

# 2014 Annual Report to Congress

## Office of the Ombudsman

Energy Employees Occupational Illness Compensation Program  
**United States Department of Labor**



**OFFICE OF THE OMBUDSMAN**  
UNITED STATES DEPARTMENT OF LABOR

Photo on the cover – General view of the "wet chemistry" facilities in a plutonium analysis laboratory operated by the Chemistry Division at Argonne. c.1965. Photo courtesy of ENERGY.GOV.

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**U.S. Department of Labor**

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



JAN 08 2016

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

Dear Mr. President:

I am pleased to present the 2014 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

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



**JAN 08 2016**

The Honorable Paul Ryan  
Speaker of the House  
Washington, DC 20515

Dear Speaker Ryan:

I am pleased to present the 2014 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".

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

Enclosure



# History Of The Energy Employees Occupational Illness Compensation Program

When some people think of the U.S. nuclear weapons program, what comes to mind are the scientists who performed the research (especially the scientists who performed research at the University of Chicago) and the testing conducted at sites in the desert and on islands in the Pacific Ocean. Yet, the activities associated with the development and production of nuclear weapons can be divided into eight (8) general categories: (1) uranium mining, milling, and refining; (2) isotope separation (enrichment); (3) fuel and target fabrication; (4) reactor operations; (5) chemical separation; (6) weapon component fabrication; (7) weapons operations; and (8) research development and testing.<sup>1</sup> In August 1942, when President Franklin D. Roosevelt approved the development of an atomic bomb under the U.S. Army Corps of Engineers Manhattan Engineer District (MED), later known as the Manhattan Project, this approval initiated work in all eight of the categories associated with the development and production of nuclear weapons.<sup>2</sup> Over time, what began as the Manhattan Project would grow to employ more than 600,000 workers in facilities located in 42 of the 50 states, as well as Puerto Rico and the Republic of the Marshall Islands.<sup>3</sup>

The work associated with the development and production of nuclear weapons often resulted in worker exposures to radioactive materials and/or other toxic substances. Concerns for the health and safety of these workers led, in October 2000, to the enactment of the Energy Employees Occupational Illness Compensation Program Act as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001.

As enacted in 2000, there were two “parts” to the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), Part B and Part D. Part B, which is administered by the Department of Labor (DOL), provides compensation and/or medical benefits/medical monitoring to eligible employees and survivors if the worker suffers (or suffered) from cancer that is at least as likely as not caused by radiation exposure, as well as chronic beryllium disease (CBD), beryllium sensitivity, or chronic silicosis.

Part D, on the other hand, directed the Department of Energy (DOE) to provide claimants with assistance in obtaining state-based workers’ compensation. In 2004, due to obstacles that prevented its efficient administration Congress repealed Part D and enacted Section 3161 of Public Law 108-375. Public Law 108-375, also known as Part E, is a federal compensation program for DOE contractor and subcontractor employees.

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

<sup>2</sup> In 1947, the functions of the MED were transferred to the civilian controlled Atomic Energy Commission (AEC). Subsequently in 1974, with the creation of the Energy Research & Development Administration (ERDA), the AEC was abolished. In 1977, the ERDA became the Department of Energy.

<sup>3</sup> 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.

The Division of Energy Employees Occupational Illness Compensation (DEEOIC), within DOL's Office of Workers' Compensation Programs administers Part B and Part E of EEOICPA. Nevertheless, other agencies also have a role with EEOICPA. The National Institute for Occupational Safety and Health (NIOSH) conducts activities to assist claimants and supports 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 regulations to develop estimates of radiation doses for workers who apply for compensation; overseeing the process by which classes of workers can be considered for inclusion in a Special Exposure Cohort (SEC) class; 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 provides direct assistance to claimants and SEC petitioners, including assistance in compiling materials needed to file SEC petitions. She also conducts outreach to promote a better understanding of EEOICPA and the claims process.

DOE ensures that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or NIOSH with information related to individual claims such as employment verification and exposure records, (2) supporting DOL, NIOSH and the Advisory Board on Radiation and Worker Health in large-scale records research and retrieval efforts at various DOE sites, (3) conducting research, in coordination with DOL and NIOSH, on issues related to covered facility designations, and (4) hosting the Secure Electronic Records Transfer (SERT) system. The SERT is a DOE hosted environment where DOL, NIOSH and DOE can send and receive EEOICPA records and data in a secure manner.

As of December 28, 2014, DEEOIC had paid out a total of \$11,110,154,317 in compensation and medical benefits on 176,156 cases representing 104,763 unique workers. These totals continue to grow.

# The Office of the Ombudsman

Public Law 108-375 which was enacted in 2004 also established the Office of the Ombudsman (the Office). While the Office is established within DOL, the Secretary of Labor is to ensure the independence of the Office within DOL, including independence from other officers and employees of the Department engaged in activities related to the administration of the provisions of EEOICPA. *See* 42 U.S.C. § 7385s-15(d).

As set forth in Public Law 108-375, the Office was scheduled to sunset on October 28, 2007. However, on October 22, 2007, former Secretary of Labor Elaine S. 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 110-118 reinstated the statutory requirement for the Office by extending the sunset date until October 28, 2012. On 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. Recently, on December 19, 2014, the National Defense Authorization Act (NDAA) of 2015, Public Law 113-291 extended the sunset date of the Office until October 28, 2019.

The statute outlines three (3) specific duties for the Office:

1. Provide information to claimants and potential claimants 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.
3. Carry out such other duties as the Secretary specifies.

*See* 42 U.S.C. §7385s-15(c). The statute 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.
- 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).

As we frequently observe, most people do not contact this Office simply to register a complaint or grievance. Instead, most people contact us because they want assistance with their claim. The assistance sought by these individuals often includes: (1) providing information about the program and the claims process; (2) directing the individual to the appropriate resources; (3) helping claimants utilize the various tools/resources developed to assist them; (4) clarifying/explaining documents; (5) providing the status of claims; (6) offering suggestions on where to search for needed information; (7) obtaining information from one or more of the other agencies involved in the administration of EEOICPA; and (8) serving as a sounding board.

The report that follows is a synthesis of the many e-mails, letters, telephone calls, facsimiles, and face to face conversations that members of this Office had over the past year.

# Preface to the Report

As required by the statute, this report sets forth the number and types of complaints, grievances, and requests for assistance received by the Office in 2014, as well as an assessment of the most common difficulties encountered by claimants and potential claimants during the year. However, before discussing the complaints and grievances that we received this year, we would like to acknowledge the efforts undertaken by DEEOIC and the other agencies involved in the administration of EEOICPA to assist claimants and to improve the EEOICPA claims process.

The chart below highlights DEEOIC’s continuing efforts to expeditiously adjudicate claims:

**Combination Part B and Part E Summary**

		<b>Cases as of 12/30/2012</b>	<b>Cases as of 12/29/2013</b>	<b>Cases as of 12/28/2014</b>
Applications Filed		159,585*	168,174**	176,156***
Total Compensation Paid	Payments	60,725	66,459	70,881
	Total Dollars	\$7,546,725,245	\$8,333,937,263	\$8,939,278,871
Total Medical Bills Paid	Total Dollars	\$1,344,088,687	\$1,745,136,681	\$2,170,875,446
Total Compensation plus Medical Bills Paid		\$8,890,813,932	\$10,079,073,944	\$11,110,154,317

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

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

\*\*\* A total of 104,763 unique individual are represented by the 176,156 reported cases.

Other achievements this year by DEEOIC included the updating of 19 of the forms used in the EEOICPA claims process and the updating of the Site Exposure Matrix (SEM) database. DEEOIC also continued the expansion of its new imaging system (OIS). This system, which is now available in all District and Final Adjudication Branch Offices, as well as the National Office, enables DEEOIC staff to view electronic images of paper case file materials. In addition, DEEOIC launched the Energy Document Portal (EDP), an electronic document submission system that allows EEOICPA claimants to electronically submit documents to their imaged case file managed in OIS.

**DEEOIC also hosted a number of outreach events in 2014.**

Site	Type of Event	Date(s)
Denver, CO	Town Hall Meeting	February 19
Denver, CO	Medical Benefits Town Hall Meeting	February 20
Albuquerque, NM	Town Hall Meeting	April 8 and 9
Attleboro, MA	Town Hall Meeting	June 18
Cromwell, CT	Town Hall Meeting	June 19
Moab, UT	Town Hall Meeting	June 24 and 25
North Augusta, SC	Town Hall Meeting	August 20
Window Rock, AZ	Town Hall Meeting	August 19
Shiprock, NM	Town Hall Meeting	August 20
Richland, WA	Open House	August 26
Amherst, NY	Medical Benefits Town Hall Meeting	September 23
Rochester, NY	Town Hall Meeting	September 25
Albuquerque, NM	Traveling Resource Center	November 13 and 20
Los Alamos, NM	Traveling Resource Center	November 3, 10, 17 and 24
Shiprock, NM	Town Hall Meeting	December 9 and 10

We also note that during the year there were claimants who specifically called to share positive encounters they had with members of the DEEOIC staff. In addition, there were instances when claimants who contacted us with complaints took the time to recognize the positive interactions they had with other staff members.

Lastly, we want to take this opportunity to thank the staff and leadership of the DEEOIC, as well as the staff and leadership of: the Division of Compensation Analysis and Support within the Department of Health and Human Services' National Institute for Occupational Safety and Health (NIOSH); the Office of Worker Screening and Compensation Support within DOE's Office of Environment, Health, Safety and Security; the Former Worker Screening Program projects; the Civil Division of the Department of Justice; and the Ombudsman to NIOSH for all of the assistance that they provided throughout the year.



# The 2014 Annual Report to Congress Office of the Ombudsman

for the Energy Employees Occupational Illness Compensation Program

# Tables

Section 7385s-15(e)(2) requires this Office to submit a report to Congress setting forth: (1) the number and types of complaints, grievances, and requests for assistance received during the preceding year, and (2) 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)(2). The numbers and types of complaints, grievances and requests for assistance received by the Office in calendar year 2014 are outlined in the following tables.

When reviewing these tables, please be mindful:

1. Claimants do not always characterize their concerns in a manner that is easy to count and/or categorize.
2. A claimant may contact us with a complaint, yet that complaint may raise several issues. We endeavor to separately count each issue raised by a claimant.
3. Only inquiries related to EEOICPA are included in these tables.<sup>4</sup>
4. While every effort is made to count each complaint brought to this Office, we continue to encounter instances where an accurate count is difficult. For instance:
  - > At some outreach events the demands placed on us render it impossible to accurately record each contact.
  - > Many individuals only provide us with the information they deem relevant to the issue at hand. This explains why we often do not know the site where the employee worked – in many instances the person reporting the complaint did not provide this information. In addition, individuals who contact us with specific complaints sometimes question the need to provide information that does not directly bear on their complaint.
5. Some complaints have the potential to impact many other claimants.

Table I reflects the complaints, grievances and requests for assistance recorded in our database. The majority of these complaints were presented to us via the telephone, facsimile or e-mail.

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<sup>4</sup> Individuals seeking assistance with other programs, especially other DOL programs, routinely contact this Office for assistance. These contacts are not included in these tables.

**Table 1 – Complaints by Nature**

	<b>Concern</b>	<b>Number</b>
1	Covered Employment	62
2	Covered Facility	11
3	Covered Illness	20
4	Eligibility of Survivors	16
5	Exposure to Toxins	35
6	Dose Reconstruction	23
7	Special Exposure Cohort	33
8	Causation	28
9	Impairment	25
10	Wage Loss	2
11	Issues With Medical Benefits Card	12
12	Home Health Care	82
13	Medical Billing Issues	28
14	Status	24
15	Issues Involving Authorized Representatives	4
16	Issues With Home Health Provider	5
17	Issues Involving RECA	9
18	Issues Involving Interactions with DEEOIC	Blank cell
	Inappropriate Conduct	45
	Calls not answered/could not get through	26
	Called to compliment DEEOIC staff	2
	Other	2
19	Processing of Claim Takes Too Long	49
20	Wanted to File a Claim	19
21	Issues Related to Reconsideration/Reopening	13
21	Requests For Assistance	179
22	Due Process Issues	37
23	Other Misc.	24
<b>Subtotal</b>		<b>815</b>

We also encounter claimants at the various outreach events that we attend and/or host. Sometimes due to the quantity and/or complexity of the complaints received at these outreach events it can be difficult to record every issue raised. The following table lists the outreach events that we attended in 2014 and provides an estimate of the number of people we directly spoke to at these events:

**Table 2 - Claimants we encountered at outreach events**

Location	Date	Type of Meeting	# of Claimants (who approached us with complaints or questions)
Kansas City, MO	1/14/2014	Ombudsman meetings	220*
Kansas City, MO	1/28/2014	NIOSH Advisory Board meeting	4
Denver, CO	2/19/2014	JOTG meeting	15
Denver, CO	2/20/2014	DEEOIC Medical Benefits meeting	
Albuquerque, NM	4/8/2014 and 4/9/201	DEEOIC Town Hall meetings	30
Denver, CO	4/15/2014	Town Hall Meeting sponsored by volunteer advisory board	14
Augusta, GA	4/29/2014	NIOSH Advisory Board meeting	0
Pahrump, NV	5/6/2014	JOTG meeting	15
Las Vegas, NM	5/6/2014 and 5/7/2014	JOTG meeting	35
Wellpinit, WA	5/14/2014 and 5/15/2014	RESEP meeting	21
Attleboro, MA	6/18/2014	DEEOIC Town Hall meeting	12
Cromwell, CT	6/19/2014	DEEOIC Town Hall meeting	9
Portsmouth, OH	6/20/2014	Town Hall Meeting sponsored by volunteer advisory board	10
Moab, UT	6/24/2014 and 6/25/2014	DEEOIC Town Hall meetings	35
Paducah, KY	7/17/2014	Town Hall Meeting sponsored by volunteer advisory board	10
Casper, WY	7/29/2014	Ombudsman meeting	43*
Riverton, WY	7/30/2014	Ombudsman meeting	40*
Kennewick, WA	8/26/2014	JOTG Open House	25
Spokane, WA	8/27/2014	JOTG meeting	12
Rochester, NY	9/15/2014	DEEOIC Town Hall Meeting	0
Buffalo, NY	9/23/2014 and 9/24/2014	DEEOIC Medical Benefits meeting	2
Paducah, KY	10/21/2014 and 10/22/2014	JOTG Outreach Event	7
Las Vegas, NV	10/31/2014	National Day of Remembrance	15
Canon City, CO	12/3/2014	Ombudsman meeting	45*
Denver, CO	12/4/2014	Retiree event	18
<b>Total number of claimants encountered at outreach events</b>			<b>637</b>

\* Everyone who attended an event sponsored by the Office of the Ombudsman is included in our count.

### Table 3 – Complaints by Facility

Table 3 provides the number of complaints, grievances and requests for assistance received from employees, former employees and survivors of former employees of various facilities. This table only reflects those instances where the complaint specifically identified the work site. Claimants do not always identify the work site, and in many instances we can answer the questions presented to us without collecting this information.<sup>5</sup>

**Table 3**

Facility	Location	# of complaints
Allied Chemical	Metropolis, IL	13
Ames Laboratory	Ames, IA	2
Area IV of the Santa Susana Field Laboratory	Santa Susana Area IV, CA	1
Bendix Aviation	Davenport, IA	4
Blockson Chemical Company	Joliet, IL	7
Dow Chemical Corporation (Madison Site)	Madison, IL	1
Feed Material Production Center	Fernald, OH	4
General Electric Company	Cincinnati, OH	2
Hanford	Richland, WA	29
Hooker Electrochemical	Niagara Falls, NY	1
Idaho National Laboratory	Scoville, ID	1
Iowa Ordnance Plant	Burlington, IA	19
Joslyn Manufacturing and Supply Company	Ft. Wayne, IN	4
Kansas City Plant	Kansas City, MO	24
Lawrence Livermore National Laboratory	Livermore, CA	4
Linde Air Products	Buffalo, NY	4
Los Alamos National Laboratory	Los Alamos, NM	4
Massachusetts Institute of Technology	Cambridge, MA	1
Mound Plant	Miamisburg, OH	1
National Bureau of Standards	Washington, DC	1
Nevada Test Site	Mercury, NV	4
Nuclear Metals, Inc.	West Concord, MA	1
Oak Ridge Gaseous Diffusion Plant (K – 25)	Oak Ridge, TN	5
Oak Ridge National Laboratory (X-10)	Oak Ridge, TN	3
Oak Ridge (Y – 12)	Oak Ridge, TN	11
Ore Buying Station at Grant	Grants, NM	1
Paducah Gaseous Diffusion Plant	Paducah, KY	6
Pantex Plant	Amarillo, TX	8
Portsmouth Gaseous Diffusion Plant	Piketon, OH	6
Rocky Flats Plant	Golden, CO	14

<sup>5</sup> Many of the claimants who contact our Office are already experiencing some degree of frustration. In many instances, this frustration is the result of the difficulties encountered as the claimant endeavors to obtain more information about the program. In other instances, we encounter claimants who are upset because they cannot get a direct answer to a question. To the extent we can, this Office strives to directly answer the questions posed by claimants.

