s requirement that hearing loss due to organic solvent exposure where the employee had less than 10 consecutive years of employment completed prior to 1990 must be forwarded to the National Office for specialist review, the FAB determined that this claim should have been sent to the National Office for specialist review. Consequently, FAB remanded the Recommended Decision to the district office.*
- o *June 2012 – the second Recommended Decision denied the claim finding that a Program Specialist had opined that because the 10 consecutive year threshold was not met, absent additional evidence, no further action was necessary.<sup>53</sup>*
- o *October 2012 – specifically citing Chapter 2-1000.18d(2), FAB found that while the file was referred to the National Office for review, the statement of accepted facts failed to provide the Program Specialist (toxicologist) with a detailed discussion of the toxic substances to which the claimant may have been exposed, and that the claim should be evaluated at the National Office consistent with PM Chapter*

<sup>53</sup> The Program Specialist further noted that while claimant expressed dissatisfaction with the program guidelines, he did not submit probative scientific evidence relating to his contention that the intensity of his exposure was excessive.

*2-1000.18d(2). Thus, FAB remanded the second Recommended Decision to the district office for further development.*

- o July 2013 – The Director of DEEOIC issued an Order acknowledging the requirements outlined in Chapter 2-1000.18d(2) for the referral of certain claims to the National Office for specialist review, but stated that she [the Director] determined that automatic referral for specialist review was no longer necessary. According to this Order, “[f]or hearing loss cases that do not meet the criteria outlined in the Procedural Manual, there is nothing for a specialist to evaluate because the criteria of having exposure to certain specific organic solvents for 10 consecutive years has not been met.” The Remand Order issued by FAB in October 2012 was vacated and the case was returned to FAB for issuance of a new decision based upon review of the sufficiency of the June 2012 Recommended Decision.*
- o July 2013 – FAB issued a Final Decision denying the claim for hearing loss.*
- o September 2013 – claimant filed a request for the data relied upon in determining that automatic referral of claims where the claimant had less than 10 consecutive years of employment was no longer necessary.<sup>54</sup>*

Some common themes that we repeatedly hear when claimants contact us to question the evaluation of the evidence include:

1. Decisions are not adequately explained and/or do not identify supporting documentation.
2. Inadequate discussion of the evidence impacts a claimant’s ability to appeal.
3. DEEOIC’s evaluation of evidence is not consistent with the Act.
4. DEEOIC does not adhere to proper rule making procedures.
5. DEEOIC sets the bar too high.

## **A. Decisions are not adequately explained and/or documented:**

In our 2011 and 2012 annual reports, we recognized a significant improvement in the reasoning and documentation provided in decisions issued by DEEOIC. See 2011 Annual Report to Congress, April 16, 2012, page 48, and 2012 Annual Report to Congress, June 5, 2013, page 55. Overall, this improvement continues. Nevertheless, claimants continue to tell us of instances where they believe decisions are not well reasoned and/or do not adequately identify the documentation relied upon in reaching the conclusions. A number of these instances involve cases where the ultimate decision was based (or impacted by) a change in policy or procedure.

<sup>54</sup> In 2014 we had discussions where DEEOIC emphasized that PM Chapter 2-1000.18(d)(2) did not mandate the denial of all claims for sensorineural hearing loss where the employee had less than 10 years of consecutive employment prior to 1990. The continued confusion surrounding this issue will be addressed in the 2014 annual report

The hearing loss case discussed above is such an instance. In the opinion of this claimant, the case appears to have been impacted by a change in policy regarding the need to refer certain hearing loss cases to a program specialist. As this claimant stressed in his discussions with us, the entire discussion of this change is contained in three sentences found in the Director's Order:

*While the requirement [for review by a specialist] was applicable at the time of the decision, it has since been removed from the Procedure Manual by EEOICPA Transmittal No. 13-04, April 2013. The Director of the DEEOIC determined that it is no longer necessary for hearing loss cases with less than 10 years of employment completed prior to 1990 to be automatically referred for a specialist review. For hearing loss cases that do not meet the criteria as outlined in the Procedural Manual, there is nothing for a specialist to evaluate because the criteria of having exposures to certain specific organic solvents for 10 consecutive years has not been met.*

Claimants often stress that it is not enough just to be told that their claim was denied. Rather, claimants want to understand why the claim was denied. Thus, where their claim is impacted by a new policy or procedure, claimants want to understand the reasoning/rationale for this change. This is especially true when, from the claimant's perspective, the change was made in the midst of the adjudication of his claim. Consequently, where a claim is impacted by a new policy or procedure, claimants want the opportunity to review the policy and the documentation relied upon in making the change (or to have their own experts review the policy and underlying documentation). In our experience, when claimants are not provided an opportunity to fully review these determinations, they sometimes come up with their own explanations for these changes. And when this happens, we encounter claimants who conclude that the lack of reasoning or explanation suggests that there is in fact, little if any reasoning for the change. Moreover, a few claimants often conclude that the change was specifically made in order to deny their claim.

Hearing loss, however, is not the only instance where claimants believe that a decision was not adequately reasoned or documented.

- As discussed on pages 32 and 33, the change in SEM involving guards at Line 1 is another example where claimants contend that a change was not adequately explained and where they encountered difficulties locating the documentation relied upon in making the change.
- In another instance a decision states that, "In evaluating [the claim]...personnel records... were carefully examined in conjunction with current policy regarding research employees under the EEOICPA and Circular 12-03..." The claimant found it troubling that the decision did not discuss how the policy impacted the claim.
- DEEOIC policy teleconference notes were another source of concern this year. There are claimants who believe that the ultimate outcome of their claim was directly impacted by policy teleconference notes. Since they believe that teleconference notes were a factor in adjudicating their claim, claimants often want the opportunity to review these notes. Therefore, it concerns claimants when their requests for copies of these notes are denied. Claimants have indicated that their requests for copies of these notes were denied on the ground that these communications are pre-decisional in nature and thus not intended to

be final opinions or final statements of agency policy.<sup>55</sup> We encounter claimants who allege that their claim was proceeding in one direction and took a decidedly different direction following a policy teleconference note. In fact some claimants believe that there are instances where CEs or HRs strictly adhered to statements in a policy teleconference note as the final statement of agency policy. Accordingly, some claimants take issue with the suggestion that policy teleconference notes are pre-decisional and not intended as final statements of agency policy.

The use of policy teleconference notes causes some claimants to ask who is actually making the decision in their claim. Claimants argue that they are led to believe that the CEs and the HRs review and decide cases. Therefore, they find it troubling whenever it appears that a policy teleconference note or other input from the National Office re-directed or over-ruled the decision of the CE or HR. Claimants suggest that it is unfair to decide claims relying on information that is not readily available and to which the claimant is not afforded an opportunity to respond.

- Claimants also have concerns with the procedures for forwarding claims to CMCs. In particular claimants frequently complain that it was not until the CMC issued his report (and sometimes not until the recommended decision issued) that they became aware that DEEOIC had forwarded their claim to a CMC. Claimants also assert that when they finally discover that their case was forwarded to a CMC, oftentimes little, if any reasoning is provided to explain why the referral was necessary. This is another instance where in the absence of a reason for an action, claimants sometimes come up with their own reasons/explanations, some of which do not cast DEEOIC in the best light.

One such instance was discussed on page 30. Since the record contained an x-ray along with an opinion from a physician stating that the x-ray was consistent with CBD, the claimant questioned why it was necessary to forward the claim to a CMC for a review of the x-ray evidence.

## **B. Inadequate discussion of the evidence impacts the ability to appeal**

Claimants further contend that not only is it difficult to understand a decision that is not fully explained, it is also hard to determine if and how to respond to such decisions. Claimants routinely note that when they approach DEEOIC to raise challenges, they are often advised of their right to appeal these decisions. Claimants note that this “right” is severely hampered when DEEOIC fails to provide a reasoned explanation for its determinations and/or when claimants encounter difficulties obtaining copies of the documents relied upon in reaching these determinations. We talk to claimants who suggest that it is futile to challenge a decision if you do not have a copy of the policy (or procedure) that DEEOIC cited in making its determination and/or if you are unable to review (or have your expert review) the documentation relied upon in making that determination. For instance, in the hearing loss case discussed above, the claimant notes that his request for documents

<sup>55</sup> Claimants indicated that they were also told that policy teleconference notes were protected under the “attorney-client privilege” and were exempt in accordance with Exemption 5 under FOIA

was answered approximately two weeks before his hearing. This claimant contends that there is no way that he will be able to develop a credible response in this short amount of time.<sup>56</sup>

On the other hand, we encounter other claimants who maintain that they do not have the energy, the expertise, and/or the money to work with experts to develop the evidence needed to challenge what are often medical, scientific and/or legal determinations. For this reason some claimants are in favor of an independent body with the authority to review policy and other determinations made by DEEOIC.<sup>57</sup>

### **C. DEEOIC's evaluation of evidence is not consistent with the Act**

Claimants also contacted the Office to question whether DEEOIC's evaluation of evidence was consistent with the Act. One such instance, already discussed on page 28 concerns the criteria for diagnosing CBD under Part E. Claimants note that while Congress established specific criteria for diagnosing CBD under Part B, Congress did not set forth any criteria for diagnosing CBD under Part E. Consequently, claimants question whether it is appropriate for DEEOIC to establish criteria for CBD in Part E claims when Congress could have, but chose not to impose any such criteria.