<b>Facility</b>	<b>Location</b>	<b># of complaints</b>
Sandia National Laboratories	Albuquerque, NM	2
Savannah River Site	Aiken, SC	20
Simonds Saw and Steel Company	Lockport, NY	1
University of Rochester Atomic Energy Project	Rochester, NY	1
Uranium Miners, Millers and Ore Transporters	Various Sites	34
<b>Total</b>		<b>244</b>

# Assessment of complaints, grievances, and requests for assistance

In the past, we organized the report so that issues were generally discussed in the order that they typically arise in the claims adjudication process. Consequently, issues related to the filing of the claim were generally addressed in the early pages of the report and issues related to medical benefits and the payment of medical bills were usually addressed towards the end of the report. However, in recent years, we have experienced an increase in the number of complaints involving medical benefits and the payment of medical bills. In fact, in 2014, one of our largest categories of complaints involved issues related to medical benefits. In light of this recent trend, we thought it appropriate to begin this year's assessment of the most common complaints that we received with a discussion of the complaints involving medical benefits and the payment of medical bills.

## CHAPTER 1

# Issues Related to Medical Benefits

Under EEOICPA, eligible claimants are entitled to medical benefits to cover the reasonable cost of treatment for accepted medical illness(es). Medical benefits include services, appliances, supplies and home health care prescribed or recommended by a qualified physician, which are likely to cure, give relief to, or reduce the period of the accepted illness. *See* 42 U.S.C. § 7384t(a).

Around 2011, this Office began to see an increase in the complaints involving issues related to medical benefits. Initially, many of these complaints were prompted when claimants received a letter informing him/her of DEEOIC's intention to apply the procedures for authorizing home health care in a significantly more robust and rigorous manner.

- Claimants and authorized representatives (ARs) often questioned the need for changes to the procedures.
- Some claimants interpreted these letters as suggesting that they had done something wrong. Consequently, claimants contacted us: (1) wanting to know what they had done wrong, and/or (2) wanting to make it clear that they had followed procedures.
- We also heard from claimants and ARs who feared that these new procedures would prove to be overly burdensome.

*See* 2011 Annual Report to Congress, April 16, 2011, page 55. In 2012, while we continued to receive complaints generally addressing DEEOIC's more robust and rigorous application of the procedures for medical benefits, we began to receive complaints specifically addressing massage therapy. These complaints questioned the guidance from DEEOIC indicating that in order to be approved for massage therapy: (1) the therapy had to be prescribed by a physician for the treatment of an accepted condition; (2) the medical condition or level of function had to be expected to improve significantly within a

reasonable and generally predictable period of time with treatment; and (3) recertification was required for any period of time beyond six (6) weeks and recertification was only allowed in six (6) week increments.

In response to this guidance, claimants argued that:

- It was inconsistent with 42 U.S.C. § 7384t(a) to authorize massage therapy only when the therapy was expected to improve the condition. Rather, it was noted that the statute provided that eligible claimants would receive medical benefits likely to give relief, as well as likely to cure the illness.
- Requiring recertification every six (6) weeks was overly burdensome, especially since the recertification process required an in-person physician's visit.

*See* 2012 Annual Report to Congress, June 5, 2013, pages 61 – 62. Subsequently, DEEOIC issued EEOICPA Bulletin No. 13-01 which recognized that “reducing pain and muscle tension; increasing flexibility and range of motion; and improving blood circulation” were benefits derived from massage therapy. This bulletin also extended the initial authorization period for massage therapy to eight (8) weeks and permitted the claims examiner (CE) to grant authorization for continuing massage therapy of no more than two (2) visits per week for a maximum of 60 visits per year. *See* 2012 Annual Report to Congress, June 5, 2013, page 62.

In 2014, issues related to medical benefits continued to generate complaints. The most common complaints received in 2014 involved: (1) massage therapy; (2) durable medical equipment, oftentimes oxygen; and (3) issues related to the authorization and/or reauthorization of home health care benefits.

## **A. Massage Therapy**

As noted, Bulletin No. 13-01 permits the CE to authorize massage therapy for no more than two (2) visits per week for a maximum of 60 visits per year. Claimants argue that it is inconsistent with the statute to impose a maximum on the number of massage therapy visits they can receive in a year. In advancing this argument, claimants note that Section 7384t does not impose a maximum on the medical benefits to which a claimant is entitled. Rather, the statute provides that the government shall furnish services, appliances and supplies prescribed or recommended by a qualified physician. *See* 42 U.S.C. §7384t. Since the statute does not impose a numerical limit on the medical services to which a claimant is entitled, claimants question the appropriateness of limiting their medical benefits, especially when the service in question was specifically prescribed by the treating physician and there is no medical evidence in the record contradicting the prescription of the treating physician.

This is the precise concern raised by a claimant whose treating physician prescribed a course of massage therapy treatments that would eventually total more than 60 visits for the calendar year. This claimant takes issue with DEEOIC's decision to only authorize up to 60 massage therapy visits for the year, especially since this course of care was prescribed by his treating physician and there is no medical evidence in the record challenging this prescription.

- Since Bulletin No. 13-01 is the sole basis cited for denying the care prescribed by the treating physician this claimant believes that such application of this bulletin requires prior public notice and an opportunity for public comment. *See* discussion at Chapter 7(B) (Due Process – An opportunity for input and to respond).

- The claimant also asserts that his ability to challenge DEEOIC’s determination was severely impacted by DEEOIC’s refusal to issue a recommended decision. According to Bulletin 13-01.15, if a claimant requests a recommended decision regarding massage therapy, the CE is to prepare a Recommended Decision. This claimant contends that in spite of this provision, when he initially asked for a recommended decision, he was informed that a recommended decision was not appropriate at that time. Following the exhaustion of his 60 massage therapy visits for the calendar year, the claimant again contacted us to report that DEEOIC still had not issued a recommended decision.<sup>6</sup>

## **B. Durable Medical Equipment (DME)**

EEOICPA Bulletin No. 13-03, which became effective on October 1, 2013, provided that if the DME purchase price was greater than \$2000, claimants had to submit, from different DME suppliers, two estimates for the exact same type of DME appliance. This bulletin also required each potential supplier to provide: (1) a signed statement describing in detail the DME equipment; (2) a breakdown of all costs; and (3) the current Healthcare Common Procedure System code for each DME item.<sup>7</sup> In response to this bulletin:

- Claimants asserted that it was overly burdensome to seek two estimates anytime the purchase price for DME was greater than \$2000.
- We were told of instances where providers decided that the cost of the DME did not make it worth their time to prepare a signed statement describing in detail the DME equipment item and a breakdown of all costs.
- We also received comments suggesting that it was not always feasible to obtain an estimate for the exact same type of DME appliance. One comment came from the representative of a company that provides hearing aids. This representative noted that to distinguish their product, some companies purposely made their product slightly different from the product offered by their competitors. Consequently, this representative indicated that it was impossible for her company to provide an estimate for the exact same type of hearing aid offered by its competitors.

## **C. Concerns specifically related to oxygen equipment**

Claimants also contacted us with complaints concerning their receipt of oxygen supplies. The three most common issues that we encountered involved:

- Requiring claimants to purchase, rather than rent, oxygen equipment.
- The inability to locate providers willing to sell the necessary supplies.
- The decision by some providers to terminate their service to DEEOIC claimants.

<sup>6</sup> In April 2015 while drafting this report, we were informed that in November 2014, some 18 months after initially requesting a decision, the claimant finally received a recommended decision.

<sup>7</sup> On October 15, 2014, DEEOIC issued Circular No. 15-03. Pursuant to this circular estimates are no longer required when the OWCP fee schedule applies.

## 1. Requiring claimants to purchase rather than rent oxygen equipment

We were contacted when some claimants received notices directing them to purchase, rather than rent, oxygen equipment.<sup>8</sup> In many of these instances, since they had previously rented oxygen equipment, as an initial matter these claimants wanted to know why DEEOIC had now decided that he/she needed to purchase this equipment.

In questioning the determination that oxygen equipment should be purchased (rather than rented), some claimants believe that too much consideration is given to cost, and too little consideration given to the added burden placed on claimants when equipment is purchased. For instance, claimants wonder how much, if any, consideration is given to the fact that when oxygen equipment is rented, the leasing company generally provides all of the supplies needed during the rental period. On the other hand, when equipment is purchased, the claimant is responsible for monitoring and purchasing the necessary supplies.

Similarly, it was noted that when equipment is rented, claimants simply called the company if maintenance was required. So far we have not encountered a situation where a claimant faced an urgent maintenance problem. There are those who argue that requiring claimants to be responsible for the maintenance of equipment imposes an added burden on claimants.

Some claimants noted that while others may view concerns involving the monitoring of supplies and the maintenance of equipment as issues of convenience, oftentimes because of the other challenges that they face these issues present major obstacles.

## 2. Difficulties locating providers

Some claimants who were directed to purchase oxygen equipment contacted us when the DME provider refused to sell them the equipment. In their complaints, claimants stressed that the refusal of their current provider to sell this equipment meant that they had to find a new provider – a task sometimes complicated by the scarcity of providers (in particular areas) and/or the scarcity of providers willing to accept the EEOICPA medical benefits card for payment. Claimants often found it unsettling to think that they would not be served by the provider with whom they had established a good relationship and would now have to work with someone they did not know.<sup>9</sup>

To assist claimants in locating providers, there is a tool that one can access from DEEOIC's website or directly access from the website of Affiliated Computer Services (ACS), the company with whom DOL contracted to handle all medical authorizations and bill processing. However:

- We routinely encounter claimants who are not aware that this tool exists.
- Since this is an online tool, claimants who do not have access to the internet (or limited access) often find it difficult, if not impossible, to use this tool.

<sup>8</sup> The procedures for authorizing oxygen therapy durable medical equipment and oxygen medical supplies were updated by Bulletin No. 15-02 which became effective on April 17, 2015.

<sup>9</sup> One claimant noted that his provider refused to sell oxygen equipment citing to "liability" issues.

- Even with access to the internet, this tool can be difficult to locate and use.<sup>10</sup>

The staff of DEEOIC is available to assist claimants in locating providers. However, as with other aspects of EEOICPA, we receive comments suggesting that there is a wide difference in the level of assistance provided to claimants. While some claimants praise the assistance offered by the CE, hearing representative (HR), or other staff members, other claimants complain that they received little, if any assistance. When claimants contact us for assistance locating providers, we usually inform them that this information is available online. In response, some claimants complain that no one ever told them about this tool and/or never offered to assist them in locating or using this tool. We also encounter claimants who suggest that it was only when they were in crisis (i.e., they were almost out of supplies or when they escalated the matter), that someone finally stepped forward to assist them. In our experience:

- Claimants often become very anxious when they fear that they are about to run out of needed medical supplies.
- From the perspective of many claimants, one of the advantages of this program is its purported “non-adversarial” nature. We routinely encounter claimants who are adamant that they do not want to “fight” the government. Accordingly, some claimants find it disconcerting when the claims process takes on, what they deem to be, an adversarial nature.

### **3. The decision by some providers to terminate service to some DEEOIC claimants**

During the course of the year, claimants, as well as health care providers, told us of instances where physicians and/or providers of DME terminated (or threatened to terminate) services to EEOICPA recipients. On the one hand, we were told of instances where physicians and other providers terminated services as a response to billing issues. For example, we were made aware of instances where oxygen providers terminated service to claimants when the provider was unable to resolve his/her billing issues with DEEOIC (or ACS). On the other hand, we were also told of instances where physicians and/or providers terminated services because they felt that this program required too much paperwork.

On October 15, 2014, DEEOIC issued EEOICPA Circular No. 15-03. The circular states that estimates are no longer required when authorizing the purchase of DME, supplies, and custom devices for which the OWCP Medical Fee Schedule applies. This circular further states that the existing procedures concerning the collection of estimates for requested DME or supplies only applies when the DME or supplies have a total purchase price greater than \$500 and the OWCP Medical Fee Schedule is not applicable. The hope is that this circular will resolve some of the concerns raised by claimants and suppliers with regard to Bulletin No. 13-03.

## **D. Home Health Care**

A majority of the complaints that we receive relating to medical benefits concern home health care and particularly arise when a claimant’s level or type of home health care services are reduced or terminated by DEEOIC. The two most common complaints question:

- Whether claimants received adequate notice advising them when the medical evidence submitted on their behalf was inadequate.

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<sup>10</sup> To access this listing from DEEOIC’s webpage, under the heading “Claimant Resources” one must click “Get Help With My Medical Bills.” Under “Available Features” you click on “Provider Search.” After accepting the agreement, you are asked to choose the program. If you select “DEEOIC,” you come to a search of EEOICPA providers enrolled in the program. (In our experience “DEEOIC” is another of the many acronyms to which some claimants are not familiar).

- The qualifications of the person associated with DEEOIC making the determination regarding the adequacy of the claimant's medical evidence.

### **1. The adequacy of the notice advising claimants when medical evidence submitted on their behalf is inadequate**

Claimants contact us to question the adequacy of the notice advising them that medical evidence submitted on their behalf in conjunction with a request for in home health care was inadequate. Pursuant to the EEOICPA Procedure Manual (PM), if medical evidence accompanying a request for in home health care is incomplete, the CE prepares a letter to the claimant and the treating physician advising that additional medical evidence is required.<sup>11</sup> See EEOICPA PM Chapter 3-300.2(k). If there is no response within 30 days (or if the response is not satisfactory) the CE prepares a second letter to the claimant, accompanied by a copy of the initial letter, advising the claimant that the treating physician did not respond to the initial request (or that the response was not satisfactory). This letter also advises the claimant that an additional period of 30 days is granted to submit the necessary evidence. See EEOICPA PM Chapter 3-300.2(m). If medical evidence is received, but the treating physician does not provide sufficient details, the CE must refer the case to a contract medical consultant (CMC) for review. See EEOICPA PM Chapter 3-300.2(p).

- We were contacted by claimants who wanted to know why DEEOIC forwarded their claim to a CMC (or why DEEOIC sought another medical examination). In many of these instances, claimants told us that prior to learning that their claim had been forwarded to a CMC (or prior to being ordered for another examination) they had no inkling that DEEOIC had an issue with the evidence they submitted.
  - > In some instances we discovered that the claimant's lack of notice occurred because his/her AR only provided DEEOIC with the AR's contact information. Thus correspondence was only mailed to the AR.
  - > However, there are other instances where it is not clear if a notice was sent to the claimant (and/or the AR) and if so, why claimant never received this notice.
- We also encountered instances where claimants complained that while they received a letter informing them that their medical evidence was insufficient, the letter was so vague that he/she did not know how to respond.
  - > Claimants complain that vaguely worded letters do not provide them with the guidance needed to correct deficiencies. Claimants wanted to specifically know what aspect(s) of their medical evidence was insufficient, and what they were expected to do to address any deficiencies.
  - > It is even more problematic for claimants, when their treating physician finds DEEOIC's letter to be vague. Claimants frequently tell us that when DEEOIC deems a physician's initial report insufficient, that physician often wants (and sometimes demands) specific guidance before investing the time to supplement the initial report.

<sup>11</sup> The treating physician is asked to provide a narrative medical report that describes the in-home medical needs; level of care required; extent to care required; and to estimate the length of time for which the patient will require in-home health care assistance. EEOICPA PM Chapter 3-300.2(k).

- > Many claimants also believe that obtaining specific guidance is the best way to avoid embarking down a path where multiple trips to the doctor are necessary in order to obtain a report that meets DEEOIC's expectations.

Here are some other complaints that we hear when claimants contact us to question the adequacy of the notice advising them that their medical evidence is inadequate:

- There is a fear that repeatedly asking a physician to modify (or supplement) his/her report will cause the physician to stop treating EEOICPA patients. In fact, we are told of physicians who stopped treating EEOICPA patients because of their concerns with all of the paperwork.<sup>12</sup> DEEOIC stresses that physicians can be compensated for the time used to prepare reports. In response, claimants, health care providers, and some physicians emphasize that money is not the only issue. We are told that physicians have, in fact, grown frustrated with the time it takes to repeatedly write reports for DEEOIC.
- We also hear of instances where a physician believed that his/her initial report sufficiently addressed the issues and thus balked when asked to supplement (or further explain) his/her conclusions. In many of the instances brought to our attention, it was suggested that the physician balked because he/she questioned the medical basis for determining that his/her report was not adequate (and/or questioned the expertise of the program official making this determination).

## **2. The qualifications of the person determining the adequacy of claimant's medical evidence**

In the 2013 annual report, we discussed complaints alleging that nurses working for DEEOIC attempted to influence the plan of care prepared by some treating physicians. *See* 2013 Annual Report to Congress, August, 12, 2014. Although we did not hear this specific complaint in 2014, claimants continue to question the identity and/or the qualifications of the person evaluating the medical evidence submitted in support of claims for medical benefits.<sup>13</sup>

In some instances, the concerns raised by claimants questioning the qualifications of the person reviewing the medical evidence were prompted by vaguely worded letters (or decisions). Where a letter (or decision) does not explain why certain medical evidence was deemed insufficient, claimants sometimes question: (1) the basis for determining that the evidence was insufficient, and/or (2) the qualifications of the person who determined that the medical evidence was inadequate.

During the course of this year we were presented with instances where claimants questioned whether a CE, HR, or other DEEOIC official had exceeded his/her expertise in evaluating the medical evidence supporting their claim for home health care. These concerns frequently arise in instances where the claimant believes that the CE, HR, or other DEEOIC official attempted to extrapolate from the evidence in the record to draw his/her own medical conclusions.

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<sup>12</sup> We also received complaints alleging that some physicians are refusing to perform impairment ratings for EEOICPA patients for the same reason.

<sup>13</sup> Concerns involving the qualifications of the person evaluating medical evidence arise both when cases are forwarded for review by a specialist, as well as when the medical evidence submitted by the claimant is not accepted in either the recommended or final decision.

# Medical Billing Issues

In 2014, this Office experienced a significant increase in the number of complaints related to medical billing.

## A. Claimants only become aware of medical billing issues at the last minute

*XXX received a notice that his oxygen with XXX is to be picked up due to non-payment on equipment...*  
(A letter written to this Office on behalf of a claimant)

Problems with the payment of medical bills have led to some of our most tense conversations with claimants. What often makes these conversations so tense is that when we are contacted, claimants often feel that they are facing an immediate crisis. The crisis often arises because when it comes to matters relating to the payment of medical bills, as a general rule, DEEOIC directly corresponds with the provider. Thus, we routinely hear from claimants who only became aware that there was a problem with the payment of a medical bill when notified by the provider of a pending discontinuation of services, or when an outstanding bill was referred to a collection agency. Consequently, when claimants contact us they are: (1) often upset that they only recently learned of these problems, and (2) very anxious to have these problems resolved.

Some claimants fear that disputes over the payment of medical bills will have a negative impact on their credit rating. This concern only adds to the frustration felt by claimants when they discover that they were not given earlier notice of problems involving the payment of medical bills. This further explains why claimants are often very anxious to quickly resolve billing issues.

## B. Difficult to locate someone willing to assist with billing issues

As we discuss in Chapter 8(A) (Telephone Calls), we routinely receive complaints alleging that when some claimants attempted to contact their CE (or HR) to discuss billing issues, the telephones were not answered, and/or messages were not returned. Since they are often anxious to resolve billing issues as quickly as possible, claimants can become dismayed when they encounter delays trying to contact someone who can assist with these matters.

We also find that some claimants are not sure who to contact for assistance in resolving billing issues – claimants are sometimes unsure whether to contact their CE or ACS.

Some claimants and ARs told us that prior to contacting our Office there had been unsuccessful attempts to resolve the matter by working with DEEOIC and/or ACS.

*...I still have no Oxygen from [my provider]. [T]hey say every time they submit some things to London KY they throw something else that she needs...My Lady in Cleveland had tried to help them and not sure if they don't understand what to do or what...  
[I]'ve did all I can do with them. [T]he DOL in Cleveland had tried several time[s] to help them. I think London Ky is the problem.*

## C. Concerns with the assistance that is provided to them

A common theme raised by claimants who come to us with complaints involving medical bills focuses on the lack of assistance provided to them. We also frequently hear from claimants who suggest that it was only when the issue became urgent (i.e., they were days away from having a service discontinued) or when they escalated the matter, that someone finally started working with them to resolve the matter.

- Claimants find it troubling when they contact DEEOIC for assistance with billing issues and DEEOIC responds by asking them to identify the bills or the particular charges on the bill in question. Since DEEOIC generally does not notify claimants when there are problems with the payment of bills, claimants cannot understand why DEEOIC would think that the claimant could identify the disputed charges on particular bills. Moreover, claimants believe that DEEOIC is in a much better position to identify the disputed (or unpaid) charges or bills.<sup>14</sup>
- Claimants also complain that in order to identify the disputed charges and/or bills, they often find that they must go back and forth between the provider and DEEOIC in an effort to obtain the precise information sought by DEEOIC. In addition, some claimants told of instances where they did not have the coding or billing expertise to understand the issues at hand.

Some claimants noted that when it came to issues related to the payment of medical bills, they felt “caught in the middle.” It was noted that while on the one side you had a provider who wanted to be paid, and on the other side you had DEEOIC/ACS demanding adherence to procedures and policies, the claimant was often caught in the middle, sometimes going without, or drawing close to going without, necessary medical equipment or services – while each side blamed the other for the problem.

We also received complaints suggesting that when claimants were able to talk to someone with DEEOIC or ACS, they were sometimes provided little, if any, assistance in addressing these billing issues. The two examples below highlight instances where claimants complained that they were not offered adequate assistance in addressing complex billing issues:

### *Example 1*

During an extended hospitalization for a covered illness an elderly claimant developed complications which required additional treatment and lengthened her hospital stay. When the claimant sought to have the medical bills paid, she was advised that she needed to file a claim for her complications as “consequential conditions.” However because her stay in the hospital was so extensive, the claimant had undergone several procedures and had accumulated numerous bills. This claimant told us that it would have helped if someone had worked with her to identify the treatment and bills that might qualify as consequential conditions.<sup>15</sup>

Moreover, while DEEOIC ultimately accepted 19 new consequential conditions, the claimant had to meet with her doctor and the hospital billing office in order to identify the 19 treatments

<sup>14</sup> In many of the instances brought to our attention, claimants only became aware of a problem with the payment of a bill when advised by the provider that services would be discontinued. In advising the claimant of the discontinuation of services, the provider often did not identify the specific bill(s) in arrears and claimants often did not think to obtain this information.

<sup>15</sup> Many claimants only want to submit bills to DOL for conditions that they reasonably believe are related to their covered illness. Thus, some claimants are not willing to submit all of their bills just to see which bills DOL is willing to pay.

and procedures in order to claim them as consequential conditions. She also encountered one bill that was repeatedly denied. The claimant was not directly informed of the reason for these denials. Rather, it was only when the bill was sent for collection that she learned that the bill was denied because the provider was not enrolled with ACS. The claimant asserted that simply telling her that the provider was not enrolled in ACS did not solve her problem – she needed to know what to do to get the bill paid.

### *Example 2*

A claimant with two covered illnesses was admitted to the hospital, and similar to Example 1, was kept in the hospital for an extended period of time due to complications and the diagnosis of a new illness. Due to a billing error, the bills related to the two covered conditions were forwarded to Medicare.<sup>16</sup> After succeeding in having these bills forwarded to DEEOIC, the claimant approached us when payment of these bills was denied because the ICD-9 codes from the hospital bills were not entered into the ACS bill-pay system as “approved.” In contacting us, this claimant wanted to know what to do when the ICD-9 codes were not entered into the ACS bill-pay system as approved. While this claimant was encouraged to submit claims for the consequential illnesses, this posed a problem since he found it difficult to distinguish the treatments and/or bills that were denied because they needed to be claimed as consequential conditions, versus the bills that were denied for other reasons, such as lack of medical evidence or proper coding. This claimant complained of feeling overwhelmed due to the lack of assistance from the agency in explaining the reason particular bills for treatment were denied.

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<sup>16</sup> In our conversation with this claimant, we also discovered another problem that he was facing. When notified that two conditions were potentially covered under EEOICPA, Medicare stopped paying for any treatments related to these two conditions. Since EEOICPA only pays for medical benefits as of the date of filing and Medicare retracted all payments for the covered illness, regardless of when the bills were incurred, the claimant was having difficulties obtaining payment for those bills related to covered conditions which he incurred prior to the filing of his EEOICPA claim. Further, adding to his problem, Medicare erroneously retracted payments for medical conditions not covered under EEOICPA and this claimant had no idea who to contact with DEEOIC and/or ACS to assist him with his Medicare issues. (The claimant wanted someone from DEEOIC to contact Medicare and explain the coverage provided by EEOICPA).

# Issues Related to the Statute

We receive complaints and grievances addressing practically every aspect of the EEOICPA claims process. Some of the complaints that we receive directly challenge the statute as written. Addressing these concerns usually requires a change to the statute. In this chapter, we address the most common complaints that we received this year regarding the statute as written.

## A. Limitations outlined in the statute

We frequently receive complaints questioning the scope of the program – i.e., the employees covered under this program and the illnesses for which employees are covered. Often underlying these concerns is the belief that in creating EEOICPA Congress intended to compensate everyone who ever worked at a covered DOE facility and intended to compensate these employees for any illness (or death) arising from exposures to toxins related to this employment.<sup>17</sup> However, EEOICPA sets forth a compensation plan that identifies both the employees, as well as the illnesses covered under this program. The following charts outline the employees and illnesses covered under EEOICPA.

**Chart 1**

Employees covered under Part B	Employees covered under Part E
DOE contractor	DOE contractor
DOE subcontractor	DOE subcontractor
Beryllium Vendor	Uranium miners, millers, and ore transporters covered under Section 5 of the Radiation Exposure Compensation Act (RECA) <sup>18</sup>
Atomics Weapons Employer	
DOE employees	
Approved RECA Section 5 Claimants	

**Chart 2**

Potential Part B Illnesses	Potential Part E Illnesses
<ul style="list-style-type: none"> <li>▪ Radiation Induced Cancer</li> <li>▪ Chronic Beryllium Disease</li> <li>▪ Beryllium Sensitivity</li> <li>▪ Chronic Silicosis (if mining of atomic weapon test tunnels in Nevada or Alaska)</li> <li>▪ “Supplement” for RECA Section 5 uranium workers</li> </ul>	Any illnesses or death (including illness or death related to cancer or beryllium) where it is at least as likely as not that exposure to a toxic substance at a covered facility was a significant factor in aggravating, contributing to, or causing the employee’s illness or death.

<sup>17</sup> Many concepts were discussed both prior to, as well as during the discussions that led to the creation of EEOICPA. Not all of these concepts were incorporated into the statute.

<sup>18</sup> A claimant with an approved RECA Section 5 claim is eligible for additional compensation under Part B. In addition, a claimant who qualifies as a RECA Section 5 uranium miner, miller, or ore transporter may be eligible for compensation and benefits under Part E. Unlike Part B, under Part E, there is no requirement that the RECA Section 5 miner, miller, or ore transporter have an approved RECA claim.

- We are routinely asked why some employees who worked at these facilities are covered under EEOICPA, while others are not. For example, former employees of the Department of Defense asked why federal DOE employees are covered under Part B, while many of the other federal employees who also worked at covered facilities are not covered at all under this program.<sup>19</sup>
- The fact that some employees are only covered under Part B, while others are covered under both Part B and Part E also continues to generate complaints. In this regard, claimants continue to question why DOE federal employees and employees of Atomic Weapons Employers (AWEs) are only covered under Part B, while DOE contractor and subcontractor employees are covered under both Part B and Part E. *See* Chart 1.<sup>20</sup> Since Part E covers a broader range of illnesses than those covered under Part B, claimants who are only covered under Part B argue that they are excluded from coverage for a host of illnesses related to their employment at these covered facilities. *See* Chart 2. In particular, we hear this concern from former employees of AWEs who question why they are not covered under Part E. In 2014, the former AWE employees who raised this concern included former employees of Allied Chemical in Metropolis, Illinois and Bethlehem Steel in Lackawanna, New York.

Another distinction found in the statute that continues to generate complaints is the fact that Part B covers different employees for different illnesses. The differences in Part B coverage are outlined below.

**Chart 3**

<b>Part B Covered Employees</b>	<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

As in previous years, in 2014 we were contacted by former employees of AWEs who are adamant that in the course of their employment they were exposed to beryllium. As a result, these former AWE employees believe that they should be covered under Part B for chronic beryllium disease (CBD) and beryllium sensitivity.<sup>21</sup>

Many claimants have the same response when notified that they (or a loved one) who worked at a covered facility are not a covered employee under EEOICPA (or not covered for a particular illness). These claimants stress how they (or their loved one) worked at the covered facility and thus were exposed to all of the same toxins as any other employee at this facility. They then argue that it is unfair to exclude them (or their loved one) from coverage simply because of the classification given to the employment.

<sup>19</sup> Beryllium vendor coverage extends to direct employees of the vendor, its contractors or subcontractors and to any Federal employee who may have been exposed to beryllium at a facility owned, operated, or occupied by the vendor. *See* Chapter 2-500.2(b)(1) of the PM.

<sup>20</sup> While employees of Beryllium Vendors could also question why they are not covered under Part E, in 2014 we did not receive any complaints from employees of Beryllium Vendors.

<sup>21</sup> While employees of Beryllium Vendors could question why they are covered under Part B for CBD and beryllium sensitivity and are not covered under Part B for cancers caused by radiation exposure or chronic silicosis, in 2014 we did not receive any complaints from employees of Beryllium Vendors.

Three other concerns that we frequently hear from individuals who do not meet the eligibility requirements for a covered employee include:

- They find it troubling when no one is able to explain why others who worked at these facilities are covered under EEOICPA and they are not.<sup>22</sup>
- It also concerns them when no one can direct them to a program that might potentially compensate them for the illnesses they suffer as a result of their employment at these facilities.
- To the extent there are other programs under which they might pursue a claim, claimants often question whether these programs are equipped to provide the assistance needed to pursue a claim for illnesses related to the toxic exposures sustained at these facilities.

Employees of the federal government may be eligible to file a claim under the Federal Employees' Compensation Act (FECA). However, in our experience many federal employees are not aware of FECA. In addition, when advised of FECA, some federal employees questioned whether FECA offered the specialized assistance needed to pursue a claim based on employment and exposures stemming from work at DOE covered facilities.

## B. Other Statutory Concerns

As noted earlier, many of the complaints that we receive address the statute and involve matters related to covered employment and/or covered illnesses. However, during the course of the year, there were some complaints that addressed other issues related to the statute:

### 1. Cap on Benefits

The lump sum payment for most Part B claims is \$150,000.<sup>23</sup> Part E, on the other hand, provides for maximum aggregate compensation not to exceed \$250,000. *See* 42 U.S.C. §7385s-12. During the year we received complaints asserting that as a result of these caps on compensation, some claimants were not fully compensated for covered illnesses. We often hear this concern:

- When the covered condition continues to deteriorate even after the claimant received the statutory maximum(s) outlined in the statute.
- Where a claimant who previously received the statutory maximum(s) under EEOICPA for one illness subsequently developed an additional illness.

### 2. Commencement date for medical benefits

Section 7384t(d) provides that an individual receiving benefits shall be furnished with medical benefits as of the date on which the claimant submitted the claim. *See* 42 U.S.C. §7384t(d). Claimants believe that this provision ought to include an exception for situations where claimants were not properly notified of this program. Where they did not receive prompt notice of this program, claimants contend that it is

<sup>22</sup> Claimants note that when they ask why they are not covered under this program, in response they are often told that this is how the statute was written. Claimants want to know why the statute is written in this manner.

<sup>23</sup> Under Part B, an employee with an accepted claim for beryllium sensitivity is entitled to medical monitoring (but no lump sum payment). In addition, an individual with an approved Section 5 RECA claim is entitled to an additional \$50,000 lump sum under EEOICPA.

unfair to deny their request for reimbursement for medical expenses on the grounds that these expenses were incurred prior to the filing of the claim.

Another claim that raised different issues came to our attention this year and involved a claim for benefits for skin cancer. The claimant previously received a determination that his claim for benefits for skin cancer was accepted under Part B because the probability of causation that his skin cancer was caused by exposure to radiation exceeded 50%. He subsequently developed additional skin cancers, and contacted our Office after being informed that the initial doctor's visit, surgery, and pathology reports to diagnose the additional skin cancers would not be covered because they were incurred prior to the filing of the claim for additional cancers. This claimant finds it troubling that while his earlier claims for skin cancer were accepted, these later bills for diagnostic treatment of the same organ system (skin) were not covered since he had not filed a claim prior to incurring these diagnostic services. Rather, the claimant was advised that 42 U.S.C. § 7384t(d) prevented the payment of these later bills. This claimant questions the feasibility of being able to file a claim for a new skin cancer prior to the diagnosis of the new skin cancer.<sup>24</sup>

### **3. Chronic Lymphocytic Leukemia (CLL)**

Confusion continues to surround the treatment of claims for CLL. Pursuant to 42 U.S.C. § 7384l(9) in order to qualify as a "covered employee with cancer," a member of the SEC must be diagnosed with a specified cancer. However, CLL is specifically excluded from the list of specified cancers. *See* 42 U.S.C. § 7384l(17). In addition to this statute, at one time NIOSH also had a regulation excluding CLL from dose reconstructions. In 2012 NIOSH announced a new rule designating CLL as potentially caused by radiation and therefore eligible for dose reconstruction and potentially compensable under EEOICPA. As a result of this new rule, claims for CLL are now forwarded to NIOSH for dose reconstructions. Confusion arises because some claimants assumed that NIOSH's recognition of CLL as potentially caused by radiation meant that CLL would be added to the list of specified cancers addressed in section 7384l(9). To date, this has not happened. Therefore, we are approached by claimants who want to know if there is anything that DOL, DOE, and/or NIOSH can do to initiate or facilitate including CLL on the list of specified cancers.<sup>25</sup>

### **4. Lack of Representation**

In their conversations with us, some claimants remark at how difficult it is to locate someone willing to serve as their ARs. Although they often do not have specific suggestions, frequently underlying these concerns is a belief that the government can do more to encourage people to serve as ARs and/or that there are current policies that discourage individuals from serving as ARs.

Some claimants believe that the inability to locate ARs willing to handle certain claims is the result of the current fee structure. 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.

<sup>24</sup> This claimant further stressed that in most, if not all instances, the doctor excised a tissue sample, sent the sample to pathology, and based on the pathology diagnosed cancer. Thus, this claimant notes that with his skin cancers, much of the costs were incurred prior to receiving a diagnosis.

<sup>25</sup> There were also situations we encountered where because leukemia is on the list of specified cancers the claimant assumed that CLL (chronic lymphocytic leukemia) was on the list as well.

- Since the percentage for the fee is the same regardless of the complexity of the claim, some claimants believe that this fee structure encourages ARs to assist with “easy” claims and to avoid the more difficult claims – the very claims where claimants need greater assistance.