Claimants also question whether it is consistent with the Act to require a medical report of tissue sample in order to diagnose cancer, (see the discussion on page 27), especially in those cases where these samples were destroyed before this program was created (or before the claimant was notified of the program).<sup>58</sup>

### **D. DEEOIC does not adhere to proper rule making procedures**

Claimants believe that there are instances where the guidance outlined in the PM or in policy teleconference notes are binding on all claims (or a large number of claims). Where procedures or policies are binding on all claims (or a large number of claims), claimants question whether DEEOIC should follow the procedures outlined for rule-making. In the opinion of claimants, an adherence to rule-making procedures would ensure that they had the opportunity to provide feedback before the guidance took effect. DEEOIC's (perceived) requirement for a medical report of tissue sample to establish a diagnosis of cancer and the imposition of criteria to establish CBD under Part E are just two of the examples where claimants question whether rule-making procedures should have been utilized.

<sup>56</sup> As we noted earlier, based on the circumstances, claimants generally have the opportunity to file for reconsideration or reopening. However, many of the claimants we encounter strongly believe that once a decision denying their claim issues, they face a tough uphill battle to overturn that decision.

<sup>57</sup> Some individuals suggest that independent review is necessary since it is virtually impossible for claimants to know the extent to which policy call notes or other sources not in the claim file may have been a factor in deciding a claim.

<sup>58</sup> DEEOIC regulations provide that if a person with knowledge of the fact submits a certified statement indicating that the medical records containing a diagnosis and the date of that diagnosis do not exist, OWCP may consider other evidence to establish a diagnosis and the date of the diagnosis. 20 C.F.R. § 30.113(c). Claimants question the extent to which DEEOIC adheres to this regulation.

## **E. DEEOIC sets the bar too high**

During the year, we also hear concerns suggesting that DEEOIC is unrealistic in terms of the evidence required to meet the burden of proof. For example, since hospitals and physicians are only required to maintain medical records for a time period that generally does not exceed 10 years, claimants argue that it is unrealistic to require them to produce such records when the diagnosis of cancer was made more than 10 years ago. Similarly, where relevant records were in the control of the government or the employer and these entities cannot locate (or destroyed) these records, claimants contend that it is unrealistic to expect them to locate these records. When situations such as these arise, claimants sometimes suggest that DEEOIC's evaluation of the evidence does not give adequate consideration to the evidence that is realistically available. While they understand that they bear the burden of proof, claimants believe that DEEOIC refuses to accept the evidence that is available and instead demands evidence that it knows is no longer in existence. Although claimants appreciate that DEEOIC has discretion when it comes to weighing evidence, they often question whether DEEOIC is too demanding in the exercise of this discretion – and question whether the high “bars” often set by DEEOIC are actually required by EEOICPA.

## XII. Additional complaints involving the administration of the program

Issues involving the evaluation of evidence are not the only issues that we receive concerning the administration of the program. Some of the other issues that we received include:

### ISSUES RELATED TO DEEOIC'S ADMINISTRATION

The main issues that we received this year involving DEEOIC's administration of the program included:

- The desire for more opportunities to discuss matters face to face with DEEOIC personnel
- Difficulties communicating with DEEOIC
- Rude/insensitive behavior
- No formal procedure for requesting a change in CE
- The impact when DEEOIC did not provide documents on request
- Information regarding EEOICPA is difficult to locate
- Limitations of some of the tools
- Unequal treatment
- Errors in decisions

#### 1. Prefer face to face contact

When they have problems or questions, some claimants prefer to discuss these matters in face-to-face conversations. The good news is that some claimants can go to one of the 11 Resource Centers and talk to the staff. The comments that we receive suggest that claimants who go to one of the Resource Centers appreciate the opportunity to talk to someone face-to-face. The problem often arises once a claim is forwarded to the district office. At that point, there is little, if any opportunity for face-to-face interactions. This can be very discouraging to claimants, especially those who took advantage of the opportunities for in-person discussions at the Resource Centers and thus expect the same level of contact with the district office. Some claimants believe they are better able to communicate when sitting across from someone, as opposed to talking to that person over the telephone, or corresponding by mail. Consequently, some claimants feel hampered when they do not have the opportunity for such direct contact.

## 2. Difficulties communicating with DEEOIC

Claimants routinely suggest that it can be difficult to communicate with DEEOIC.

- **E-mails:** Claimants find it inconvenient that they cannot correspond with DEEOIC via e-mail. This concern is raised by a variety of individuals, including those who contend that due to advanced age or debilitating illnesses it is difficult to leave their homes. Claimants also suggest that e-mailing can be less costly than mailing (especially where lengthy documents are involved) and in some instances may be less costly than using the telephone.<sup>59</sup> We also talk to claimants who assure us that it is not always easy to talk to someone when they call DEEOIC. Thus, where they need a quick response or where they feel that their question is relatively easy, claimants view it as an unduly burdensome to have to mail a letter or engage in “phone tag” with DEEOIC.
- **Telephone calls not answered:** We are frequently told of instances where telephone calls to DEEOIC were not answered, or where it took an inordinate amount of time for DEEOIC to return a call. When we discuss these matters with DEEOIC, we are assured that procedures are in place to facilitate the prompt answering of telephone calls and to ensure that where the staff is not readily available the telephone call will be returned within a reasonable amount of time. In spite of these assurances, claimants continue to raise concerns.

*I sent new employment information and new work related cancer findings...I sent it to the address noted on the last rejection letter...I have been unable to get anyone in that office to respond. Can you help.*

## 3. Rude/Insensitive behavior

Each year personnel associated with DEEOIC interact with hundreds, if not thousands, of claimants and potential claimants and while we have no way of evaluating every interaction, we believe that it is safe to say that the vast majority of those interactions do not result in complaints.<sup>60</sup> In fact, every year some claimants and ARs contact us to specifically compliment the treatment they received from a CE or HR.

However, each year there are some interactions that cause claimants to contact our Office. These contacts are usually prompted by comments/actions that claimants view as rude or insensitive.<sup>61</sup> Some of the concerns raised by claimants include:

- **No formal procedures for reporting rude/insensitive behavior:** In its response to our 2012 Annual Report, DEEOIC stated that, “[a]ny instances of inappropriate customer service should be reported to the DEEOIC immediately.” However, for many of the claimants who contact us with concerns regarding rude behavior, the problem is that DEEOIC does not provide a specific procedure for reporting these concerns (i.e., DEEOIC does not provide a telephone number or the name of a contact). Claimants contend that without specific

<sup>59</sup> Some claimants no longer have land line phones, but rather have mobile telephone plans in which they must be mindful of the minutes.

<sup>60</sup> On July 2, 2012, the OWCP implemented an improved customer satisfaction survey which can be found at <http://www.dol.gov/owcp/OWCPSurveyLetter.pdf>.

<sup>61</sup> Even where a claimant calls with concerns involving a CE or HR, in many instances that same claimant will note that they worked with other CEs and/or HRs who were very helpful and very courteous.

procedures, they are often left to report these concerns to the very office, and sometimes the very people who are the subject of the concern. For instance, claimants note that if they call the district office, their call is screened by a receptionist and the problem is that sometimes their complaint concerns the receptionist. Similarly, claimants note that when they call the district office, they are often referred to the CE and yet sometimes their complaint concerns the CE.

Many of the claimants who contact us to report rude or insensitive behavior admit that they are concerned with the possibility of retaliation and thus are hesitant to share these concerns with just anyone. To address these concerns, claimants suggest that the system for reporting rude/insensitive behavior needs to be more than just calling an office and registering a complaint with whoever answers the telephone. Rather, claimants contend that it would make them feel more comfortable if there was a designated person (or a designated office) tasked with receiving complaints and if they knew that this person or office was authorized to only share these complaints with appropriate personnel.<sup>62</sup>

- **No response/feedback when behavior is reported:** In spite of the lack of formal procedures for reporting rude/insensitive behavior, some claimants take it upon themselves to bring these matters to the attention of DEEOIC. Claimants who take these actions sometimes tell us that they never receive a response to their concerns, while others suggest that the response that they received was very vague. Some claimants interpret this lack of response (or these vague responses) as an indication that there is little interest in the complaints they report.