Claimants routinely remind us that while this program is often characterized as “claimant friendly,” there are instances where, in spite of the various tools and resources developed to assist them, they are ultimately faced with the burden of locating evidence to verify employment and exposure, and/or linking their illness to exposures at work. Moreover, claimants frequently stress that the task of locating evidence is sometimes further complicated by health and other challenges, as well as by the complexity of the underlying issues. As a result, some claimants maintain that it is extremely helpful (and sometimes necessary) to have someone who can directly assist with the claim (as opposed to someone who simply tells them what to do).

#### **5. Eligibility of Employees of Wholly-Owned Subsidiaries of AWEs for Benefits Under the EEOICPA (EEOICPA Bulletin No. 04-12)**

Although this issue concerns Bulletin No. 04-12, since it is directly impacted by the statute and concerns coverage, we address it here. After recognizing that 42 U.S.C. § 7384l(5) requires that an AWE facility be owned by a DOE-designated AWE, Bulletin No. 04-12 states that a wholly-owned subsidiary of an AWE cannot be an AWE unless the wholly-owned subsidiary itself is designated as an AWE. Former employees of South Buffalo Railroad, a wholly owned subsidiary of Bethlehem Steel take exception with this bulletin. Since this railroad operated on the grounds of Bethlehem Steel and operated for the benefit of this AWE, former employees of South Buffalo Railroad argue that the company’s status as a wholly owned subsidiary of this AWE should not impact coverage.

# Problems Filing Claims and Obtaining Information

Throughout the year, we were contacted by individuals searching for information about the program. In our experience, we routinely encounter individuals with little, if any, previous contact with this program who have already started to develop negative attitudes about this program. These negative attitudes often stem from what these individuals believe are delays in notifying them of this program and/or the difficulties they encounter trying to obtain information about this program.

## A. Potential Claimants Not Aware of the Program

Even though DOL and the other agencies involved in the administration of EEOICPA have, since the inception of this program, endeavored to notify potential claimants about this program, we continue to receive complaints that focus on the lack of notice (or lack of prompt notice) about this program. Just in fiscal year 2014 alone, DEEOIC hosted/participated in approximately 30 outreach events at locations around the country. Yet, in spite of these efforts, we continue to encounter claimants who assure us that they only recently learned of this program.

While they may not specifically cite to 42 U.S.C. § 7384v(b), many claimants are generally aware that the government is to inform potential claimants of the availability of this program. Consequently, we receive complaints questioning whether the government is taking adequate steps to inform employees of the availability of this program. Section 7384v(b) provides that:

(b) ASSISTANCE FOR POTENTIAL CLAIMANTS – The President shall take appropriate actions to inform and assist employees who are potential claimants under the compensation program, and other potential claimants under the compensation program, of the availability of compensation under the compensation program...

The concerns that we receive questioning the adequacy of the government's efforts to inform claimants of this program are frequently raised by claimants who contend that they only learned of this program by coincidence – i.e., they learned of the program from a friend or neighbor. These claimants find it very unsettling to think that but for a passing remark, they may never have known of this program.

As we noted, the agencies involved with EEOICPA continue to host outreach events. Yet, it is our experience that when claimants complain about the lack of notice (or lack of prompt notice), they usually are not interested in hearing responses that simply address the number of events held by an agency, or the amount of money that the program has paid to date. Rather claimants want to know why notices of this program were never directly mailed (or not promptly mailed) to them. A frequent explanation for the lack of direct mailings suggests that when this program was created, the government did not have complete employee rosters. In light of the security that generally surrounded these facilities, we talk to claimants who find it hard to believe that the government could not locate them. For instance, some claimants responded to this explanation by assuring us that they routinely received a retirement check from their former employer, and thus questioned why the government did not work with this former employer to notify potential claimants about this program. Moreover, believing that some

employee rosters may now be available, claimants question the extent to which the available rosters are used to notify potential claimants of this program.<sup>26</sup>

We attended outreach events where attendees questioned the efforts undertaken to disseminate information about this program to colleagues who had since moved to other parts of the country.

Lastly, there are claimants who believe that they were financially impacted by the delay in receiving notice of this program. Pursuant to Section 7384t(d) entitlement to medical benefits under EEOICPA begins on the date the claim for benefits was filed. 42 U.S.C. § 7384t(d)<sup>27</sup> We are approached by claimants who contend that it is unfair to deny reimbursement of medical expenses when the lack of prompt notice about this program is the reason they did not file their claim until after incurring the expenses in question.<sup>28</sup>

*Then someone told me about [the program] and how I could file a claim, but I never was told earlier [about this program]... now Department of Labor is saying that since [the services were incurred prior to the date of filing]... [DOL] will not go back and pay this bill...*

## **B. Difficulty accessing and/or using tools and information**

Over the years, DEEOIC and the other agencies that administer EEOICPA have developed a number of tools/resources to assist claimants with the EEOICPA claims process. There can be no question that these tools are helpful – we routinely talk to claimants who tell us that these tools/resources were a great help in processing their claim. Still, we encounter other claimants who, for a variety of reasons, are unable to take full advantage of these tools/resources. In our experience, the most common factors hindering a claimant’s use of these tools include: (1) do not know that tools/resources are available; (2) do not have access to these online tools/resources; and (3) information is difficult to understand.

### **1. Do not know that tools/resources are available**

It is quite common to talk to claimants who indicate that when they first heard of this program, all they were told was that there was a program that awarded compensation to former employees of a particular facility. As a result, we talk to claimants who indicate that when they initiated their search for more information, they did not know the name of the program and had no idea who administered the program. In fact, it is not usual to receive inquiries where the individual simply forwarded a request for help to multiple agencies, in the hopes that one of these agencies could provide relevant information.

*We’re uncertain if your office is the correct one to make this inquiry. If not, please forward to the proper party...*

<sup>26</sup> We are aware of instances where employee rosters were utilized to contact former employees living in select areas of upcoming outreach events as well to inform former employees of the availability of medical screenings.

<sup>27</sup> An individual receiving benefits under this section shall be furnished those benefits as of the date on which that individual submitted the claim for those benefits in accordance with this subchapter. 42 U.S.C. § 7384t(d).

<sup>28</sup> Although this argument could also be raised to challenge the denial of medical benefits rendered prior to the creation of the program in 2000, to date, claimants have only challenged the denial of medical benefits incurred subsequent to 2000, but before a claim was filed.

*The above information is all I have at this writing. The question is: can XXXX file a claim for compensation as a benefactor for benefits with the Department of Labor?*

As such, we frequently encounter claimants who know very little about the program, and even less about the tools/resources available to assist them. When we encounter such claimants, we endeavor to give them proper direction and/or to make them aware of the various tools/resources available to assist them. Depending upon the circumstances, our assistance often includes directing claimants to one of the Resource Centers or District Offices.

We frequently encounter claimants who assure us that when they first learned of EEOICPA, they knew so little about the program they did not have specific questions. Rather, when they initially call seeking more information, claimants often suggest that they are hoping that whoever they talk to will first listen to what they (the claimant) has to say (i.e., what many claimants refer to as telling their story) and then based on this information, provide guidance (or suggestions) on how to proceed. Claimants find it frustrating when they are asked a lot of questions and never get the opportunity to fully discuss the issues and factors that they deem important.

In our experience, this lack of awareness about the availability of tools/resources is not limited to claimants who only recently learned of this program. We also encounter claimants with recommended and/or final decisions, who were not aware of all of the tools and resources available to assist them in the development of evidence for their claim. For example, we frequently encounter claimants with pending claims (including instances where the claimant already received a recommended and/or final decision) who admit that they do not understand the Site Exposure Matrix (SEM) database. These claimants often tell us that while the SEM database was frequently mentioned by DEEOIC, no one ever took the time to tell them they could access the database, or explain/show them how to use it.<sup>29</sup> This is often cited by claimants as an example where people associated with the program use acronyms (and/or scientific, medical or legal terms) without ensuring that the claimant fully understands what is being discussed.

## **2. Do not have access to online tools/resources**

The usefulness of some of the tools/resources developed to assist claimants is diminished because some claimants do not have access to these online tools/resources.<sup>30</sup> Throughout the year we routinely encountered claimants who, when advised of the various tools/resources available online, responded by remarking that it was presumptuous to assume that everyone had access to, or was proficient in the use of, the internet. As a result, we encounter claimants who process their entire claim without accessing any of the tools/resources that exist. For example, when working with claimants on matters related to exposure and/or causation, it is common to discover that due to a lack of access, the claimant never accessed the SEM database. Where the claimant has an active claim, we will often supply him/her with copies of the relevant pages from the SEM database (or copies of relevant pages of other online tools/

<sup>29</sup> Claimants note that these terms are sometimes used so matter-of-factly they are embarrassed to ask someone to explain these terms.

<sup>30</sup> For some tools the internet is the only effective way to present information. This is certainly true with the SEM database – there is a large volume of information in this database. Claimants who cannot access SEM sometimes ask us to forward to them copies of relevant pages of SEM (or copies of other online tools). We are more than happy to oblige. It is not entirely clear the extent to which the other agencies that administer EEOICPA provide claimants with hard copies of documents from the internet.

resources). However, in other instances, especially where a final decision already issued, we find that claimants without access to the internet often have their claims adjudicated without ever benefiting from access to these tools/resources.

Another example of a tool/resource that some claimants are unable to access is the list of health care providers enrolled in the program. Such a list can be accessed from DEEOIC's website or, directly from ACS's website. Nevertheless, it is common for claimants to contact us asking for assistance locating a provider who will accept the DEEOIC medical benefits card. When informed that a list of enrolled providers is available online, some claimants respond noting that they do not have access to the internet, or that they looked for, but were unable to locate this tool/resource. See discussion at page 16.

### 3. Information difficult to understand

Claimants complain that:

- The information discussing EEOICPA is sometimes worded using legal, scientific, and/or medical terminology that is difficult to understand.
- It can be difficult to find someone who is willing to explain these legal, scientific, and/or medical terms.

One example of this concern involves the inquiries that we receive every year asking if EEOICPA compensation is subject to federal taxes. Claimants routinely suggest that prior to coming to us with this question, they asked DEEOIC if EEOICPA compensation was subject to federal taxes and in response they were referred to Section 7385e of the Act, which provides in relevant part that:

*Compensation or benefits provided to an individual under this subchapter –*

*(1) shall be treated for purposes of the internal revenue laws of the United States as damages for human suffering...*

42 U.S.C §7385e. Claimants assured us that even after reading this statutory provision, they still had no idea if EEOICPA compensation was subject to federal taxes.<sup>31</sup>

Another example involves the waiver of rights to file objections form that is included with all recommended decisions. When a claimant receives a recommended decision, he/she must state in writing, whether he/she objects to any of the findings of fact and/or conclusions of law contained in this recommended decision. Claimants who do not object to any of the findings of fact or conclusions of law in the recommended decision may complete a DEEOIC waiver form that reads as follows:

*Dear Sir or Madam:*

*I, \_\_\_\_\_, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights.*

<sup>31</sup> At one outreach event this year, an attendee asked if EEOICPA compensation was subject to federal taxes. In response the DEEOIC presenter answered "no." Other claimants contend that they did not receive a definitive answer to this question.

By signing this form, claimants give up their right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision and their Final Decision is then expedited. We are contacted by claimants who do not fully understand the concept of “waiver.” We also encounter claimants who admit that they understand the form, but nevertheless thought it prudent to discuss this form (and the implications of this form) with a neutral party prior to waiving their rights.

The examples discussed above are just two of the instances where claimants did not fully understand the documents they received from DEEOIC. Throughout the year, we encountered situations that ranged from claimants seeking someone to explain a word or phrase, to claimants who could not grasp the significance of documents that they received. Some claimants find it ironic that this program is often characterized as claimant-friendly and yet some find it necessary to hire an AR or medical professional just to understand the documents that they receive.<sup>32</sup>

### C. Incomplete information/guidance

We are also approached by claimants who question whether available information is complete and accurate. In some of the instances brought to our attention, the concerns with the accuracy of information arose when claimants encountered rules and/or procedures that were not in writing.

- One example of this concern involves the procedures for changing health care providers. In its presentation on medical benefits, DEEOIC states that “[a] claimant may change providers at any time.” In spite of this statement, two claimants contacted us when they attempted to change providers and were informed that: (1) the request had to be in writing (which both had done) and (2) prior to approving the request, DEEOIC had to verify the request. These claimants do not question the need for procedures. Rather, they found it troubling that DEEOIC’s requirement for verification prior to approval was not addressed in DEEOIC’s presentation or anywhere else that they could find. Thus, these claimants questioned the appropriateness of denying their initial request to change providers on the grounds that they failed to follow a procedure that they were not informed of and was not in writing.
- Two other claimants approached us when they were informed that they had to wait one year from their last wage loss payment before filing a claim for an additional year of wage loss.<sup>33</sup> These claimants found it odd that they could not find this requirement in the statute, regulations, or PM. In fact, these claimants noted that the only written articulation of such a policy was found on Form EE-10, the DEEOIC form filed when claiming additional year(s) of wage loss. This form states that,

*A claim for additional wage-loss benefits may only be submitted if at least one year has elapsed since you were previously awarded benefits for wage-loss in a final decision...*

It is our understanding that both claimants were subsequently advised that they did not have to wait one year from the last wage loss payment before filing a claim for additional wage loss and their claims for wage loss were processed.<sup>34</sup>

<sup>32</sup> Recent revisions to Chapter 2-1600 of the PM provide guidance in drafting recommended decisions. This guidance includes using simple words and short sentences. See Chapter 2-1600.6. (August 2014).

<sup>33</sup> In each instance, the claimant initially filed claims for wage loss covering multiple prior years. Within one year of receiving payment from DEEOIC for these years of wage loss, these claimants endeavored to file additional claims for wage loss. They were informed by DEEOIC that they would have to wait one year from the receipt of payment for the earlier claims for wage loss before filing their additional claims for wage loss.

<sup>34</sup> Uncertainty remains regarding DEEOIC’s policy on whether a claimant must wait one year from the last wage loss payment to file a subsequent claim for wage loss benefits. The examples above involved claimants who had multiple years of wage loss claims pending while additional years of wage loss accumulated in the interim.

Another factor that sometimes causes claimants to question the accuracy of information arises when the discussion of an issue or concept is disbursed among various documents and /or websites.

- Complaints arise when claimants discover that certain aspects of an issue are discussed in one document while other relevant aspects of the same issue are discussed in a separate document. We particularly hear this concern when claimants develop their claim based on the information found in a bulletin, circular, or PM provision, only to later discover that their claim is impacted by a relevant discussion of the same issue found in another document. In the instances brought to our attention, claimants found it particularly frustrating when the document they relied upon made no reference to the relevant discussion found in the other documents. Claimants believe that it would really help if: (1) documents specifically referred the reader to all relevant provisions found in other documents and/or (2) there was a general index to which they could turn.
- Claimants contend that even when they are aware that information may be disbursed among various documents and websites, it is time-consuming and inefficient to review multiple sources (for example, the statute, the regulations, the PM, the bulletins, and the circulars) in an effort to locate the information that they need. Claimants stress that since information on a particular subject can be disbursed among several documents and websites, it can be difficult to know when all of the relevant information has been identified and located.<sup>35</sup>

Accordingly, claimants contend that it would be helpful if DEEOIC provided better guidance on the information that is available and where to locate specific information as they go through the claims process.<sup>36</sup>

In attempting to locate information, another factor that sometimes adds to the confusion is the fact that some claimants do not understand the difference between bulletins and circulars. While DEEOIC has endeavored to explain the difference, we continue to encounter claimants who do not appreciate the distinctions drawn by DEEOIC. One example of this confusion involves Bulletin No. 13-03 entitled “Authorizing Durable Medical Equipment,” and Circular No. 15-03 entitled, “Requiring estimates for Durable Medical Equipment or Supplies.” Even after reading this bulletin and circular, claimants tell us that they cannot understand why certain information addressing DME was placed in a bulletin and other information was placed in a circular. In light of the inability to appreciate this distinction, some claimants, when searching for information, feel compelled to search both the bulletins and circulars. Others express that they do not understand if both are to be applied, or if one takes precedent over the other.

A complaint involving a claim for CLL is an example of an instance where confusion arose because the issue was discussed in multiple documents. The claimant approached us to ask if the policy concerning CLL had changed. We responded indicating that on March 7, 2012, NIOSH issued a rule instructing that CLL be treated as potentially caused by radiation. Consequently, claims for CLL were now forwarded to NIOSH for a dose reconstruction. The claimant was troubled by this response. As the conversation

<sup>35</sup> For example, in the adjudication of a claim, the claimant may need to find information on the following websites: DOE’s covered facilities list, the NIOSH SEC site; the NIOSH dose reconstruction site; the SEM database; or the ACS bill pay site.

<sup>36</sup> With access to DEEOIC’s website a claimant can perform a word search to locate relevant information. However, as noted earlier, we encounter claimants who do not have access to the internet, as well as claimants who are not proficient utilizing word search. We also talk to claimants who believe that their word search was not fruitful because they were not familiar with the specific terms used by DEEOIC.

continued, we discovered the reason for his concern. Although DEEOIC issued Bulletin No. 12-01 announcing NIOSH's new rule and instructing that CLL claims be forwarded to NIOSH for a dose reconstruction, this claimant was not aware of Bulletin No. 12-01. Rather, this claimant was relying upon Chapter 2-0900.17(i) of DEEOIC's PM which in relevant part still stated that, "[s]ince CLL has a PoC of zero, the CE adjudicates the claim without sending the case to NIOSH..." DEEOIC Procedure Manual, Chapter 2-0900.17(i). When this matter was brought to DEEOIC's attention, we were informed that this PM provision is slated for revision.