#### 4. No formal procedure for changing CEs

There were occasions during the year where both ARs and claimants contacted our Office to inquire if the DEEOIC had procedures whereby a claimant could request a new CE or HR. In almost every instance, the individual making this request emphasized that if their claim file information was reviewed, it would be clear that they had worked well with other CEs and/or HRs. These individuals felt that the fact that they had worked well with other CEs or HRs should be an indication that something significant had occurred if they now saw the need to make such a request. Unfortunately, DEEOIC does not have formal procedures for requesting a change in the CE or HR.

In many ways, the concerns expressed by individuals seeking a change in the CE (or HR) mirrors many of the concerns that we heard from individuals who wanted a formal procedure for reporting rude/insensitive behavior, namely: (a) they viewed the lack of formal procedures for requesting a change in CE/HR as a strong indication that DEEOIC had no interest in hearing these concerns, and (b) since there were no formal procedures, claimants who took it upon themselves to submit such a request, did so not knowing who would read the request or how widely the request would disseminate around the office.<sup>63</sup>

<sup>62</sup> Claimants further noted that calling the district office to voice a concern did not appear to be a good idea when the subject of the concern was the district director.

<sup>63</sup> As with reporting rude/insensitive behavior, some claimants were concerned with what could happen if the CE who was the subject of the request learned of the request

## 5. The impact when DEEOIC did not provide documents requested by claimants

This year situations were brought to our attention where claimants felt that their claims were impacted when their requests for documents from DEEOIC were not addressed in a timely manner.

- As discussed on page 26, we encountered instances where even though it had not received SSA records, DEEOIC proceeded to deny the claim on the ground that the claimant did not establish covered employment.
- In another instance, a claimant was upset that even though DEEOIC had not fully responded to his request for documents, DEEOIC refused to reschedule his hearing.<sup>64</sup>
- In two other instances, claimants were upset when DEEOIC finally provided them with the documents they requested only weeks before their scheduled hearing.

According to DEEOIC, where claimants obtain relevant evidence following a recommended decision, they are free to submit that evidence to the FAB for consideration. Moreover, where a claimant obtains relevant new evidence following a final decision by the FAB, the claimant can, depending upon the circumstances, request reconsideration of the decision or re-opening of the claim. However, as noted earlier, some claimants do not view these as optimal choices. Among the claimants we encounter there is a strong belief that once DEEOIC issues a decision denying a claim, they face a steep uphill battle to try to change that result.

## 6. Information regarding EEOICPA can be difficult to locate

Claimants frequently suggest that unless they specifically know what they are looking for, it can be difficult to locate information concerning EEOICPA. One hurdle discussed by claimants is the fact that much of the information addressing EEOICPA is found on the internet. This poses a problem for claimants who do not have (easy) access to the internet, as well as those who are not comfortable surfing the internet. Whenever possible we provide hard copies to claimants.<sup>65</sup>

Another hurdle cited by claimants is the fact that even if they have access to the internet, the specific information that they seek may be difficult to find. DEEOIC's response to our 2012 Annual Report highlights the problem. In response to our statement that a listing of physicians was not "clearly noted," DEEOIC indicated that a link to a listing of physicians enrolled through ACS is listed under "Get Help with My Medical Bills." DEEOIC is absolutely correct that this link has a listing of enrolled physicians. The problem encountered by claimants is that while it may be obvious to DEEOIC that a listing of enrolled physicians is available under "Get Help with My Medical Bills," claimants routinely assure us that it never occurred to them to go to a link for medical bills to find a listing of physicians.

<sup>64</sup> DEEOIC informed the claimant that due to the size of the claim file, it would take additional time to fulfill his request.

<sup>65</sup> For instance, we have provided claimants with copies of various provisions of the statute, regulations, and PM. We also frequently, provide claimants with copies of pages from SEM.

Other claimants note similar problems. While the DEEOIC website contains links to very useful information, some claimants do not fully appreciate what can be found at certain links. For example, while the DEEOIC website has a link entitled “Site Exposure Matrices (SEM),” some claimants looking for this site only know that they are looking for a list of toxins and are not aware that this tool is entitled “SEM”.

Comments that we received suggest among the steps that would make the DEEOIC website more user friendly:

- Add a direct link on the website to the listing of enrolled physicians.
- Describe links such as the one for SEM so that those who are not familiar with such terms know what is available at the link.

## **7. Limitations of some of the tools**

While there are a number of tools and resources available to assist claimants, claimants find that some of these tools/resources have limitations. Two limitations that can impact a claimant’s ability to utilize a tool/resource were discussed in the section above, namely:

- Some tools/resources are only available online.
- Claimants who are not familiar with the program are sometimes hampered in their ability to locate certain tools/resources.

Another tool/resource that some claimants find of limited use is the link to “Significant EEOICP Decisions” found on DEEOIC’s webpage. As DEEOIC states in its response to our 2012 report, this tool currently contains 202 final decisions addressing one or more of 24 major topics and each of these 24 major topics is further broken down into related areas of interest. Moreover, as DEEOIC states, this database is regularly updated. Nevertheless, there are other topics/issues which are of interest to claimants for which there are no decisions in the database. For example, while this link currently contains six decisions addressing medical benefits, the most recent decision is dated in 2005. Thus there are no decisions addressing the many changes affecting medical benefits that occurred in the past few years. In addition, while one of the topics on this link addresses “Beryllium Illnesses” this link does not contain a decision that discusses DEEOIC’s determination that a positive or abnormal BeLPT is necessary in order to prevail in a claim for CBD under Part E.

Nevertheless, claimants agree that this database can be a valuable tool. In fact, claimants often express a desire for a procedure whereby they can suggest decisions that ought to be included on this database.

## 8. Unequal treatment

There is a belief by some claimants that there are some practices and policies by DEEOIC that are sometimes applied in an inconsistent manner. Specifically, there are allegations that certain policies are interpreted one way when applied to claimants, and interpreted differently when applied to DEEOIC. Just some of the practices and policies that generated these concerns:

- **Time frames:** Claimants contend that throughout the claims process they are held to very tight timeframes and that it is rare when their request to extend a deadline is granted. In fact some claimants suggest that it is not unusual for their request for an extension of time to be denied even when actions by DEEOIC are the reason for seeking the extension. Consequently, claimants find it troubling whenever DEEOIC, often without notice and without providing an explanation, takes it upon itself to delay a claim. Claimants cannot understand why timeliness is so important when they want an extension, but often seems so less critical when DEEOIC needs more time.
- **Reasoned and documented opinions:** Claimants also question the consistency in requiring medical reports submitted by claimants to be well reasoned and documented and yet the decisions issued by DEEOIC sometimes contain little, if any reasoning and/or documentation. One example brought to our attention involved a case where in denying the claim, DEEOIC noted that medical literature supported its conclusion, and yet in this decision DEEOIC failed to identify the medical literature (nor did it explain how this literature supported its conclusion). In his conversation with us, this claimant stressed that, in his opinion, if the situation was reversed, DEEOIC would never accept a medical report where the physician simply stated a fact and did not specifically identify the medical literature supporting that fact.

There are similar concerns with the weighing of evidence. Claimants contend that DEEOIC holds evidence they submit to a higher standard. A common allegation by claimants is that DEEOIC “nitpicks” their evidence, while the many factors that could call into question the credibility of evidence not favorable to them is often left unexplored. For instance, claimants routinely contend that while the medical evidence favorable to them is carefully scrutinized, little, if any, consideration is given to the fact that CMCs almost never examined the worker, and in some instances, only reviewed limited evidence.

- **Use of nurses:** Another instance where claimants allege unequal treatment is discussed on pages 71 – 75 and concerns the use of non-physicians in authorizing home health care. This year claimants and some home health providers contacted us to say that they found it inconsistent that DEEOIC repeatedly chastised them whenever it appeared that a nurse (instead of a physician) was the driving force in preparing an authorization for home health care, only to have DEEOIC hire nurses who among other things, allegedly contacted physicians in an effort to direct their authorization of home health care.

## 9. Errors in decisions

With the number of documents that DEEOIC processes every year, some errors are inevitable. Many of the errors brought to our attention involve matters such as misspelled names or the misidentification of an illness. Based on the perspective of this Office, DEEOIC makes every effort to avoid errors. However, for some claimants, the existence of an error raises questions concerning the thoroughness with which the claim was reviewed. Throughout the year, we encountered claimants who upon discovering an error in their claim, asked if it was possible to be sure that DEEOIC had not made other errors in the processing of their claim.

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**Another concern brought to our attention came from an AR who indicated that whenever certain CEs called claimants, the CEs started the conversations with, “is this XXX,” or “I am calling for XXX.” The AR indicated that some claimants suggested that, out of caution, they were reluctant to identify themselves to a caller who did not first provide his identity. This AR suggested that CEs and other DEEOIC personnel consider starting their conversation with, “I am XXX and I am calling from the U.S. Department of Labor.”**

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### XIII. Authorized representatives/home health companies

There are four (4) major concerns that we received this year involving ARs and home health providers: (1) complaints concerning the application of the fee schedule for attorneys, (2), DEEOIC's response when contacted for assistance, (3) complaints from claimants concerning actions by a small number of representatives, and (4) the prohibition against serving as both an AR and home health provider.

**Complaints concerning the application of the fee schedule:** Pursuant to §7385g and as incorporated by §7385s-9, a representative may not receive more than the following percentages for services: (a) 2 percent for the filing of an initial claim for payment of lump-sum compensation, and (b) 10 percent with respect to objections to a recommended decision denying payment of lump-sum compensation.

One issue brought to our attention concerns the fact that while EEOICPA specifically outlines a schedule for attorney fees under Part B, see 42 U.S.C. §7385g, when it comes to Part E, EEOICPA simply incorporates the fee schedule outlined for Part B. See 42 U.S.C. §7385s-9. Since there are differences in the procedures applicable for Part B and Part E, the fee schedule outlined for Part B does not always neatly apply in every Part E case, and as a result, problems sometimes arise. One such problem is the fact that some ARs believe that as a result of the fee schedule, they are not fully compensated for the services they render. For example:

- We were approached by ARs who filed claims for claimants and who then developed evidence (sometimes in response to DEEOIC's request for additional evidence) that resulted in a recommended decision accepting the claim. As the fee schedule is written, since the efforts of the AR resulted in a recommended decision accepting the claim, the AR's fee was limited to 2% for the filing of the fee. ARs argue that it is not fair that in instances such as this their fee is limited to the same amount someone receives if they simply filed the claim and did not perform any additional work. ARs argue that in these situations the fee schedule does not fully compensate them for working hard to ensure that their clients receive an expedient and successful decision, and in fact some ARs suggest that this provision punishes them for doing a good job. Accordingly, some ARs suggest that this provision is inconsistent with the best interest of the claimant.
- ARs note that the structure of the fee schedule and one of the corresponding regulations place them in an awkward position when approached by claimants who have already filed a claim for benefits. Pursuant to a regulation promulgated by DEEOIC, an AR is only entitled to the 2% if they were retained by the claimant prior to the filing of the initial claim. See 20 C.F.R. §30.603(b)(1). ARs contend that whether intended or not, this regulation impacts the financial incentive to represent a claimant who has already filed a claim. ARs fear that this regulation could result in instances where their efforts to assist the claimant in establishing

a compensable claim would go uncompensated simply because the claimant filed an initial application form.<sup>66</sup>

- Another frequent comment that we receive notes that not every successful case results in monetary compensation. A Part B claimant successful in establishing beryllium sensitivity is awarded medical monitoring, but no monetary compensation. Similarly, where a claim filed by a former worker is accepted under Part E, that former worker may be entitled to medical benefits, but may (or may not) be eligible for compensation for impairment and/or wage loss. ARs contend that it is unfair that they can work hard to obtain medical benefits, which in some cases may be more valuable than the monetary compensation, and yet the fee schedule does not address when the claimant is only awarded medical benefits.

**DEEOIC's response when contacted for assistance:** Some ARs have suggested that there were instances when they contacted DEEOIC but were unable to obtain advice. What bothered these ARs is that they often were seeking advice to ensure compliance with DEEOIC rules and procedures.

This year we were told of instances where ARs contacted DEEOIC for guidance with the attorney fee schedule and did not receive a response.<sup>67</sup> A few ARs complained that when they asked for assistance, they were simply referred to the provision of EEOICPA that caused the confusion in the first place. ARs find it frustrating that no seems willing to provide them with guidance, even though they are endeavoring to follow the rules.

- For instance, ARs want guidance in those situations where they filed the claim and developed evidence, but the client-attorney relationship ended before the claim was accepted. These ARs want to know if they were entitled to a fee if they can demonstrate that the services they provided were a significant factor in the acceptance of the claim.
- ARs also reported that they could not obtain an answer from DEEOIC regarding whether they are permitted to recover expenses in addition to the fee outlined in the fee schedule.

**Complaints concerning the actions of a small number of representatives:** We receive complaints concerning the actions of some ARs and home health care providers. While these actions are not reflective of the vast majority of representatives or providers, there are a small number of ARs and home health care providers whose actions cause concerns. The complaints brought to our attention include:

#### A. Home Health Companies

This Office began to receive complaints involving the actions of a few providers and/or their employees towards the end of 2011. For a while a majority of these complaints came from people living in the southwest part of the country and often involved Native Americans who make up a percentage of the former uranium miners, millers, and ore transporters covered under this program.

<sup>66</sup> If the claim is already filed, then pursuant to 20 C.F.R. §30.603(b)(1), the AR would not be entitled to the 2% fee for the filing of the claim. Moreover, if the recommended decision is to accept the claim, there is no basis for the 10% fee with respect to objections to a recommended decision denying payment.

<sup>67</sup> While this provision of EEOICPA is entitled "Attorney fees," by its terms it also applies to those serving as non-attorney representatives. See 42 U.S.C. §7385g and 42 U.S.C. §7385s-9.

We are now starting to see more complaints from other parts of the country. The complaints that we receive allege that a few companies (or representatives of these companies) in an effort to lure claimants to use the services of specific companies, engage in practices that range from annoying to what some view as harassment. These practices include:

- Contacting claimants by telephone or showing up at their door any hour of the day or night in an effort to get the claimant to sign up to use certain providers, and refusing to take “no” for an answer.
- Allegations that individuals representing a few companies mislead claimants into assuming that the company was affiliated with or endorsed by DOL (or the government). A frequent tactic brought to our attention involves the erroneous designation as a “Preferred EEOICP Medical Provider.” Enrollment as an “EEOICP Medical Provider” does not signify DEEOIC’s endorsement of that provider. Rather, if a claimant utilizes a provider who is not “enrolled,” the claimant pays for the services out-of-pocket, and can seek reimbursement from DEEOIC. On the other hand, if the claimant utilizes an enrolled provider, then DEEOIC will directly pay the provider for the services rendered. Nevertheless, we continue to hear allegations suggesting that providers (or their representatives) hold themselves out as “Preferred EEOICP Medical Providers,” and with no one around to explain otherwise, claimants assume that this means that the provider is endorsed by or affiliated with DEEOIC.

#### B. Authorized Representatives

As in previous years, we received complaints concerning the actions of a few attorneys and lay representatives. We note that in many of the instances brought to our attention this year, it was not the claimant (the client) who brought the matter to our attention. Rather, a third party contacted us to report conduct that they found questionable.<sup>68</sup>

One of the biggest concerns we hear alleges that certain ARs impress upon claimants the need to have a representative even in instances where a representative may not be necessary. This concern frequently arises when a new SEC is announced. As noted earlier, when a new SEC is announced, DEEOIC automatically identifies previously denied claims potentially impacted by the new SEC. These previously denied claims are reviewed by DEEOIC to determine if they are impacted by the SEC. We continue to receive allegations suggesting that when new SECs are announced, there are a few ARs who specifically focus on these previously denied claims, and suggest to these claimants that they need a representative. Some people find it troubling that these ARs do not advise claimants that DEEOIC intends to automatically review these previously denied claims for inclusion in the new SEC class. Others have voiced their suspicion that some ARs collect a fee in circumstances where the statute does not authorize a fee.

Another concern that is starting to surface (although at this point in small numbers) alleges that there are certain ARs who actively endeavor to lure claimants away from other ARs.

<sup>68</sup> In some instances this third party was a family member or friend of the claimant. In other instances, the third party was another AR or provider.

## Prohibition against serving as an authorized representative and also providing medical services

This year we were approached by family members who had issues with DEEOIC's policy that prohibits an individual from serving as a claimant's AR and also providing medical services to that claimant.<sup>69</sup> It bothers some claimants that while they are told of this policy, they cannot find this policy in the regulations or PM. Family members also believe that the concerns that prompted this policy are far outweighed by the realities that often surround these cases.