# Developing Evidence

As a claim proceeds, there are instances when claimants find it necessary to search for relevant evidence in order to prove their claim. To assist claimants in searching for evidence, DEEOIC and the other agencies involved in the administration of EEOICPA have developed a variety of helpful tools and resources. Without a doubt, there are claimants who benefit from their use of these tools/resources. However, there are other claimants who question the adequacy of the assistance offered to them in developing evidence.

Section 7384v of the statute provides that the government “shall” provide claimants and potential claimants with assistance in connection with their EEOICPA claims. *See* 42 U.S.C. § 7384v. While most claimants are not specifically aware of Section 7384v, in our experience, many claimants are generally aware that that the government is to provide assistance in connection with their claims. Consequently, we frequently encounter claimants who question the sufficiency of the assistance offered by the government. We also encountered claimants who complained that although they were initially assured by those administering the program that they would receive assistance, the assistance they received was less than what they had been led to believe.<sup>37</sup>

## A. Employment

### 1. Subcontractor Employment

When a claim is filed, DEEOIC attempts to verify any claimed employment. As appropriate, this includes contacting DOE and, in some instances, other sources for information.<sup>38</sup> In our experience, a large percentage of the complaints that we receive concerning the verification of employment involve subcontractor employment. This is probably explained by the fact that while the program has enjoyed success locating records addressing DOE contractor employment, the program has not enjoyed the same success locating DOE subcontractor employment records.

The lack of records addressing subcontractor employees is discussed in the PM,

**d. Subcontractor employment at DOE facilities. Because the DOE generally did not keep records of employees of subcontractors, the CE is faced with particular evidentiary challenges in establishing subcontractor employment. To establish each of the elements needed, it is generally necessary to gather and evaluate documentation from multiple sources, including the DOE, the SSA and the CPWR.**

*See* EEOICPA Procedure Manual, Chapter 2-500.13(d).<sup>39</sup>

<sup>37</sup> For instance, some claimants noted that when they initially filed their claim, they were told that DOL would assist with the verification of employment. Therefore, these claimants found it troubling when DOL informed them that it could not locate any records and thus, that he/she would have to locate the evidence necessary to verify their claimed employment.

<sup>38</sup> When a claim is filed, using the information provided by the claimant on the employment verification form (Form EE-3), DEEOIC contacts DOE for employment verification. As appropriate, DEEOIC also endeavors to verify employment through the Oak Ridge Institute for Science and Education, the Center for Construction Research and Training, Social Security Administration wage data, and/or corporate verifiers.

<sup>39</sup> DOE notes that DOE subcontractors often retained the employee records when their work at a DOE facility was finished, and as such, DOE typically does not have formal employment records for subcontractor workers.

- Citing Chapter 2-500.13(d) of the PM, some claimants believe that no one should be surprised when DOE, and the other sources contacted by DEEOIC, are unable to locate subcontractor employment records. In fact, some claimants contend that in promulgating Section 7384v and instructing that the government “shall” provide assistance in connection with an EEOICPA claim, Congress was well aware that it would sometimes be difficult, if not impossible, to locate relevant employment records. Accordingly, it is argued that in enacting Section 7384v Congress anticipated the government doing more than merely contacting sources to see if records existed - especially in those instances where one could reasonably assume that records do not exist. Rather, it is argued that the assistance offered to claimants should, at the least, include help locating former employers (and former colleagues).
- Going a step further, some claimants believe that it would be more productive if DEEOIC took the initiative to reach out to former employers. This contention is based on the assumption that: (1) former employers are more likely to respond to a request from the government as opposed to a request from a former employee, especially a former employee who last worked for the company many years ago, and (2) the government is in a better position to explain to these companies the specific information needed.
- There is the belief by some claimants that regardless of the initial response from DEEOIC concerning the availability of employment records, if one is persistent, there is a chance that additional records will be uncovered. We especially hear this belief from ARs who cite to prior experiences as support for this belief. This belief explains why some ARs (and claimants) make repeated requests to DEEOIC, and sometimes DOE, for documents.

The following example addresses many of the concerns that we hear regarding efforts to verify subcontractor employment. In endeavoring to establish employment as a covered subcontractor employee:

- The initial response from DEEOIC/DOE informed the claimant that no evidence existed with respect to the employee’s employment at the facility.
- Subsequently, when the claimant contacted the facility and DOE, it was determined that records of the employee’s employment with the facility existed.
- Moreover, in response to a Freedom of Information Act (FOIA) request to DOE, claimant received a copy of the employee’s “personnel security clearance assurance index card file.”
- DOL experienced a delay in obtaining the claimant’s Social Security Administration (SSA) records. The claimant questions whether, absent his/her insistence DEEOIC would have obtained these SSA records.
- Although records from DOL/CPWR suggested that one employer might still exist, claimant contends that he/she was not provided with an address or telephone number for this former employer. Rather, he/she had to initiate his/her own search for this employer.
- This claimant further contends that DEEOIC did not adequately explain the decision not to accept the evidence that he/she worked so hard to develop. This is an argument that we routinely hear from claimants. Claimants contend that it is vital that decisions explain why relevant evidence is or is not accepted. The fear is that without such an explanation, newly developed evidence (or

rehabilitated evidence) will contain the same flaws that caused DEEOIC not to accept the evidence in the first place.<sup>40</sup>

In the example discussed above, the claimant also contends that the various decisions issued in his/her claim do not accurately describe what he/she went through to locate evidence. He/she feels that the decisions give the impression that employment evidence was easily located, and that DEEOIC located much of this evidence, when in fact that was not the case.

During the year, other claimants also pointed to instances where they believe that the provided assistance was overstated. For example, we were approached about instances where initial comments suggested that the government had enjoyed great success compiling employee records. Some claimants, specifically subcontractor employees, noted that it was only when they spoke up that these statements were clarified and it was recognized that the government had not enjoyed the same level of success obtaining subcontractor records.

**Note:** DEEOIC recently revised PM Chapter 2-1600 - Recommended Decisions in August 2014. The revised chapter emphasizes numerous concepts including using simple words and short sentences; addressing all matters raised by the claimant; and providing an explanation for findings. The hope is that this revision to the PM will address the concerns that we receive from claimants.

## 2. Evidence of DOE Contract

Another employment issue that continues to generate concerns involves instances where claimants must locate evidence to establish that their employer had a contractual relationship with DOE (or a DOE contractor). Again, most of the cases brought to our attention involved subcontractor employment.

Claimants argue that asking them for evidence to establish a contractual relationship between their employer and DOE (or between their employer and a DOE contractor) is asking them to prove a fact for which they usually had little, if any, involvement. Claimants are often adamant that the terms of any agreement between their employer and DOE (or the DOE contractor) was something that was rarely, if ever shared with them. Moreover, in light of the emphasis placed on secrecy, claimants are often confident that had they asked to see these documents, their request would have been denied.

- Claimants find it hard to believe that records documenting an agreement between their employer and DOE (or the DOE contractor) cannot be located. We most often hear this sentiment when the claimant is adamant that he/she (or a loved one) worked at a covered facility. In light of the emphasis placed on security, there is a belief that if a company performed work at a covered facility, there had to be an agreement. Accordingly, claimants argue that since the government (and not the employee) was a party to these agreements, the government ought to bear the responsibility for producing these agreements (or producing information outlining the terms of these agreements).<sup>41</sup>

<sup>40</sup> Since most employees obeyed the instruction not to discuss their employment, survivors often feel at a distinct disadvantage when endeavoring to establish employment. The challenge faced by survivors can be especially daunting when the employee worked for multiple employers – a scenario that sometimes arises. Survivors have suggested that when they are faced with verifying employment, it would help if they could review a listing of the known contractors and subcontractors associated with a particular facility. It is our understanding that DEEOIC has such listings for a number of facilities. However, these listings are not available to the public.

<sup>41</sup> This argument is especially stressed by claimants when the facts show that the employer performed services at the covered facility, but DOL is demanding evidence establishing that the contract meets the criteria outlined in the statute. In such instances, claimants believe that since work was performed on the site, there must have been a contract and thus, the government is in a better position to produce this contract.

- This is another instance where claimants believe that, consistent with its duty to provide assistance, DEEOIC ought to actively assist in locating evidence – here, actively assist in locating these agreements and/or locating former employers who can verify these agreements. One claimant stressed how he searched to find the son of the owner of the company in hopes that the son could provide information on the arrangement between the employer and DOE. This claimant believes that DEEOIC should have assisted in this search.<sup>42</sup>

### 3. Obtaining Social Security Earnings Records

During this calendar year, we received complaints alleging that the processing of some claims was delayed while DEEOIC awaited receipt of SSA earning records. Claimants also complained when DEEOIC issued recommended decisions prior to receiving the SSA earning records. In contacting us, claimants:

- Questioned why DEEOIC did not do more to ensure that SSA records were obtained in a timely fashion.
- Wanted to know why it was so critical to issue a decision when relevant evidence was outstanding.<sup>43</sup>

According to some claimants, the need to meet a timeliness standard was cited as the reason for issuing a decision before the SSA records were obtained. Some claimants questioned this response noting that they were aware of instances where DEEOIC, on its own initiative, had delayed the processing of a claim, without any apparent concern for timeliness.

Claimants do not always find it reassuring to be told that there are avenues of appeal that they can pursue if the SSA earning records are received following the issuance of the recommended decision to deny their claim. Some claimants believe that once DEEOIC issues a recommended decision, it is difficult to overturn that decision. Consequently, some claimants believe that when DEEOIC issues a recommended decision prior to receipt of the SSA earning records, it will be difficult to overturn that decision.

We also talked to claimants who feared that issuing a recommended decision prior to receipt of the SSA records would result in increasing the amount of attorney fees for which they would be responsible. Section 7385(g)(b) provides the following percentages for attorney fees in EEOICPA claims: (a) 2% for the filing of an initial claim for payment, and (b) 10% with respect to objections to a recommended decision denying payment of compensation. *See* 42 U.S.C. §7385g(b). Citing this schedule, claimants questioned whether they would be responsible for an attorney fee of 10% (as opposed to maybe 2%) if:

1. Without obtaining the SSA records, DEEOIC issued a recommended decision denying the claim.
2. Within 60 days of this denial a claimant who was represented by an AR objected to the recommended decision.<sup>44</sup>

<sup>42</sup> The current discussion addresses issues related to verifying employment. Issues related to the weighing of evidence are discussed in Chapter 6.

<sup>43</sup> Section 7385j-1 specifically requires SSA to make available to DOL, upon request, the Social Security earnings information of living or deceased employees who may have sustained an illness that is the subject of a claim. *See* 42 U.S.C. §7385j-1.

<sup>44</sup> Once a recommended decision is issued, the claimant has 60 days to file objections. *See* 20 C.F.R. §30.310(a).

3. Subsequent to filing the objections, the SSA records were obtained and as a result, the claim was ultimately accepted.

On October 15, 2014, DEEOIC issued EEOICP Bulletin No. 15-01. This bulletin announced that on October 1, 2014, the SSA and DEEOIC agreed to new procedures to expedite the process for requesting earnings data to assist in verifying covered employment and/or to establish wage loss. Claimants hope that these new procedures eliminate situations where the processing of claims is delayed while DEEOIC awaits SSA records, as well as instances where recommended decisions are issued prior to receipt of the SSA records.<sup>45</sup> While everyone hopes that this bulletin resolves these concerns, one claimant noted that Bulletin No. 15-01 did not address what DEEOIC would do if, in the future, there was a delay in the receipt of the SSA earning records.

## **B. Exposure/Causation**

Claimants also raise concerns with the assistance (or lack of assistance) that they receive when endeavoring to establish: (1) that in the course of covered employment the employee was exposed to a toxic substance, and (2) a link between the toxic exposures at work and the employee's illness (or death).

### **1. Little assistance locating/navigating the SEM database**

Frequent complaints address the lack of assistance provided to claimants in locating information on and/or navigating the SEM database. For a variety of reasons, some claimants are unable to take advantage of the wealth of information found on SEM.

- Some claimants are not aware that the SEM database exists.
- Some claimants do not have access to this online tool.<sup>46</sup>
- Claimants who are not proficient in navigating the internet sometimes find it difficult to navigate the SEM database.
- Since they do not (fully) appreciate the wealth of information available on this database, some claimants do not put forth the effort to review the database.

### **2. Discussion of exposure/causation found in decisions sometimes is not very informative<sup>47</sup>**

Over the years, we received complaints suggesting that the discussion of exposure evidence and/or causation found in some decisions, as well as some of the pre-adjudication development letters forwarded to claimants, were not very informative. Since we only have access to the letters and decisions that claimants and others forward to us (or authorize us to obtain) our ability to assess these complaints is

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<sup>45</sup> Complaints involving delays in obtaining SSA records were discussed in our 2009 Annual Report to Congress, March 4, 2010, page 20, footnote 12; the 2012 Annual Report to Congress, June 5, 2013, page 27; and the 2013 Annual Report to Congress, August 12, 2014, page 26. Furthermore, in footnote 12 of our 2009 annual report we reported that DEEOIC issued policy guidance designed to allow for more expeditious interaction with SSA to obtain vital employment verification and wage-loss information.

<sup>46</sup> Some claimants, without access to the internet ask us to provide them with copies of relevant pages from SEM. While we are not aware of any instances where DEEOIC refused to provide a claimant with copies of relevant pages from SEM, claimants have nevertheless expressed a reluctance to ask DEEOIC for copies of relevant pages from SEM. Many of these claimants are unaware that they can ask for copies of the SEM queries run by DEEOIC.

<sup>47</sup> The current discussion focuses on concerns brought to our attention involving the lack of assistance in developing evidence on exposure and causation. In Chapter 6 we discuss issues related to the weighing of evidence concerning exposure and causation

limited. Nevertheless, a few years ago DEEOIC asked us to provide examples of areas where there could be improvement in the drafting of recommended decisions. In response, we noted a significant improvement in the drafting of recommended decisions.<sup>48</sup> While we continue to see improvement in the drafting of recommended (and final) decisions, we still encounter instances where decisions and letters are not very informative.

A recent final decision on a hearing loss claim illustrates the complaints brought to our attention alleging that some decisions contain a vague discussion of causation and/or exposure evidence.

Under the “Explanation of Findings,” the final decision stated that based on EEOICPA PM 2-1000.18 all of the following conditions had to be met:

1. *Exposure to certain specific organic solvents for 10 consecutive years,*
2. *Verified covered employment within one of the specified job categories for a period of 10 consecutive years, completed prior to 1990,*
3. *Diagnosed sensorineural hearing loss in both ears.*

The next paragraph of the final decision stated that,

*The [xxx] District Office verified that you were employed as a stores materials person at XXX, which is not one of the referenced specified job categories. Development was undertaken to ascertain whether your hearing loss was linked to exposure to a toxic substance: however, evidence reviewed in the case failed to show any established link between occupational exposure to a toxic substance and the onset of your hearing loss. Accordingly, there is insufficient probative evidence to establish that occupational exposure to a toxic substance caused, contributed to, or aggravated your hearing loss. Therefore, you are not eligible to receive benefits under Part E for hearing loss.*

In the claimant’s opinion, this decision did not discuss the evidence considered in his claim. The decision indicated that “[d]evelopment was undertaken...” but did not specifically identify what development actions were taken by DEEOIC. Moreover, the decision did not acknowledge that the CE’s search of the SEM database verified that those who worked in his job category were potentially exposed to toluene and trichloroethylene, two toxins associated with bilateral sensorineural hearing loss.<sup>49</sup> Consequently upon reading this final decision the claimant was unsure if:

- a. the CE only reviewed SEM and did not realize that Chapter 2-1000.18(b) of the PM showed a link between hearing loss and the solvents, toluene and trichloroethylene<sup>50</sup>, or if
- b. the CE was aware of the link between hearing loss and the toxins toluene and trichloroethylene, but concluded that there was evidence in the record refuting this link; or if
- c. the CE was suggesting that even if the SEM database indicated that a store materials worker was exposed to toluene and trichloroethylene, the claim for hearing loss would only be accepted if the claimant worked in one of the enumerated job categories.<sup>51</sup>

<sup>48</sup> Again it must be emphasized that this office only has access to decisions provided to us or that we are authorized to obtain. Moreover, some claimants have questions with decisions drafted years ago.

<sup>49</sup> Chapter 2-1000.18(b) of the EEOICP PM recognizes toluene and trichloroethylene as linked to hearing loss.

<sup>50</sup> While Chapter 2-1000.18 of the PM recognizes that there are certain toxic substances (organic solvents) that have been linked to bilateral sensorineural hearing loss, the link between these substances and hearing loss is not found in the SEM database.

<sup>51</sup> Hearing loss claims drew a lot of inquiries this year. We discuss these issues in more detail starting at page 67.

Another example of a vague decision involved an instance where the claimant submitted a request to reopen his claim after it was denied under Part E. In support of his reopening request, the claimant submitted a letter from an expert that had not been previously provided to DEEOIC, as well as updated medical evidence. The decision denying the reopening request acknowledged that the claimant had submitted a letter from an expert, but did not acknowledge the medical evidence submitted by the claimant, nor did the ‘Discussion’ section of the denial address the evidence submitted by the claimant. Rather, the denial simply repeated the findings of the DEEOIC expert and referenced a search of the SEM database.<sup>52</sup>

### 3. Instances where a specialist is sought

DEEOIC’s use of specialists is another issue that generates complaints.<sup>53</sup> The concerns brought to our attention focus on DEEOIC’s practice of forwarding claims for review by a specialist without providing the claimant with notice of this review and without providing the claimant with a copy of the report prepared by the specialist.

- When a claimant contacts us because they do not understand the reasoning of a decision, we often find that contributing to this lack of understanding is the fact that: (1) the decision relies on the findings of a specialist; (2) the decision does not fully discuss the findings of the specialist and/or (3) the claimant never reviewed the report of the specialist.
- Claimants question the fairness of relying upon the opinion of a specialist without first providing him/her with an opportunity to review and respond to this opinion.

While claimants have the right to request a copy of the report prepared by the specialist, claimants frequently complain that they were never informed of this right.<sup>54</sup> Moreover, even when they are informed of their right to request a copy of these reports, some claimants interpret the failure to automatically provide them with a copy of these reports as an indication that DEEOIC did not want them to have these reports. Accordingly, we find that some claimants decide against requesting a copy of these reports because they do not want to “make waves.”

In most of the instances brought to our attention, the CE sought the input of the specialist while the claim was at the district office. Thus, claimants usually did not have the opportunity to respond to the report of the specialist until they filed their objections to the recommended decision. (In many of the instances brought to our attention, the claimant filed his/her objections without the knowledge that they could ask DEEOIC for a copy of any/all reports prepared by specialists, as well as request a copy of the questions and documents/facts sent by DEEOIC to the specialist). Some claimants believe that responding to the report of the specialist in conjunction with filing his/her objections to the recommended decision is inadequate. Some claimants adamantly believe that once a decision recommends denial of their claim, they face an even higher hurdle to overcome this denial. Thus, some claimants contend that they ought to have an opportunity to review and respond to evidence prepared by a specialist before the issuance of the recommended decision.

<sup>52</sup> In the various decisions, DEEOIC referenced the absence of a link in SEM between the claimed illness and a toxic substance. The decisions did not acknowledge that the claimed illness was not found in SEM.

<sup>53</sup> The specialists utilized by DEEOIC includes contract medical consultants (CMCs); industrial hygienists (IHs); toxicologists; and referee specialists.

<sup>54</sup> It is not entirely clear the extent to which claimants are advised of their right to request a copy of these reports.

## **C. SEM Updates and DEEOIC's Response to 2013 Institute of Medicine of the National Academies Report on SEM**

Claimants who accessed the SEM database also shared with our Office the complaint that they were unable to determine when specific data was last updated in SEM. For instances, a general search of a toxin, labor category, process, or health effect will include the date(s) the data on the page was last updated, but does not identify which data on the page was updated.<sup>55</sup> DEEOIC acknowledges that there is up to a six month lag time between when updates are made to its internal SEM database and when these updates appear on the public version of SEM. Thus, a real consequence for claimants is that in adjudicating claims, the CEs sometimes rely upon SEM data that is not available to the claimant. Thus, a claimant may work to develop causation evidence based upon data in the public version of SEM showing a link between his/her illness and toxins to which he/she was exposed to at the covered facility while unbeknown to the claimant, the CE has access to updated SEM information that contradicts what is available on the public version of SEM. In one case brought to our attention this year, this is exactly what happened. Although the claimant developed his case based on information available on the public version of SEM showing a link between his illness and toxins to which he had been exposed, his claim was nevertheless denied. It was only when the claimant made inquiries that he discovered that updates to the internal version of SEM had deleted information that was germane to his claim. It is unclear if such discrepancies in SEM would be a sufficient basis for reconsideration or reopening.

On March 27, 2013, the Institute of Medicine of the National Academies (IOM) issued the report, Review of the Department of Labor's Site Exposure Matrix Database. Shortly, after the release of this report, DEEOIC issued a response. In January 2015, DEEOIC announced that the SEM database had undergone a general update, and specifically referencing the IOM report, announced that SEM no longer listed the health effects of individual constituents that comprise mixtures or trade names of toxic substances. Claimants have suggested that it would be helpful to have all updates/modifications to SEM as a result of the IOM Report published.

## **D. Issues with the assistance involving medical billing**

Many of the complaints that we received this year concerning assistance (or the lack thereof) involved issues related to medical billings. Due to the variety and number of complaints that we received this year involving medical bills, we separately discuss these concerns in Chapter 2.

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<sup>55</sup> Moreover, once the database is updated, claimants do not have access to the earlier version of the database. Thus, claimants contend that it can be extremely difficult to identify updates.

# Issues Related to the Weighing of Evidence

As one might imagine, the issuance of a decision by DEEOIC is the catalyst for some complaints. In our experience, when claimants contact us following the issuance of a decision, many of their complaints involve more than the mere disagreement with the outcome. As discussed in Chapter 4(B) (3), there are instances when claimants contact us because they do not understand the decisions or other correspondence that they receive. Moreover, some claimants contact us when decisions do not contain an adequate explanation of the findings of fact and/or conclusions. Yet another concern that we encounter involves the weighing of the evidence. In particular, we receive concerns suggesting that:

- Decisions were not always based on accurate and complete information.
- Claimants are not provided an opportunity to respond/challenge DEEOIC policy.
- There were instances where in weighing evidence, DEEOIC did not follow its own rules.
- Claimants believe that some decisions reveal a determination by DEEOIC to accept the opinion of the experts sought by DEEOIC and/or to disregard the opinion of the treating physician.<sup>56</sup>

## A. Use of data in decisions

Claimants question the accuracy of the information relied upon in adjudicating claims. In support of these concerns, it is frequently suggested that one of the factors that led to the creation of EEOICPA was the realization that unmonitored exposures impacted the safety and health of the workforce.

*Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the Department of Energy and its predecessor agencies have been, since World War II, self-regulating with respect to nuclear safety and occupational safety and health. No other hazardous Federal activity has been permitted to be carried out under such sweeping powers of self-regulation.*

42 U.S.C. § 7384(a)(3). Since Congress recognized that there were unmonitored exposures and other continuing problems, claimants question the deference that ought to be accorded to the records maintained by these facilities.

This is the precise question raised during visits this year to the Denver area. Former employees of Rocky Flats noted that a 1989 raid by the Federal Bureau of Investigation (FBI) uncovered environmental violations that led to \$18.5 million in fines. These former workers firmly believe that there were worker safety and health violations at Rocky Flats as well – we encounter claimants who contend that they can personally attest to worker safety and health violations. In light of this raid and its aftermath,

<sup>56</sup> DEEOIC stresses that the experts that it utilizes are independent. Some claimants question this assertion. Claimants note that DEEOIC has total control in determining when the opinion of an expert is sought and is solely responsible for determining the process by which experts are selected. In fact, claimants emphasize that in many instances, they only learn that the opinion of an expert was sought after the expert has rendered his/her opinion. Consequently, in spite of DEEOIC's assertions, claimants often view these individuals as experts selected by DEEOIC.

former Rocky Flats employees question the appropriateness, in the adjudication process, of giving such deference to the documents prepared by Rocky Flats.

While Rocky Flats is the only site ever raided by the FBI, it is not the only site where employees question the accuracy of the records compiled by these facilities. Similar concerns are raised by employees of many of the facilities associated with this program. For example, we are routinely told by workers from various facilities how, in the course of the day, it was not unusual to be “ordered” to remove their dosimetry badges – thus manipulating the dosimetry reading. We also encounter claimants who contend that existing records minimize (or ignore) accidents and releases. This concern was raised by former employees of the Hanford facility who questioned the accuracy of the information addressing releases of chemical vapors that occurred and continue to be reported around the tank farms.

Claimants note that when DEEOIC evaluates evidence to verify employment, DEEOIC generally gives less weight to affidavits prepared by family members because family member might have a financial stake in the outcome of the claim. *See* Chapter 2-500.12(d)(1) of the PM. Claimants argue that to be consistent, DEEOIC ought to similarly recognize that covered facilities often had numerous reasons, financial as well as other reasons, for not maintaining accurate safety, health and exposure records.

In response to what they see as an inclination to accept the records compiled by these facilities, claimants believe that there needs to be an investigation into the accuracy of the records (and the record keeping process) at these facilities. In asking for an investigation, claimants emphasize that they are not trying to assign blame. Rather, the goal is to document the extent to which the records compiled by these facilities either are (or are not) accurate. Obviously, claimants believe that such an investigation will show that many of the records compiled by these facilities are not accurate.<sup>57</sup>

## **B. Some claimants believe they have no opportunity to respond/challenge DEEOIC data/policy**

It concerns claimants when fundamental questions concerning their claim are decided without a realistic opportunity to respond. We often encounter this concern when DEEOIC resolves an issue by relying upon data and/or policies outlined in SEM, bulletins, circulars, or the PM. Claimants question the fairness of not being able to directly respond to and/or challenge such DEEOIC positions.

The issue involving security guards at the Iowa Ordnance Plant (IOP) is an example of this concern. While an earlier version of SEM listed toxins to which security guards at IOP were exposed, the information in SEM relating to IOP was subsequently revised. The revisions indicated that the source information used to compile SEM did not verify any toxic substance exposure for security guards. To date, efforts by claimants to obtain the source information used to compile this information relating to IOP security guards has been unsuccessful.<sup>58</sup> Former security guards at IOP argue that it is impossible to develop a credible challenge to this determination when they cannot review the documentation upon which the determination was based.

<sup>57</sup> The FY2015 NDAA created an Advisory Board on Toxic Substances and Worker Health. Claimants hope this board will make a separate investigation into the accuracy of records unnecessary.

<sup>58</sup> We are aware of one claimant who sought the information from DEEOIC. DEEOIC referred this claimant to DOE, who in turn, referred the claimant to NIOSH. Subsequently, NIOSH referred the claimant back to DEEOIC. While we do not know the specifics, other claimants have also told us that they have been unable to obtain this information from DEEOIC.

Another example involves the period of coverage for Blockson Chemical Company (Blockson). Initially Blockson was listed as an AWE for the period 1951 to 1962. However, the coverage period for Blockson was subsequently shortened to June 30, 1960. In response to his/her request for an explanation for this change, DEEOIC informed the claimant that this change was based on documentation indicating that actual production of radioactive materials at Blockson was only up to June 30, 1960. The claimant would like the opportunity to challenge the one page document provided by DEEOIC in support of its determination that actual production ended on June 30, 1960. In particular, while DEEOIC responded to an earlier challenge raised by this claimant citing to this one page document, this claimant would like the opportunity to challenge (and have someone adjudicate) the adequacy of this document. This claimant believes that questions concerning the source of the information provided on this one page document, as well as inconsistencies found in this document, could impact the reliability of this document.

### C. Implementation of Program Rules

Claimants assert that DEEOIC is not always consistent in the application of its rules. In raising this argument, claimants recognize that every case must be adjudicated on its own merits. Nevertheless there is a belief that there are instances that display an inconsistent approach to the application of rules, policies and/or procedures.

**Example One:** Involves the weight to be accorded to animal studies in the disease/toxic exposure relationship. Bulletin No. 08-38 recognizes that animal (and environmental) studies may be useful in certain circumstances.

1. Programmatic Evidence. *This type of evidence may allow DEEOIC to make a program-wide policy decision regarding how to treat a certain disease/exposure relationship. Programmatic evidence should be based on studies that are occupational in nature, cover a statistical significant human population, and be published in a peer reviewed journal. This would include, for example, large-scale studies conducted by a university regarding occupational or environmental etiology. Animal and environmental studies may also be useful in certain circumstances. Some chemical used in the production of nuclear weapons are so unique and exotic that no broad-based studies of their health effects exists; therefore, animal and environmental studies must be assessed for possible program-wide applications. [Emphasis added].*

EEOICPA Bulletin No. 08-38 (June 25, 2008). In spite of this bulletin, a claimant contacted us when his claim was denied without any discussion of the animal studies that he submitted. When asked why these studies were not accepted, DEEOIC responded:

Right now we generally do not recognize data obtained from animal studies for the following reasons:

*One cannot extrapolate (use the results from animal data) from animals and apply it to humans given the design of most animal models (studies):*

*The route of exposure is generally different.*

*The dose given the animals is not relevant to human exposure.*

*Human physiology and disease are not adequately captured by animal models (studies).*

*When human physiology is taken into account, the mechanism of action (how the disease or disorder is expressed) is generally different in humans versus animals.*

*In those unusual organ systems when the mechanism of action is known and operates the same way in both humans and animals, extrapolating from animals to humans can be appropriate.*

*Animal models (studies) can and are used to complement the interpretation of human scientific studies. [Emphasis added].*

This response by DEEOIC, coupled with the fact that the decision made no mention of the animal studies he submitted, caused this claimant to believe that his studies were summarily rejected without any consideration as to their relevance. He believes that such an approach is inconsistent with Bulletin No. 08-38 which recognizes that such studies can be useful in certain circumstances, and thus must be assessed for possible program-wide applications. Furthermore, this claimant wonders who determined that these studies were not relevant, or if applicable, who determined that these studies did not have program-wide application. In particular, this claimant questions whether the person who made this determination (if such a determination was made) had the expertise to make such a determination.

Adding to the confusion surrounding the use of animal studies, a few months later, another claimant shared a letter from DEEOIC. This letter specifically indicated that, in general, animal studies were evaluated in assessing the health effects of an exposure to disease:

1. *Analysis of epidemiological data assessing the health effects of a[n] exposure to disease is a scientific question that can certainly be addressed by any type of specialist, doctor, or lay person. In matters of establishing credible causative links – anyone can offer input on the science – but focus should be on making a compelling argument that there is established epidemiological data to support a health effects argument. When evaluating epidemiological data – here are some of the considerations that I know we look at - ...*
  - *Experimental evidence: Does any experimental evidence support the hypothesis? (i.e., animal models/studies that support the exposure/disease association).*

Accordingly, claimants want to know: (1) if DEEOIC considers animal studies; and (2) who makes the determination as to the relevance of animal studies that are submitted.

**Example Two:** As discussed at page 14, in spite of an order from his treating physician for a regimen that would eventually total more than 60 massage therapy treatments in the calendar year, DEEOIC cited Bulletin No. 13-01 in only authorizing up to 60 massage therapy visits during the calendar year. Among the concerns raised by this claimant is the fact that, although Bulletin No. 13-01 specifically states that if a claimant makes a request for a recommended decision, the CE should complete the recommended decision process, DEEOIC had not responded to his request for a recommended decision or offered an explanation as to why his medical evidence is insufficient.<sup>59</sup>

**Example Three:** Claims for hearing loss are yet another instance where claimants suggest that DEEOIC does not always follow its own rules. (Issues arising from claims for hearing loss are discussed in more detail at Chapter 7(C)(5)). Before it was revised, Chapter 2-1000.18 of the PM provided that with respect to claims for hearing loss due to organic solvent exposure, where the employee had less than 10 years of consecutive employment prior to 1990 the claim must be forwarded to the National Office (NO) for

<sup>59</sup> The decision to approve up to 60 massage therapies was announced in a letter. The claimant contends that when he initially asked for a decision, he was informed that the case was not ready for a recommended decision. Subsequently, upon exhausting his 60 massage therapies for the year, the claimant again contacted us to say that he still had not received a recommended decision. In 2015, we were informed that this claimant finally received a recommended decision approximately 18 months after initially making his request.

specialist review. In spite of the PM's use of the word "must," claimants contacted us when their claims for hearing loss where the employee had less than 10 years of consecutive employment prior to 1990 were not forwarded for specialist review.

Some claimants pursuing hearing loss claims believe that their complaints suggesting that DEEOIC did not follow its own rules were further buttressed when DEEOIC subsequently revised the relevant provisions of the PM. These claimants found it interesting when, in the midst of questioning why, consistent with the language of the PM, their hearing loss claims were not forwarded for specialist review, DEEOIC revised Chapter 2-1000.18 of the PM, deleting the requirement that these claims be forwarded to the NO for specialist review. These claimants questioned the appropriateness of revising the PM and then citing to the revised version of the PM to support actions taken prior to the revision. For some claimants this turn of events supports their belief that rules and policies are sometimes altered to support a specific result. Citing to encounters such as this, some claimants characterize DEEOIC's application of rules, policies, and procedures as a "moving target."

Some claimants were advised that while their claims were forwarded to the NO, it was determined that since the employee was not close to having 10 consecutive years of employment prior to 1990, review by a specialist was not necessary. This response simply generated more questions from claimants. In particular, claimants:

- Wanted to know who decided that review by a specialist was not necessary – was this determination made by someone with the expertise to evaluate whether there was sufficient exposure?
- Found it difficult to reconcile the PM's requirement that cases where the employee had less than 10 consecutive years of employment completed prior to 1990 must be forwarded to the NO for specialist review, with DEEOIC's response that certain cases were not forwarded for specialist review since the employee did not have 10 consecutive years of employment. Claimants questioned the purpose of forwarding a case to the NO if the case was not thereafter forwarded to and substantively reviewed by a specialist.

**Example Four:** Chapter 3-0300.3(b) of the EEOICPA PM recognizes that, if properly trained, a claimant's relative may be compensated for providing home health care attendant services, i.e., unskilled care. The CE may authorize attendant services when a treating physician determines that these services are required for an accepted condition. *See* Chapter 3-0300.3(b)(2). Since the PM clearly outlines that attendant services may be authorized when the treating physician includes these services in his/her plan of care, we were contacted when a CE questioned the inclusion of attendant services in the plan of care, noting that this care could be provided by a family member free of charge. In another instance, the physician to whom DEEOIC had sent the claimant noted the need for attendant care, but did not include such services in the plan of care, suggesting that this care could be provided by family members. Thus, claimants raised the concern that even though DEEOIC will compensate a claimant's relative for attendant services, in some instances DEEOIC staff and/or CMC physicians do not appear to follow programmatic guidance that authorizes compensation for attendant services provided by family members.