Family members point out that due to advanced age and/or their illnesses some claimants do not have the capability to actively participate in the day-to-day activities associated with the processing of their claim. Yet, while these claimants need assistance, it can be difficult to locate someone they trust, who is willing to provide the needed assistance – and in advancing this argument, family members emphasize that a big concern is finding someone that the claimant trusts. It is noted that when an individual is authorized to serve as the AR, they have access to the claimant's SSA number and will be privy to medical and other records. Claimants are often reluctant to share this information with someone they do not know or trust. Family members also believe that DEEOIC does not appreciate the extent to which some claimants are reluctant to let strangers into their homes, especially if they feel that they will not be able to monitor this person while in the home. Thus, especially where the issue is unskilled home health care, some claimants strongly prefer to use someone they trust, such as a family member. In many of the conversations that we have had, family members suggested that it was not so much that they wanted to serve as the AR and home health care provider - rather they were the only person the claimant was willing to trust with personal information and was willing to let into the house. Other comments that we hear about this policy include:

- This policy often creates another layer of bureaucracy and adds more hurdles to the claims process. Throughout the year we encountered instances where claimants became critically ill and since no one in the family was listed as the authorized representative (sometimes because the family member was providing home health care), the family encountered significant difficulties obtaining information from DEEOIC concerning this claim. Accordingly family members argue that because only the AR is entitled to obtain information from DEEOIC concerning a claim, it simply adds to the problems that they must overcome when the worker is ill (and cannot communicate his wishes) and no one in the family is authorized to speak with DEEOIC.
- A frequent comment characterizes this policy as an example of a double standard. Claimants note that while DEEOIC does not permit family members to serve as both the AR and home health care provider at the same time, DEEOIC contracts with QTC to provide independent contract medical specialists (CMCs) even though QTC is owned by Lockheed Martin, a major contractor at certain facilities covered under this program.<sup>70</sup>

<sup>69</sup> All of the instances brought to our attention involved situations where the family member attempted to serve as the AR and provide home health care services.

<sup>70</sup> While claimants recognize that an employer is not liable for compensation/benefits under EEOICPA, claimants nevertheless believe that there other reasons an employer might want to limit the availability of information addressing the toxic substances to which it exposed its employees. For instance, claimants contend that since all employees are not necessarily covered under EEOICPA, an employer may be concerned with limiting its potential liability in suits brought by those employees not covered under EEOICPA.

- Some claimants suggest that it is inconsistent for DEEOIC on the one hand to tell them that they are free to choose who they want as their AR and home health care provider and then on the other hand to impose a rule forbidding them from using the same family member to provide both services. These claimants further find it troubling that after imposing a rule that sometimes prevents them from using the person they trust (and want) as their AR and home health care provider, DEEOIC then refuses to get involved if problems arise with the AR or home health provider they are forced to use because of this policy. Claimants argue that DEEOIC should not be able to have it both ways. In the opinion of claimants, if they are free to use the AR and home health care provider of their choice, they should have the option of utilizing the same person for both services. On the other hand, if DEEOIC wants to dictate who claimants can (or cannot) use, then DEEOIC ought to intercede when a claimant is not allowed to use the person that they trust, and problems subsequently arise involving the AR and/or home health care provider that they had to use in light of this policy.

## XIV. Medical benefits – in general

There are three issues related to medical benefits that continue to generate concerns: (1) locating providers; (2) the fee schedule; and (3) number of illnesses that can be included on a medical benefits card.

**1. Locating Providers:** Some claimants remark that it can be extremely difficult to locate providers who are willing to treat EEOICPA claimants. Some of the reasons that physicians are difficult to locate are factors that are not necessarily limited to EEOICPA:

- In some areas of the country, there are not a lot of providers.
- Some providers have no desire to get involved with government programs and/or worker compensation programs.<sup>71</sup>

However, some of the reasons claimants cannot locate physicians are directly related to EEOICPA. A major concern that we hear suggests that some providers are not inclined to treat EEOICPA patients because they find the frequency and volume of paperwork excessive and overly burdensome. Claimants and providers contend that they know of physicians who have become frustrated with EEOICPA. In many of the instances, it is suggested that a major cause for this frustration relates to the number of times physicians are required to re-write or clarify their reports. The claimants and the providers with whom we speak believe that these concerns can be traced to a couple of factors:

- DEEOIC does not provide clear instructions. Some claimants have asserted that it was only after they submitted a medical report that DEEOIC finally provided clear instructions on what was needed. Claimants contend that if more (and better) information were available earlier, physicians could rely on this information and possibly avoid re-writes.
- There is also a belief that some problems are caused when non-medical personnel from DEEOIC review medical reports. Two instances that continue to frustrate physicians involve circumstances where physicians are asked to clarify reports and: (a) DEEOIC does not identify the specific aspect of the report that needs clarification, and (b) the aspect of the report that needs clarification is identified, however the physician believes that this aspect of the report is already clearly written.

Another problem encountered by claimants involves their inability to locate physicians willing to treat EEOICPA claimants. As noted earlier, in its response to our 2012 annual report, DEEOIC noted that its website provides a link to a list of physicians who are enrolled with the Affiliated Computer Services (ACS), the contractor who processes medical bills for DEEOIC. Yet, as we discuss at page 59, this response highlights the difficulty encountered by claimants. The resource cited by DEEOIC is listed under “Get Help with My Medical Bills” and directs the user to the ACS web portal. Many of the claimants we encounter note that it never occurred to them to use a link

<sup>71</sup> DEEOIC is willing to talk to providers to clarify the program and to explain away any misconceptions. However, we are aware of instances where providers had no desire to talk to DEEOIC, or even after talking to DEEOIC continued to refuse to treat EEOICPA patients.

that offered help with their medical bills to find a listing of ACS enrolled physicians.<sup>72</sup> Claimants suggest that it would be more helpful if the link had a title that alerted them that it contained a listing of enrolled physicians.

- 2. The fee schedule:** OWCP maintains a fee schedule of maximum allowable fees for professional medical services performed in a given locality. As discussed in the 2012 annual report, DEEOIC's most recent adjustments to this schedule resulted in a decrease in the maximum allowable fee for many services. See 2012 Annual Report to Congress, June 5, 2013, pg. 58. Claimants contend that this decrease has caused some providers who participated in the program to reconsider and stop treating EEOICPA patients, thereby adding to the difficulties of locating a physician.
- 3. Number of illnesses that can be included on a medical benefits card:** As it currently stands, DEEOIC can list the ICD-9 code for up to ten illnesses on a medical benefits card and does not list the name of the covered illness on the medical benefits card. If a claimant has more than ten covered illnesses, they receive a letter listing the ICD-9 code for the other covered illnesses. Claimants with more than ten covered illnesses reported that it is cumbersome to carry the card and the letter. It was also suggested that some health care providers balk when presented with the letter, instead of having the ICD-9 codes included on the card.<sup>73</sup> Furthermore, claimants have alleged that they had to contact DEEOIC on multiple occasions to request the letter listing their additional accepted covered illnesses and corresponding ICD-9 codes.

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<sup>72</sup> Some of the claimants we encounter are not very adept at surfing the internet.

<sup>73</sup> It has been suggested that in the future, DEEOIC may move away from including ICD-9 codes on medical benefits cards. In response to this suggestion some claimants question whether this will simply cause more confusion. It is noted that claimants, especially those with multiple illnesses find it very convenient to just hand the card to a provider, as opposed to trying to remember these illnesses. Moreover, some claimants suffer from illnesses that are difficult to pronounce.

## XV. Home health care

Starting in calendar year 2011, this Office began to notice an increase in the complaints involving medical benefits, especially home health care benefits. Many of the complaints that we received in 2011 were prompted by letters mailed to claimants and providers informing them of DEEOIC's determination to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner. In contacting us, claimant and providers not only questioned the need for this change, they also noted that the letters were not very clear (some claimants read the letters as accusing them of doing something wrong). Other comments suggested that the new procedures would be overly burdensome. See 2011 Annual Report To Congress, April 16, 2011.

In calendar year 2012, while this more robust and rigorous application of the procedures for authorizing home health care continued to generate inquiries, we also encountered a number of inquiries concerning massage therapy. Claimants and providers contacted us to voice their concerns regarding DEEOIC's guidance relating to the authorization of massage therapy. This guidance requires: (1) the massage therapy to be prescribed by a physician for treatment of an accepted condition, (2) the medical condition or level of function to be expected to improve significantly within a reasonable and generally predictable period of time with treatment, and (3) recertification for any period of time beyond six (6) weeks and only allowing recertification in six (6) week increments. In particular, claimants argued that requiring massage therapy to improve the condition or level of function was inconsistent with 42 U.S.C. §7384t(a) which authorized medical benefits not only to cure, but also to "give relief." Claimants also argued that recertification in six (6) week increments was too burdensome. Subsequently, DEEOIC issued EEOICPA Bulletin NO. 13-01 in which it recognized "reducing pain and muscle tension" and "increasing flexibility and range of motion and improving blood circulation" as potential benefits from massage therapy. This bulletin also extended the initial authorization period for massage therapy to 8 weeks, and at the end of the initial 8-week authorization period, permitted the CE to grant authorization for continuing massage therapy of no more than two visits per week for a maximum of 60 visits per year. See 2012 Annual Report to Congress, June 5, 2013.