## D. DEEOIC's use of the opinion of specialists

While DEEOIC asserts that CMCs, industrial hygienists and toxicologists are independent, we encounter claimants who do not share this view. In questioning the independence of these specialists, claimants note that it is DEEOIC who: (1) establishes the procedures/criteria by which specialists are selected; (2) determines when a specialist is utilized; and (3) is the party who pays the specialist. We also receive complaints suggesting that there are times when DEEOIC exhibits a bias towards accepting the opinion of the specialist that it chose over the opinion of a claimant's treating doctor or specialist. We especially hear this concern when DEEOIC accepts the report prepared by the specialist chosen by DEEOIC without providing an explanation as to why this report was credited over the other evidence in the record.

Similarly, claimants raise concerns when DEEOIC credits the opinion of the specialist that it chose without evaluating the relevant factors that might cause one to question the credibility of this report. For instance, claimants note that Chapter 2-0800.6 of the PM provides that,

In evaluating the merits of medical reports, the CE evaluates the probative value of the report and assigns greater value to:

- (1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the opinion on an accurate factual basis has weight over a physician conducting a file review...

See Chapter 2-0800.6 of the EEOICPA PM. Therefore, it troubles claimants when the report of the specialist chosen by DEEOIC is credited over the report of the treating physician without any discussion of the fact that, in some instances, one physician physically examined the patient, while the other did not. Similarly, claimants question whether adequate consideration is given to the qualifications and experience of the respective physicians.

Here are two instances that claimants believe exhibit a desire by DEEOIC to accept the opinion of the specialist that it chose.

In one instance, among other findings, the CMC concluded that it was not at least as likely as not that exposure to toxic substances (at the covered facility) was a significant factor in aggravating, contributing to, or causing the employee's Parkinson's disease:

*...However, the temporal relationship of the development of symptoms in relation to the claimant's last documented year of employment [at the covered facility], and thus possible exposure, is not consistent with manganese poisoning due to workplace exposures. There is no evidence provided that the claimant experienced any of the classic signs of manganism while employed at [the facility], or in the decade that followed.*

In denying the claim for hand tremors, the recommended decision specifically cited the CMC's conclusion that there was no evidence that claimant experienced any of the classic signs of manganism while employed at the facility or in the decade that followed.<sup>60</sup> In response to a final decision denying his claim, the claimant filed a request for reconsideration and submitted an affidavit from a co-worker attesting that he suffered from hand tremors while employed, and submitted a copy of a 1992 medical report in which the physician specifically cited to hand tremors. The claimant's contention was that the

<sup>60</sup> Claimant's last employment was in 1981 and hand tremors are recognized as a sign of manganism.

affidavit disputed the CMC's findings that he had not suffered tremors while working at the covered facility, and the medical report showed he developed the tremors within the time period the CMC suggested would be indicative of employment-related exposures. However, in spite of these submissions, DEEOIC did not grant claimant's request for reconsideration. This claimant cannot understand how the recommended and final decisions could specifically rely on the opinion of the CMC and yet his subsequent submission of evidence directly refuting the CMC's opinion was not sufficient to warrant a remand so that the CMC could at least review this new evidence.

Subsequent efforts by this claimant to understand this outcome simply led to even more confusion. When claimant asked if the CMC had reviewed the 1992 medical report that he submitted subsequent to the denial of his claim, he was told "no" and further informed that this report would not change the outcome. DEEOIC informed the claimant that the claim was denied because there was not significant exposure to toxic substances during the worker's employment. This response came as a surprise to the claimant since in addressing the claim for hand tremors neither the recommended or final decision discussed the extent of exposure. In fact, the final decision indicated that FAB did not refute that the worker had exposures during his employment. Rather, the final decision suggested that the issue in the claim was the link between these exposures and the Parkinsonism.

Subsequent to the issuance of the final decision, claimant questioned the basis for the denial of his claim. In response to one of the claimant's inquiries, DEEOIC stated that,

*Given the CMC statement as to the "total body half-life (the length of time "half" of a substance remains in the body) of manganese being from 15 to 35 days, there is no evidence submitted that it would remain in the body at sufficient levels to effect a physiological change (i.e. tremors) some 11 years after last exposure.*

This response by DEEOIC raised concerns since the CMC's entire discussion of the half-life consisted of the statement, "[t]he total body half-life of manganese varies from 15-35 days..."

The other instance involves a claim for CLL where an industrial hygienist (IH) was asked by DEEOIC to specify the amount of benzene to which the employee was exposed and whether the employee was exposed for at least 250 work days.<sup>61</sup> In response, the IH stated that there was no data to support that the employee worked directly with benzene or had significant exposure. The IH further stated that,

The SOAF [statement of accepted facts] includes comments by [the claimant] indicating that he worked on projects...that involved major earthwork and the excavation of soil contaminated with 'high levels of benzene.' If the soil in these construction areas had been contaminated with benzene, such contamination would have been remediated prior to the initiation of construction activities (in accordance with environmental regulations established in the 1970s). In addition [facility] documentation...describes a high level of recognition and control of benzene and other carcinogenic and/or suspected carcinogenic materials in the early 1980s. It is highly unlikely that [the claimant] was significantly exposed to benzene... [Emphasis added].

<sup>61</sup> Pursuant to Bulletin No. 06-13 (which replaced Bulletin No. 06-08), DEEOIC established criteria for the presumption of causation in certain specific situations. Where applicable, if the evidence of record is sufficient to establish all of the necessary criteria identified in the attachment (to Bulletin 06-13) then causation is presumed to exist. According to the attachment, with respect to leukemia, if the worker was exposed to benzene for at least 250 aggregate work days and has at least 1 year latency between first exposure and the diagnosis of leukemia, there is a presumption of causation.

Consequently, the claimant received a recommended decision to deny his claim for CLL. In objecting to the recommended decision, the claimant submitted a variety of documents. Among the documents submitted by the claimant to refute the findings of the IH were two reports, prepared by the facility for DOE, which found benzene in the ground water at concentrations above drinking water standards. These reports also indicated that concentrations of benzene were found in the area where the employee worked and that these concentrations existed during the years the employee worked in this area. The final decision denying the claim for CLL noted that the documents provided by the claimant did not indicate the specific amount of benzene that he had been exposed to, and that the IH had concluded that his exposure “had not been significant enough...” This language troubles this claimant. Since the IH specifically stated that any benzene would have been remediated (removed) prior to the claimant’s employment, claimant cannot understand DEEOIC’s continued adherence to the IH’s report in light of his subsequent submission of evidence (prepared by the facility for DOE) that shows that there was benzene in the ground water at concentrations above the drinking water standard, and that it would have been present in the areas he worked. Moreover, since DEEOIC asked the IH if the employee had 250 work days of exposure to benzene, the claimant questions how, in light of this new evidence (and without further review by an IH), DEEOIC determined that his approximate 21 years of exposure was not significant.

# Due Process

Over the past few years, we have seen an increase in complaints alleging that decisions by DEEOIC were based on evidence that was not in the record, and/or that claimants were not provided an opportunity to adequately respond to the denials of their claim. In the past, some of these complaints involved what claimants referred to as “policy teleconference notes.” In 2013, we encountered claimants who firmly believed that the adjudication of their claim was significantly impacted by a discussion contained in a policy teleconference note. *See* 2013 Annual Report to Congress, August 12, 2014, pages 52 and 53. However, because they generally did not receive and/or could not obtain a copy of the policy teleconference note, in all but a very few cases, claimants could not document their concerns by providing a copy of these notes. Rather, claimants usually approached us with an allegation suggesting that a CE (or HR) had originally indicated that the claim was moving in one direction, and then following communication with the National Office (often via a policy teleconference call), the case went in an entirely different direction.<sup>62</sup> In many instances, it only heightened the claimant’s suspicions when his/her request to review the communication with the National Office was denied.

While claimants continue to question the use of teleconference policy notes, a major concern in 2014 involved instances where claimants questioned the reliance on documents such as the PM, bulletins and/or circulars. The most frequent complaints that we receive concerning these documents include:

## A. DOL’s use of the PM provisions, bulletins, and circulars

Claimants take issue with weight afforded certain provisions found in the PM, a bulletin, or a circular. In particular, claimants question whether there are instances when provisions of the PM, a bulletin, or a circular are applied to decide a claim without any consideration of the facts of the specific claim. Claims for hearing loss vividly illustrate this concern. Chapter 2-1000.18(a) of the PM outlines what is characterized as the “conditions of acceptance” for claims for hearing loss. In support of their argument that this provision is more than mere guidance, claimants note that there are instances when claims for hearing loss are denied solely on the grounds that one (or more) of these “conditions of acceptance” were not met.

*The FAB has carefully reviewed the record in its entirety, in particular employment documentation and exhibits submitted in support of your claim for hearing loss. As you first began working at the [XXX] site on [XXXX], the employment evidence does not support that you have the necessary 10 consecutive years prior to 1990 worked required under the Act...<sup>63</sup>*

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*You did not have at least ten (10) consecutive years employment in at least one specific job category for a period of 10 consecutive years prior to 1990. The evidence of record establishes that you had just over (a number less than 10) years of covered DOE contractor employment prior to 1990.*

*We notified you of the eligibility requirements for Part E claims for sensorineural hearing loss. You have not submitted evidence of at least ten years of covered DOE contractor employment prior to 1990...*

<sup>62</sup> In some instances, a reference in the decision alerted the claimant to the existence of a policy teleconference note. In other instances, claimants indicate that they learned of the existence of a policy teleconference note when they specifically asked.

<sup>63</sup> Note: the passage cited above is from a decision issued by DEEOIC. Contrary to the statement above, the requirement for 10 consecutive years worked prior to 1990 is not found in the Act. This requirement is found in Chapter 2-1000.18 of the PM.

Claimants contend that where a PM provision, bulletin, or circular establishes requirements that must be met in order for a claim to be accepted, this provision ought to first undergo a period of public notice and opportunity to comment before it can be applied as law.

## **B. An opportunity for input and to respond**

A common complaint that we receive concerns the lack of an opportunity to challenge provisions of the PM, bulletins, and circulars. This concern often arises when bulletins, circulars, or PM provisions are given the weight of law or are cited as authority for conclusions of law in a decision.

Claimants believe that when it comes to the work performed at these facilities, they have relevant insights and information that are not taken into consideration by DEEOIC. Thus, when their input is not sought prior to the issuance of PM provisions, bulletins, and circulars, and these documents are later given the weight of law, or cited as authority for conclusions of law, claimants often take exception to the substance of the PM provision, bulletin or circular.

As one might imagine, claimants find it especially troubling where a PM provision, bulletin, or circular is cited as the legal authority (or cited as the basis) for the denial of a claim. It concerns claimants that in addition to the lack of an opportunity to provide input prior to the passage of the provision, they also often find that they are limited in their ability to challenge a PM provision, bulletin or circular when it is cited and/or relied upon in a decision.

Claimants complain that they cannot find a procedure for challenging the issuance of a PM provision, bulletin, or circular. Thus, even where they may want to raise a challenge, claimants contend that they are unsure how to proceed.

In some instances where DEEOIC cited a provision of the PM, bulletin, or circular as authority in adjudicating their claim, claimants subsequently complained that they encountered difficulties obtaining from DEEOIC the documents (or literature) that supported the provision. These claimants questioned the reasonableness of expecting them to develop a credible challenge to programmatic rules/guidance when they did not have access to the underlying documentation. In fact, some claimants questioned whether failing to provide them with the underlying documentation was intended as a way to discourage challenges. In addition, we are aware of instances where claimants were so overwhelmed by the difficulties encountered attempting to obtain the underlying documentation that he/she finally chose to forego the challenge.

As earlier noted, for some claimants one of the advantages of this program is that it purports to be non-adversarial. This concept resonates with former employees who often view themselves as the army of civilian workers who helped keep America safe by working to develop and build nuclear weapons. Thus, for many of these former workers, the thought of “fighting” the government for compensation is unacceptable. Consequently, we find that some claimants are unwilling to engage in actions that they deem adversarial, even when they have the legal right to take the action.

For example, we find that even when they disagree with a provision of the PM, a bulletin, or a circular, claimants are sometimes reluctant to ask for the documents relied upon by the agency in developing these provisions. Often bolstering their reluctance to ask for these documents is the belief that if DEEOIC wanted them to have these documents, DEEOIC would have provided these documents. Claimants also point to the lack of procedures for obtaining these documents (as well as the failure to tell them of their right to request these documents) as further proof that DEEOIC did not intend for them to review these documents.

In addition, some claimants have little interest in pursuing a Freedom of Information Act (FOIA) request to obtain documents. Many of the claimants we encounter are not familiar with FOIA. Others fear that pursuing a FOIA request will make the process more adversarial.

Claimants also maintain that it is unfair to resolve their claim based on evidence that is not in the record and to which they never had a realistic opportunity to respond.

## C. Are these provisions consistent with the statute and/or regulations?

Complaints that we received during the year also questioned whether certain PM provisions, as well as certain bulletins and circulars, were consistent with the statute and/or implementing regulations. The following examples highlight some of the concerns raised by claimants during the year:

### 1. Security Guards at IOP

The facts of this issue were already discussed at page 44. However, it is sufficient to reiterate claimant’s contentions that:

- **Lack of an opportunity to provide input.** Claimants question the accuracy of the information relied upon in determining that security guards at IOP were not exposed to any toxins. Many of these claimants are former security guards at IOP.<sup>64</sup> These former employees complain that the SEM database was revised without first seeking their input and contend that they can provide relevant information that should prompt DEEOIC to reconsider this determination.<sup>65</sup>

<sup>64</sup> We are aware of meetings held by former IOP security guards. While we do not know the number of attendees at these meetings, it is our understanding that the consensus among the attendees was that they had not been contacted to discuss the specifics of how and where they performed their jobs.

<sup>65</sup> When SEM is updated, claimants no longer have access to the previous version. Thus, in the instant case, while DEEOIC documents recognize that SEM once listed specific toxins to which guards at IOP were exposed, claimants do not have access to this previous version of SEM. Claimants assert that this can hamper their efforts to develop an effective challenge. They note that without access to these previous versions, they must base their argument on their recollection of these provisions.

- **Ability to challenge this revision has been stymied.** Claimants contend that their efforts to challenge this change in the SEM database are stymied by their inability to obtain the documentation relied upon to support this revision. In light of the difficulties encountered attempting to obtain this documentation, some claimants have started to question if this documentation exists, and/or if it fully supports the determination that there are no known toxins to which security guards at IOP were exposed.<sup>66</sup>

## 2. Notice of Appeal Rights and Timeliness of Decisions

Claimants complained that they were prejudiced by the fact that the agency that adjudicated their claim for benefits did not inform them of their right to appeal to U.S. District Court. In support of this concern, claimants provided us with copies of final decisions and reconsideration denials that did not inform them of their right to appeal the denial of their claim to U.S. District Court, and which did not inform them of the statute of limitations for the timely filing of such appeals.

Some claimants also found it troubling that while the right to file for administrative review (reconsideration and reopening) is discussed in detail in the PM, the PM does not address the process for filing an appeal to the U.S. District Court. Chapter 2-1800 of the PM is devoted to FAB decisions. This chapter does not mention that claimants are entitled to file an appeal in U.S. District Court; does not outline the process for filing such an appeal; and does not alert claimants that there is a deadline by which an appeal can be timely filed with U.S. District Court. The only mention of “District Court” in this chapter is found in the reference in Subsection 6(a)(8) where it states, “A reconsideration request does not come with further reconsideration rights but only reopening rights or right to file suit in District Court.” This is another example where some claimants only learn of a right well after the time has expired for them to take advantage of the right.

In the past few years claimants also made our Office aware of the greater frequency with which they received a “letter decision” regarding their claim for home health care benefits or durable medical equipment. While the language of these letter decisions denying benefits indicate that claimants were entitled to request a recommended decision if they disagreed with the letter decision (provided they make such a request in writing), some claimants complained that when they requested a recommended decision, they encountered difficulties obtaining this decision. Some claimants noted that they waited long periods of time to receive a recommended decision, while others suggested that in spite of their request, they did not receive the recommended decision. We also encountered claimants who suggested that the issuance of letter decisions added another level of adjudication to the process, and did so without informing them when they could expect to receive a recommended decision.

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<sup>66</sup> We are aware of one instance where a claimant made a request to DEEOIC for the documentation underlying this revision. DEEOIC referred the claimant to DOE, who referred the claimant to NIOSH, who in turn referred the claimant back to DEEOIC. To date, the claimant has not received any documentation.

### 3. Massage Therapy

This is another instance that we previously discussed. (See the discussion at page 14 and page 46).

- **Bulletin No. 13-01 is given the weight of law.** Claimants take exception with the weight afforded to Bulletin No. 13-01 in the adjudication of claims. In particular, claimants take exception with the fact that the numerical limitation outlined in this bulletin is cited in decisions (or letters) as the authority for denying a prescription of massage therapy ordered by the treating physician – sometimes even in the absence of contravening medical evidence.
- **What is reason for this limitation?** Bulletin No. 13-01 does not offer any rationale for imposing a limit of no more than 2 massage therapy visits per week with a maximum of 60 visits for the calendar year. Claimants argue that without an explanation, it is difficult to develop a credible challenge. Moreover, the lack of an explanation causes some claimants to question whether there is a medical basis for limiting the number of massage therapy visits in a calendar year or whether this limitation was simply imposed as a means of reducing costs.
- **Is Bulletin No. 13-01 consistent with the statute?** Section 7384t does not impose a numerical limit on the medical benefits to which a claimant is entitled when prescribed by a treating physician for a covered illness. Consequently, claimants question whether it is consistent with the statute for Bulletin No. 13-01 to impose a numerical cap on the number of massage therapy treatments a claimant may receive.