This year, we were approached by at least one claimant who had issues with the rule regarding a maximum of 60 visits for massage therapy per year. The treating physician authorized a course of massage therapy that over the course of the year would exceed this maximum. Pursuant to its policy, DEEOIC approved up to 60 visits for the year. When the claimant objected, DEEOIC issued a letter reaffirming the approval for 60 visits. DEEOIC denied the claimant's request for a recommended decision addressing DEEOIC's refusal to consider his treating physician's recommendation for more than 60 visits for the year. This claimant strongly believes that DEEOIC's refusal to issue a recommended decision hampers his ability to appeal this denial.<sup>74</sup>

A large number of the inquiries that we received this year involving home health care addressed issues surrounding decisions by DEEOIC to deny the level of care outlined by the treating physician,

<sup>74</sup> This claimant believes that he can only appeal a final decision.

and/or to seek the opinion of yet another physician.<sup>75</sup> In particular, we received allegations questioning the procedures followed by DEEOIC, as well as the motive behind these decisions.

- **No notice of DEEOIC’s follow up**

Some claimants provided us with letters from DEEOIC that they received advising them that DEEOIC might request information from their physicians. Since these letters specifically informed the claimant that DEEOIC would provide them with a copy of any correspondence between DEEOIC and their physician, these claimants assumed that any correspondence with their physicians would be in writing, and that DEEOIC would provide the claimant with prompt notice of any such correspondence. Therefore, claimants found it troubling when they discovered that instead of mailing a request to the physician, DEEOIC sometimes telephoned the physician. Likewise, some claimants also found it troubling that they only learned of DEEOIC’s correspondence with the physician when they received a letter or a recommended decision from DEEOIC advising them of a reduction of benefits in their plan of care. Claimants contend that the letters from DEEOIC informing them that they will receive a copy of any correspondence between DEEOIC and their treating physicians is either misleading or shows that DEEOIC does not always adhere to its own policies. Claimants also suggest that because some contacts between DEEOIC and their physicians concerning their plan of care were telephone conversations, they have been severely hampered in their ability to obtain an accurate summary of what was discussed.<sup>76</sup>

- **Who is developing the plan of care?**

Some claimants and home health providers view this as another instance where DEEOIC does not play by the rules that it imposes on claimants. It is noted that, whenever DEEOIC suspects that a nurse or home health care provider developed a claimant’s plan of care, DEEOIC is emphatic that a physician must determine the level of care. Therefore, claimants and providers found it inconsistent when they came across instances where it appeared that a CE or a nurse associated with DEEOIC was very instrumental in questioning the plan of care prepared by a physician and in developing a revised plan of care.

Here is one case that highlights this concern. The CE initially wrote to the physician explaining that:

*I [the CE] am currently conducting a 6 month review of the home health care regarding [claimant]...It has been requested that ...continue to receive...hours a week of RN/LPN and...hours a month case management. After review of the most current nursing notes, it appears that the requested number of skilled nursing and case management hours maybe excessive and a modification in hours or level of care maybe warranted.*

<sup>75</sup> In a typical case, the treating physician develops a “plan of care” and writes a letter of medical necessity describing the medical justification for the plan of care. Such care may include: nurse care management, skilled nursing care, and/or unskilled home health aide. DEEOIC does not permit a home health company to draft a claimant’s plan of care.

<sup>76</sup> Where these interactions were not in writing, some claimants found it difficult to ascertain what was discussed. There are instances where claimants allege that DEEOIC’s recollection of these conversations is drastically different from the version provided by their physician. Claimants believe that this confusion could have been avoided if the interaction between DEEOIC and the physician had been in writing.

In his response to the CE, the physician indicated that his opinion as to the level of care required by this claimant remained unchanged, and then responded to the suggestion that the nursing notes may demonstrate that the requested level of care is excessive,

*I have access to all the nursing notes, including the 34 pages of nursing notes that accompanied your letter to me dated... The majority of skilled nursing care that this patient requires is related to ongoing assessments and education, which is what I see, reflected in several nursing notes. Nurses must use their knowledge base, critical thinking skills, and assessment findings to provide care as outlined by my orders, but they are unable to chart every single concept related to assessment, education, and intervention as the care they provide within their scope of practice is constant...*

Questions also arise as to whether the CE and/or DEEOIC nurse reviewing the plan of care prepared by the treating physician are qualified and/or have adequate data available to sufficiently review the plan. For example, in the case discussed above, while the CE appears to base his concerns with the plan of care on a review of current nursing notes, the physician emphasizes that the actual plan of care was premised on more than nursing notes.

Similarly, claimants, providers, and physicians raise concerns as to whether a DEEOIC nurse who never examined the claimant is in a position to question a plan of care prepared by the treating physician.

*In another case brought to our attention, a letter from a nurse associated with DEEOIC informed the physician that a DEEOIC policy stated that "a periodic review must be done on all consecutive requests for 24/7 home health care." The letter then listed the facts that had been reviewed. Following this listing of the facts the letter indicated that upon review of the record, DEEOIC would need further justification for RN/LPN care 24/7. However, the nurse then stated that, "[d]ue to the age of the claimant, I propose the following" – and what followed was a reduced plan of care. The physician was asked to sign a "verbal order" if this plan proposed by the nurse was acceptable.*

Claimants ask how DEEOIC can be so insistent that physicians, not nurses, are to prescribe the plan of care, and then allow DEEOIC nurses to propose plans of care to the treating physician for signature.

Claimants also believe that situations such as these where DEEOIC nurses and/or CEs question the plans of care prepared by a treating physician helps explain why some physicians are reluctant treat DEEOIC claimants. It is argued that some physicians find it very annoying when required to rewrite a report in an effort to explain concepts that, in the opinion of the physician, have been more than adequately explained.<sup>77</sup> We also are told that physicians do not always take it well when their opinions are questioned especially where the physician does not believe that there is a sound basis for this questioning.

<sup>77</sup> Our Office was also made aware of treating physicians who were confused regarding the affiliation of the nurse contacting their office and only after signing the verbal order from the DEEOIC nurse did they understand they were no communicating with the claimant's home health care nurse.

Furthermore, while DEEOIC stresses that it will reimburse physicians for the time used to rewrite or clarify reports, for some physicians the issue is not money – rather it is an issue of time. We are assured that some physicians feel that they do not have the time to rewrite or clarify reports, especially if these rewrites and clarifications are not, in the opinion of the physician, absolutely necessary.

### • **The motivation behind seeking additional input**

Earlier this year, we encountered cases where DEEOIC sought additional input from the claimant's treating physician. Recently, we have begun to hear of instances where DEEOIC is sending claimants for independent medical examinations. This practice by DEEOIC is now raising concerns. Claimants find it troubling when DEEOIC schedules them to be evaluated by a CMC for further input and yet no one explains why the opinion of the treating physician is not sufficient and/or why further input is needed. In our experience, when they are not provided an explanation for such actions, some claimants start to draw their own conclusions. A frequent conclusion that we hear questions whether DEEOIC is simply "shopping" for the physician who will authorize the lowest level of care.

- Claimants and providers find it interesting that there were instances where DEEOIC prepared and forward an amended plan of care, lowering the levels of care, to a treating physician on the same day or within days of talking to that physician. These claimants commented that it was interesting that DEEOIC could move so quickly on this issue when for so many other actions relating to claims, DEEOIC does not respond so quickly.
- In a letter shared with us, a physician stated that he agreed to lower the levels of care only after being told by a DEEOIC nurse that the reports of the claimant's home health provider contained an indication for adjusting the hours of care. The physician noted that otherwise, he would not have altered the claimant's plan of care.
- It is alleged that there are instances where nurses associated with DEEOIC telephoned the treating physician, discussed a lower level plan of care and then promptly forwarded to the physician a letter authorizing the lower level of care that the physician simply had to sign. In one instance it is alleged that following the telephone conversation with the treating physician, the DEEOIC nurse called the physician's office and instructed the physician to write "verbatim on a letter head" a plan of care outlined by the nurse. Claimants and providers believe that these instances show that it was the DEEOIC nurse who instigated and suggested the lower level of care.
- In a letter to DEEOIC a physician wrote that when he agreed to lower the level of care, he "felt coerced" and "...did not know who [he] was talking to..." The physician concluded his letter by indicating that he stood by his original plan of care and not the amended plan of care that the DEEOIC nurse had faxed to him.
- The fact that some physicians felt coerced into lower levels of care was mentioned by other physicians as well. In one instance a physician told us that the reference by DEEOIC to the "financial integrity of the program" led him to believe that DEEOIC was asking him

to lower the levels of care in an effort to save money. In another instance, in response to DEEOIC's recommendation for a lower level of care, a physician wrote that while he could not remember the exact details of the telephone conversation, he remembered having the impression that "a reduced level of care was all that was going to be considered..." This physician concluded his letter to DEEOIC by indicating that after thinking about it and reading his response, he was instead "standing by [his]" initial recommendation.<sup>78</sup>

- In one case, although the Final Decision noted that a telephone conversation was not considered medical documentation, the decision nevertheless discusses the content of a telephone conversation between the treating physician and the district office claims examiner in which the treating physician supposedly stated that the claimant's need for home health services was required for non-covered conditions. Accordingly, the Final Decision concluded that the evidence was not sufficient to establish the claimant's need for home health care as a result of a covered illness, and thus the request for home health care was denied. In response to this Final Decision, the treating physician wrote to DEEOIC asserting that he did not recall a conversation with DEEOIC and stating that if DEEOIC spoke to someone else in the office, he (the physician) could not support or validate the information. The physician concluded his letter by asking that all quotes attributed to him be removed from all documentation. In a subsequent letter, DEEOIC acknowledged the correspondence from the treating physician, but concluded that, "[b]ased on the review [of the physician's] entire letter and [the claimant's] case file, did not change the findings of the Final Decision..." Since the Final Decision specifically cited to the alleged conversation with the physician as the basis for denying home health care, and the physician subsequently repudiated this conversation, the claimant wonders what DEEOIC relied upon in denying his request for home health care and questions whether there is medical evidence to support this denial.

Here is yet another instance that highlights the concerns that we heard from claimant regarding these decisions to seek further input regarding home health care:

*According to the AR, in the midst of a discussion with the CE addressing whether to send the claimant for an independent medical assessment, the AR explained that claimant's treating physician (physician #1), who wrote the original plan of care, had left the area and that claimant was now scheduled to see a new physician (physician #2). The AR states that he and DEEOIC then agreed that instead of the independent medical assessment, claimant would obtain a plan of care from physician #2.*

*To the total surprise of the AR, and in spite of the agreement, a DEEOIC nurse contacted a third physician (physician #3) and obtained an amended plan of care which lowered both the level and hours of care. Although physician #3 was the replacement for physician #1 at the medical practice, the AR could not understand why DEEOIC sought physician #3's input since physician #3 had never examined claimant and was not the physician with whom claimant had the upcoming appointment. Therefore, believing that someone had made a mistake, claimant followed through with his appointment*

<sup>78</sup> In this case, although DEEOIC approved the plan of care as authorized by the treating physician for three (3) months, the claimant was subsequently referred to a CMC for a second opinion evaluation.

with physician #2, who prepared a plan of care that was consistent with the plan of care previously developed by physician #1.

In a subsequent telephone conversation, the AR contends that he was told by the CE that in spite of the submission of the two separate plans from two separate treating physicians outlining the same levels of care, the CE intended to approve the lower plan of care submitted by physician #3, the physician who never examined claimant and with whom claimant had never established a treatment relationship. When the AR voiced his objections, DEEOIC sent claimant for an evaluation by a CMC. Based on this evaluation the CMC concluded that home health services were not required for claimant's covered illness and as a result his home health benefits were terminated.

This claimant questions whether his home health care would have been terminated if he had accepted the lower level of care approved by a physician who never examined him.<sup>79</sup>

Moreover, this claimant notes that it is difficult to challenge this termination since the entire discussion of this termination is contained in two sentences:

***On...you were evaluated by a third party physician called a Contract Medical Consultant (CMC), who is a specialist in the field of Pulmonology. Based on the medical testing and the evaluation by the CMC, it was determined that home health services are not required from a pulmonary standpoint, or for your accepted conditions. Therefore, your home health benefits will terminate...***

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Claimants have the right to request a copy of the CMC's report relied on in their case. However, the letter advising this claimant of the termination of his home health care did not inform him of this right to request a copy of the CMC report. In addition, this claimant questions whether he has the right to appeal a letter issued by DEEOIC and thus questions whether since DEEOIC only issues a letter, he is limited in his ability to challenge this determination.

In another case brought to our attention, a claimant is upset that while he asked for a recommended decision addressing DEEOIC's determination to limit his massage therapy to 60 visits for the year, DEEOIC will only issue a letter.

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<sup>79</sup> In support of this argument, claimant notes that in a letter approving the lower level of care authorized by physician #3, DEEOIC specifically stated that a second medical opinion was no longer required. Yet, when he challenged this determination and submitted a plan of care from physician #2 in accord with the plan outlined by physician #1, DEEOIC then required him to undergo another evaluation.

## XVI. Summary

Without a doubt, DEEOIC has made great strides in the time that it has administered EEOICPA. Moreover, while we only hear from a small percentage of the claimants, one only needs to review the statistics provided by DEEOIC to realize that there are claimants who have benefited from the assistance offered by DEEOIC and the other agencies involved with the administration of EEOICPA.

Yet, in spite of the success enjoyed by some claimants, there are others who find EEOICPA to be a confusing and daunting process. Consistent with the mission of the Office, a vast majority of the people who contact this Office do so because they are encountering (or encountered) difficulties with the program. In this report, we first set forth the number and types of complaints, grievances, and requests for assistance that we received in 2013. We then endeavor to assess the most common difficulties encountered by claimants, potential claimants, ARs, and providers during the year. As in previous years, any attempt to summarize the issues brought to our attention over the course of the year is complicated by the fact that these issues address a wide range of subjects, covering practically every aspect of the EEOICPA claims process. Further complicating any attempt to summarize these issues is the fact that many of the concerns brought to our attention do not neatly “fit” into set categories. Nevertheless, a common way to summarize the issues relating to EEOICPA is by categorizing these issues as either statutory, regulatory/policy, or administrative. The thought is that these categories reflect the source that must be addressed in resolving these issues. Statutory concerns are issues that can only be addressed by revising or modifying EEOICPA. Regulatory/policy concerns are issues that directly address a regulation or policy issued by one of the agencies involved in the administration of EEOICPA. The category of administrative concerns is a catchall that encompasses a wide variety of activities associated with the processing of claims and the administration of this program.

### **Statutory:**

Some concerns brought to our attention this year involved issues directly addressed by EEOICPA. Some of the statutory issues that we encountered this year include:

- The fact that some of the employees who worked at these facilities are not covered under EEOICPA.
- Issues related to the structure of EEOICPA and the fact that certain employees are only covered for certain illnesses.
- Questions as to why the burden of proof was placed on claimants, and why this burden remains on claimants even when the government or the employer is responsible for the loss or destruction of relevant records.
- Inquiries regarding why some claimants must undergo a dose reconstruction even though everyone acknowledges that it is not feasible to estimate with sufficient accuracy the radiation dose received.

- Inquiries asking why CLL is not included in the list of specified cancers.
- Concerns related to the structure and implementation of the attorney fee provision.

Where an issue is directly addressed by EEOICPA, DEEOIC and the other agencies that administer EEOICPA are not in a position to effectuate the changes that are often sought. Rather, if an issue is directly addressed by EEOICPA, normally in order to effectuate change, EEOICPA must be modified – something that is beyond the authority of these agencies.

### **Regulatory/Policy:**

There are some issues that directly address the interpretation or application of a regulation or policy. In most instances, these concerns address regulations and policies enacted by DEEOIC. Some of the issues related to regulations and policies that we received this year included:

- Comments suggesting that in some instances DEEOIC provided little, if any reasoning or explanation for changes in policy.
- Concerns with the requirement that a pathology report was almost always needed to establish a diagnosis of cancer.
- DEEOIC's determination that a positive or abnormal BeLPT test was necessary in order to prevail in a claim for CBD under Part E.
- DEEOIC's policy concerning claims for hearing loss due to organic solvent exposure where the employee has less than 10 years of consecutive employment prior to 1990.
- The determination to change the information in SEM regarding "guards" at Line 1 of the Iowa Ordnance Plant.
- The determination that in order for an attorney to collect the 2% for the filing of the fee, the attorney must have been retained prior to the filing of the claim.

Some of the questions that claimants often raise with respect to these regulations and policies are, (a) whether these regulations and policies are consistent with EEOICPA, and (b) whether existing medical and scientific literature supports these regulations and policies.

### **Administrative Issues:**

By far, the vast majority of the issues that we encounter involve issues related to the administration of this program. These issues address a wide variety of concerns spanning from DEEOIC's evaluation of evidence to the conduct of a small number of the personnel associated with DEEOIC. Just some of the administrative issues that we encountered this year included:

- Questions relating to DEEOIC's evaluation of evidence, mainly whether DEEOIC has unrealistic expectations in terms of the evidence that must be submitted to meet one's burden of proof.

- Concerns with the lack of reasoning provided in some decisions, and the concurrent concern that this lack of reasoning impedes the ability of claimants to develop a credible challenge to these decisions.
- Instances where requests for documents from DEEOIC were not provided in a timely manner, sometimes resulting in the issuance of a denial of the claim without the input of all of the relevant evidence.
- Concerns suggesting that DEEOIC does not always promptly answer the telephone, or that messages are not always promptly returned.
- Questions related to the placement of some information on DEEOIC's website – i.e., that those who are not familiar with the website encounter difficulties locating information.
- A number of questions related to decisions concerning home health care.

Every year we see efforts by DEEOIC to address some of the concerns raised by claimants, and 2013 was no exception. Therefore, we are hopeful that 2014 will not be any different. In fact, our own review of DEEOIC's website reveals a number of recent changes, as well as other changes that already appear to be underway. Nevertheless, when it comes to addressing their concerns, claimants often raise two issues:

1. Claimants believe that with respect to many of the issues involving EEOICPA, their input is essential. Former workers note that they are the ones who worked at these facilities and thus have a firsthand knowledge of how things were done. These workers contend that in many instances, records and documents are incomplete, not only because some were destroyed or lost, but also because for a variety of reasons, some information was never recorded.<sup>80</sup> Thus, former workers and other interested parties believe that they have valuable information that they can contribute. More importantly, these individuals would prefer to contribute their information as early in the process as possible, as opposed to finding themselves in a position where they have to oppose or object to the conclusions that have already been drawn. Thus, claimants want a meaningful opportunity to provide input.
2. Some claimants believe that in addition to seeking their input, there also needs to be a more effective system for reviewing determinations and policies affecting EEOICPA. In light of the technical nature of many of the issues involving EEOICPA, some claimants believe that an independent advisory board made up of experts, claimants, and advocacy organizations is needed.

Other claimants believe that there needs to be an alternative to requiring claimants to appeal to district court if they disagree with final decisions issued by EEOICPA. We encounter claimants who note that they are overwhelmed by the prospect of having to appeal a case to district court on their own. Many of these claimants further note that they do not have legal representation, and do not have the money to afford legal representation. (Many of

<sup>80</sup> Former workers notes that in some instances, certain events were so routine, no one took the time to record these events. In other instances, we hear from claimants who believe that some information was omitted from reports in an effort to minimize potential liability or in an effort not to scare the public.

these individuals further note that even if they went to court and prevailed, they would need the money to pay medical and other necessary bills – not to pay an attorney). Moreover, it must be emphasized that for some claimants, the idea of having to go to court against the government is just not something these individuals would ever want. Claimants often note that EEOICPA bills itself as a “non-adversarial” process and thus did not see why they should have to go to court to get an independent review of a determination made in their claim.

Based on the comments that we received over the course of this year, we would like to conclude this report with some recommendations.

## **RECOMMENDATIONS**

1. We concur with the recommendation by the IOM that DEEOIC provide a direct link on its homepage to the SEM database.
2. While we realize that there are limits to the information that can be placed on DEEOIC’s homepage, we suggest that DEEOIC consider better explaining some of the technical terms on its webpage. The technical term that stands out for us on the homepage is “SEM.” We find that claimants who are not familiar with SEM oftentimes look right over this tool.
3. Similarly, we believe that it would be a tremendous help to claimants if DEEOIC provided a direct link on its homepage to the listing of enrolled physicians.
4. We agree with DEEOIC that it is committed to improving the decision process. Thus, as DEEOIC continues its efforts, we hope that DEEOIC ensures that where a decision is impacted by a change in policy or procedure the decision provide a reasoned explanation for the change (and provide a citation where this change can be found).
5. While it is true that if a claim is denied, the claimant has the opportunity, based on the circumstances, to seek reconsideration or re-opening, in many instances, a denial of their claim is very discouraging. Every effort should be made to address requests for documents as quickly as possible.
6. Beyond informing claimants that they can contact DEEOIC to report inappropriate customer service, it would alleviate some fears if DEEOIC provided a name and telephone number to contact.
7. We encourage DEEOIC to consider establishing a procedure whereby claimants could recommend that certain cases be included on DEEOIC’s database “Significant EEOICP Decisions.”
8. Lastly, while we are already aware of changes that we believe are a response to the IOM Report, we wish to emphasize that we believe that the findings and recommendations outlined by the IOM Report offer a means of improving the EEOICPA claims process. Therefore, we sincerely hope that this report is used as a guide for future improvements to this program.

## Appendix 1 - Acronyms (abbreviations) used in this report

<b>ACS</b>	Affiliated Computer Services
<b>AEC</b>	Atomic Energy Commission
<b>AR</b>	Authorized representative
<b>AWE</b>	Atomic Weapons Employer
<b>BeLPT</b>	Beryllium lymphocyte proliferation test
<b>CBD</b>	Chronic beryllium disease
<b>CE</b>	Claims examiner
<b>CLL</b>	Chronic lymphocytic leukemia
<b>CMC</b>	Contract Medical Consultant (formerly known as District Medical Consultant)
<b>DEEOIC</b>	Division of Energy Employees Occupational Illness Compensation
<b>DOD</b>	Department of Defense
<b>DOE</b>	Department of Energy
<b>DOJ</b>	Department of Justice
<b>DOL</b>	Department of Labor
<b>EEOICPA</b>	Energy Employees Occupational Illness Compensation Program Act
<b>ERDA</b>	Energy Research & Development Administration
<b>FAB</b>	Final Adjudication Branch
<b>FOIA</b>	Freedom of Information Act
<b>FWP</b>	Former Worker Medical Screening Program
<b>FY</b>	Fiscal year
<b>HHS</b>	Department of Health and Human Services
<b>HR</b>	Hearing Representative
<b>IOM</b>	Institute Of Medicine of the National Academies
<b>JOTG</b>	Joint Outreach Task Group
<b>NIOSH</b>	National Institute for Occupational Safety and Health
<b>NLM</b>	National Library of Medicine
<b>OIS</b>	OWCP Imaging System
<b>PM</b>	Procedure Manual
<b>PoC</b>	Probability of causation
<b>RECA</b>	Radiation Exposure Compensation Act
<b>RESEP</b>	The Radiation Employees Screening and Education Program
<b>SEC</b>	Special Exposure Cohort
<b>SEM</b>	Site Exposure Matrix
<b>SSA</b>	Social Security Administration
<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

## Appendix 2 - DEEOIC Statistics as of December 29, 2013

### EEOICP Program Statistics<sup>81</sup>

#### Combined Part B and E Summary

		CLAIMS	CASES
Applications Filed		252,250	168,174*
Total Compensation Paid	Payments	91,262	66,459
	Total Dollars		\$8,333,937,263
Total Medical Bills Paid	Total Dollars		<u>\$1,745,136,681</u>
Total Compensation + Medical Bills Paid			\$10,079,073,944

\* The above numbers of applications filed represent 99,831 unique individual workers.

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**Part B**

		<b>CLAIMS</b>	<b>CASES</b>
Applications Filed		139,452	89,122
Final Decisions	Approved	66,407	42,687
	<u>Denied</u>	<u>58,559</u>	<u>40,606</u>
	Total	66,407	42,687
Compensation Paid	Payments	62,421	39,958
	Total Dollars		\$5,221,042,188

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**Part E**

		<b>CLAIMS</b>	<b>CASES</b>
Applications Filed		112,798	79,052
Final Decisions	Approved	42,839	35,890
	<u>Denied</u>	<u>56,087</u>	<u>35,881</u>
	Total	98,926	71,771
Compensation Paid	Payments	28,841	26,501
	Total Dollars		\$3,112,895,075

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## Part B Cancer Cases - NIOSH and SEC Statistics

### Part B - Status and Location of NIOSH Referrals

<b>Cases Referred to NIOSH for Dose Reconstruction (DR)</b>	<b>41,171</b>
Cases Returned by NIOSH	
With Dose Reconstruction (DR)	33,174
Without Dose Reconstruction (DR)* <sup>1</sup>	<u>5,797</u>
	<b>Total 38,971</b>
Cases Currently at NIOSH	2,200

\*<sup>1</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.

### Part B - Cases with Dose Reconstruction (DR) and Final Decision

Final Decision to Accept and Probability of Causation (POC) 50% or Greater	9,553
Final Decision to Deny and POC Less Than 50%	<u>17,488</u>
	<b>Total 27,041</b>

**Part B Cancer Cases with Final Decision to Accept<sup>\*2</sup>**

<sup>\*2</sup> Accepted Part B Cancer cases are defined as either a NIOSH or SEC approval; additional medical conditions could also be included within the Final Decision.

**Accepted DR Cases**

Cases Paid	8,852
Individual Claims Paid	12,524
Amount Paid	\$1,316,489,181

**Accepted SEC Cases**

Cases Paid	20,233
Individual Claims Paid	33,621
Amount Paid	\$3,020,009,795

**Cases Accepted Based on SEC Status and POC 50% or Greater<sup>\*3</sup>**

Cases Paid	673
Individual Claims Paid	812
Amount Paid	\$100,875,000

<sup>\*3</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.

**TOTALS: All Accepted SEC, DR Cases, and Combined**

Cases Paid	29,758
Individual Claims Paid	46,957
Total Amount Paid	\$4,437,373,976



UNITED STATES 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