*The United States shall furnish, to an individual receiving medical benefits under this section for an illness, the services, appliances, and supplies prescribed or recommended by a qualifying physician for that illness, which the President considers likely to cure, give relief, or reduce the degree or the period of that illness.*

In light of Section 7384t claimants believe that DEEOIC ought to be required to provide a medical reason when limiting the medical services or DME to which a claimant is entitled, particularly when refusing to follow the prescription of the treating physician.

### 4. CBD under Part E

Claimants continue to challenge DEEOIC's approach to adjudicating CBD under Part E. Part B outlines specific criteria for establishing CBD, going so far as to distinguish the evidence needed to establish CBD prior to and after 1993. See 42 U.S.C. §7384l(13)(A) and (B). Part E of the statute, on the other hand, does not outline specific criteria for establishing CBD. In 2011, an AR contacted us when she was informed that a positive or abnormal BeLPT result was now necessary to establish a diagnosis of CBD under Part E. In bringing this matter to our attention, the AR noted that in prior claims DEEOIC had not required a positive (or abnormal) BeLPT, and thus, she could not understand the sudden change. In response to our inquiry, DEEOIC informed us that a positive or abnormal BeLPT was now necessary in order to prevail in claims for CBD under Part E. See 2012 Annual Report to Congress, June 5, 2013. We continue to encounter claimants who take exception with this requirement.

- Claimants note that neither the statute nor the regulations identify specific criteria needed to establish CBD under Part E. In fact, some claimants complain that they cannot find a written articulation of DEEOIC’s policy regarding Part E CBD claims.<sup>67</sup>
- Some claimants question whether there are exceptions to DEEOIC’s approach to Part E CBD claims. In particular, it is noted that this policy makes no allowance for instances where lung tissue biopsy or an autopsy reveals the presence of granulomas consistent with CBD. Lung tissue biopsies and autopsies are often viewed as the “gold standard” for diagnosing CBD and thus claimants question whether DEEOIC would require a positive or abnormal BeLPT under Part E if the record contained a lung tissue biopsy or autopsy revealing the presence of granulomas consistent with CBD.
- As with other policy guidance, claimants question how to challenge this policy.

## 5. Employment issues concerning the status of a facility

We received complaints this year involving the determination of whether a facility was a covered facility, as well as the determination of the years during which a facility was deemed a covered facility. Specifically, in 2014, claimants had concerns with the determinations regarding the status of the National Bureau of Standards (NBS) in Washington, D.C.; Allied Chemical Corporation Plant in Metropolis, Illinois; and Blockson Chemical Co. in Joliet, Illinois.

The determination as to whether a facility is covered under EEOICPA is made by DEEOIC or DOE, and is usually announced in the Federal Register and/or DEEOIC Bulletin or Circular.

- Claimants are unsure how to challenge a determination announced in a bulletin or circular.
- Claimants who wish to challenge these designations also complain that their ability to develop a challenge is often hampered by their inability to obtain relevant information. This is the precise argument raised by a claimant who took exception with the revision that modified the dates during which Blockson Chemical Co. is considered an AWE facility. *See* discussion on page 45.

Ultimately, claimants question the fairness of deciding that their facility was not a covered facility without providing them with an opportunity to review the documentation used to make this determination. In addition, this is another instance where claimants contend that in order to develop a realistic challenge to these determinations, it is essential to receive an explanation for these determinations and to have the opportunity to review and respond to the underlying documentation supporting these determinations.<sup>68</sup>

<sup>67</sup> Chapter 2-1000.9 states that “[c]ausation under Part E is developed in one of two ways for beryllium sensitivity and CBD. The first way is through a positive determination under Part B. The second way is through medical evidence as described below.” Subsection b of Chapter 2-1000.9 discusses narratives by physicians and in relevant part provides that,

<sup>A</sup> Part B Final Decision under the EEOICPA approving beryllium sensitivity or CBD is sufficient to establish the diagnosis and causation under Part E. However, if there is no Part B decision, a positive LPT result is required to establish a diagnosis of beryllium sensitivity and a rationalized medical report including a diagnosis of CBD from a qualified physician is required to establish CBD under Part E...

*See* Chapter 2-1000.9(a) and (b) of the EEOICP PM. Some claimants read this provision as requiring a positive LPT to establish a diagnosis of beryllium sensitivity, but only requiring a rationalized medical report to establish CBD under Part E. Moreover, to the extent this statement is only found in the PM, claimants question whether it is guidance, a policy, or a rule of law.

<sup>68</sup> There are some claimants who challenge these determinations during the adjudication of their claim.

## 6. Hearing Loss

Claims for hearing loss continue to generate complaints that raise due process concerns, as well as questions regarding whether the hearing loss criteria in the PM creates an additional burden of proof under Part E of EEOICPA.

- **Is Chapter 2-1000.18(a) given the weight of law to deny claims?** Chapter 2-1000.18(a) of the PM outlines what DEEOIC characterizes as the “conditions of acceptance” for hearing loss claims. The conditions are:
  - a. Exposure to certain specific organic solvents for 10 consecutive years; and
  - b. Verified covered employment within at least one specific job category for a period of 10 consecutive years, completed prior to 1990; and
  - c. Diagnosed sensorineural hearing loss in both ears (conductive hearing loss is not known to be linked to toxic substance exposure).

Claimants complain that claims for hearing loss are routinely denied when one of these conditions is not met. One final decision from 2014 states,

*The FAB has carefully reviewed the record in its entirety, in particular employment documentation and exhibits submitted in support of your claim for hearing loss. As you first began working at the XXX site on XXXX, the employment evidence does not support that you have the necessary 10 consecutive years prior to 1990 worked required under the Act...<sup>69</sup>*

Another final decision brought to our attention stated,

*You did not have at least ten (10) consecutive years employment in at least one specific job category for a period of 10 consecutive years prior to 1990. The evidence of record establishes that you had just over [a number less than 10] years of covered DOE contractor employment prior to 1990.*

*We notified you of the eligibility requirements for Part E claims for sensorineural hearing loss. You have not submitted evidence of at least ten years of covered DOE contractor employment prior to 1990...*

In another decision, DEEOIC informed the claimant,

*Regulations governing claims for sensorineural hearing loss provide that, in order for such a claim to be accepted, an employee must have been exposed to specific organic solvents and must have worked in at least one specific labor category **for ten (10) consecutive years during a covered time period prior to 1990.***

<sup>69</sup> Contrary to the statement found in this decision, the requirement for 10 consecutive years worked prior to 1990 is not found in the Act or regulations. This requirement is only found in Chapter 2-1000.18 of the PM.

Claimants contend that decisions such as the ones cited above clearly demonstrate that PM Chapter 2-1000.18 is not merely used as guideline. Rather, claimants contend that these decisions show that the “conditions of acceptance” outlined in Chapter 2-1000.18(a) are mandatory and that claims are denied if they do not meet all of the conditions of acceptance outlined in Chapter 2-1000.18(a).<sup>70</sup>

Two claimants bolstered their belief that CEs and HRs treated Chapter 2-1000.18(a) as mandatory, by noting that the CE or HR had erroneously stated that the conditions of acceptance outlined in Chapter 2-1000.18(a) were found in the Act or in the regulations. (See the quotes above). While some may suggest that these were mere misstatements uttered by a CE or HR, claimants believe that these statements reveal the extent to which some CEs and/or HRs view this criteria as mandatory.

- **Providing opportunities for input.** Chapter 2-1000.18(a) outlines three conditions of acceptance for hearing loss. Claimants routinely question the underlying basis for two of these conditions of acceptance, namely, (1) exposure to certain specific organic solvents for 10 consecutive years, and (2) verified covered employment within at least one specific job category for a period of 10 consecutive years, completed prior to 1990.

Claimants question the basis for requiring 10 consecutive years of exposure. They question whether the studies relied on by DEEOIC specifically indicate that at least 10 consecutive years of exposure is always required to cause, contribute to, or aggravate any instance of bilateral sensorineural hearing loss. In particular:

- Some claimants believe that although their exposure lasted less than 10 consecutive years, the exposure was of such intensity that it contributed to their hearing loss. Accordingly, claimants question whether the literature that DEEOIC relies upon in requiring 10 consecutive years of exposure specifically addressed the level of exposure that they sustained. This was the specific concern raised by a claimant with approximately five years of exposure. Even though he did not have 10 consecutive years of exposure, this claimant believes that the evidence establishes that he sustained very high levels of exposure. Therefore, this claimant questions why his claim was not forwarded to a specialist for a determination as to whether this exposure caused, contributed to, or aggravated his hearing loss.
- We encountered claimants with ten or more years of exposure to toxins that have been linked to hearing loss whose claims were nevertheless denied because they did not have 10 consecutive years of exposure. These claimants wonder if the literature relied on by DEEOIC specifically rules out any link between exposure to toxins and hearing loss where the claimant had more than 10 years of exposure, but not 10 consecutive years of exposures.
- Claimants would also like to know the rationale for requiring 10 consecutive years prior to 1990. During the course of this year, this question was posed by painters who noted that toluene is found in paint and paint thinners. These claimants want to know what happened in 1990 to render exposure to toluene no longer harmful.

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<sup>70</sup> A previous version of Chapter 2-1000.18, as well as the current version refers to forwarding claims with “non-conforming circumstances” to the NO for specialist review. Claimants complain that it is unclear when and under what circumstances this provision applies. As noted earlier, with respect to a previous version of this Chapter, claimants reported that they were informed that although their claims were forwarded to the NO, the claim was not forwarded to a specialist because the employee was not close to having the requisite ten years of consecutive exposure. In the opinion of these claimants, it was precisely because they did not have ten years of consecutive exposure that the case needed to go to a specialist. For instance, one case brought to our attention involved a claimant who did not have ten years of consecutive exposure prior to 1990, but who nevertheless had more than ten years of consecutive exposure if you included exposures after 1990. This claimant questioned the basis for denying his/her claim without forwarding the case for review by a specialist.

- We also received complaints concerning the development of the specific job categories listed in Chapter 2-1000.18(c). Claimants argue that this is not a complete list of the job categories potentially exposed to the enumerated toxins.<sup>71</sup> In one instance where the claim was denied because the employee did not work in one of the listed job categories, the employee noted that while he did not work in one of the job categories listed in Chapter 2-1000.18(c), a search of the SEM database showed that workers in his job category were potentially exposed to toluene and trichloroethylene, two toxins associated with hearing loss. When this claimant contacted us, among the questions that he asked: (1) since SEM shows that workers in his job category were potentially exposed to toluene and trichloroethylene, why was his job not included as one of the specific job categories listed in Chapter 2-1000.18(c), and (2) why was his claim denied without any consideration of whether his exposure to toluene and trichloroethylene contributed to his hearing loss.<sup>72</sup>
- In another instance, the claimant contacted us when it appeared his hearing loss claim would be denied since the employment evidence obtained by DEEOIC from DOE did not indicate that he worked in one of the specified job categories. It was only when he produced evidence in the form of co-worker affidavits stating that he worked as a painter and that the facility did not have the labor category of “painter,” (painter is a job category listed in Chapter 2-1000.18(c)) that his claim was referred to a specialist for review.

Although there are known links between hearing loss and certain toxic substances, these links are not found in the SEM database. Hearing loss is not included in the “health effects” found in SEM. Thus, while the SEM database can be a useful tool, it cannot assist in linking a worker’s labor category and toxic substance exposure linked to hearing loss.

- **Chapter 2-1000.18.** Claimants complain that Chapter 2-1000.18 provides very little, if any reasoning. In particular, claimants complain that they are unable to identify the literature that DEEOIC relied upon in enacting Chapter 2-1000.18, and as a result, it can be difficult, if not impossible to develop a challenge to this provision.<sup>73</sup>

<sup>71</sup> The SEM database includes a listing of aliases for specific labor categories at specific covered facilities. In our experience, claimants often are not aware of this listing of aliases.

<sup>72</sup> The decision found that the claimant was not employed in one of the specified job categories and then proceeded to note that “evidence reviewed in the case failed to show any established link between occupational exposure to a toxic substance and the onset of [the employee’s] hearing loss.” In light of this language, the claimant was unsure if the CE realized that SEM revealed that people who worked in his job category were potentially exposed to toxins(which according to the PM were) associated with hearing loss.

<sup>73</sup> We are aware of one claimant who working with his own specialist asked and received some documentation from DEEOIC regarding Chapter 2-1000.18. While other claimants have questioned the existence of documentation supporting Chapter 2-1000.18, we are not aware if these claimants specifically requested such documentation from DEEOIC.

# Issues Involving Interactions with DEEOIC

For reasons that we cannot fully explain, this year we experienced an increase in the complaints that we received involving interactions with DEEOIC. In most instances, without any prompting, the person raising the complaint would emphasize that their complaint was with a particular staff member, and not against the whole agency. In fact, in most instances, the person raising the complaint went out of their way to emphasize that in the course of processing their claim, they had encountered other staff members who were extremely helpful and courteous.

This helps to explain why some claimants become upset when notified of a change in their CE or HR. Since claimants believe that the quality of service can vary, when they find a CE or HR who is helpful, they prefer to continue working with that CE or HR.

The most common issues that we hear involving interactions with DEEOIC involve:

- Telephone calls that are not answered or messages that are not returned.
- Unable to reach CE/HR because the person answering the telephone would not allow the call to go through to the CE/HR.
- Discourteous conduct.

## A. Telephone calls

There are occasions when claimants contact us to specifically report that a telephone call(s) was not answered or that a message(s) was not returned. However, more often we hear these concerns when claimants contact us to discuss other matters. In response to concerns regarding the answering of telephones, DEEOIC cites to technological improvements implemented to ensure that telephone calls are promptly answered and that when the staff is not available, telephone calls are returned within a reasonable amount of time. In spite of these improvements, the complaints continue.

- We talked to claimants who insisted that they telephoned DEEOIC and their calls were consistently not answered.<sup>74</sup>
- Some claimants complained that DEEOIC's telephone system kept them in an on-hold queue for a very long time. In some instances, claimants reported of being on-hold for so long that they became exasperated and just hung up. Others told of being on-hold for long periods of time, only to finally learn that the person they were calling was not available.

<sup>74</sup> While some claimants specifically identify the office that they called, others are not so specific.

Cellular telephone users with service plans where they pay by the minute found it especially annoying when they called DEEOIC using their cell phones and were put on-hold for long periods of time. Claimants also complained that when calling ACS one had to first listen to a very long greeting.

- We also encounter claimants who contend that messages that they left were not returned.

In some instances when we reported complaints alleging that telephone messages were not returned, in response, DEEOIC provided us with the dates and times of their return calls (and attempts to call). In other instances, while we were assured that DEEOIC contacted the claimant, we were not provided a specific response to the allegation that messages were not returned.

## **B. Customer service**

As one might expect, complaints alleging that staff members were rude are often wrought with emotion. As with other complaints involving interactions with DEEOIC, those who contact us complaining of rude conduct often go out of their way to stress that their problem is with one or two employees, and not the entire agency.<sup>75</sup> The complaints that we receive range from allegations that a staff member was disinterested to allegations of rude comments.

- Some claimants reported instances where the response by a staff member gave the impression that the staff member did not care.
- In some instances, it was not so much what was said, as how it was said. Thus, we receive comments alleging that staff members raised their voice, or used a belittling tone. A frequent issue comes from claimants who complain of being spoken to as if they were trying to get something for nothing from the government.

Other concerns raised by claimants include:

### **1. Process for reporting discourteous conduct**

While DEEOIC has indicated that instances of inappropriate customer service ought to be reported, claimants contend that they have no idea how or where to report such complaints. Accordingly, while some claimants make attempts to report inappropriate customer service, the lack of procedures serves to dissuade other claimants from reporting service that they deem inappropriate. In addition, this is another occasion where some claimants view the lack of procedures as an indication that DEEOIC is not interested in hearing about these incidents.

We also find that some claimants are reluctant to blindly make a complaint against a DEEOIC staff member. Claimants fear retribution if their complaint ends up on the desk of the person who is the subject of the complaint (or on the desk of a friend of that person). Claimants who are willing to

<sup>75</sup> We especially hear this from ARs who can compare the treatment they receive with one case to the treatment they encountered with other claims. Nevertheless, in the course of processing a claim, some claimants work with multiple CEs and/or HRs. As a result, some claimants are able to contend that while other CEs (or HRs) were helpful, one particular CE (or HR) was rude or discourteous.

complain about inappropriate customer service would prefer to lodge their complaints using procedures specifically designed for receipt of such complaints (or to file their complaint directly with an office designated to receive such complaints).

Some claimants fear that they could face retribution if they complain about inappropriate customer service. In this regard, claimants contend that there is almost never a “perfect” time to file a complaint. It is noted that in many instances, the possibility of interacting with DEEOIC exists for many years. For instance, if a claim is denied, the claimant may later decide to pursue another claim. On the other hand, even when a claim is accepted, the possibility exists that the claimant will have subsequent illnesses or will require approval for impairment or wage loss benefits. Similarly, a claimant who already received the maximum amount of compensation may still have many years of interactions with DEEOIC due to the need for medical and/or home health services. Accordingly, some claimants feel that there is never a good time to file a complaint alleging rude conduct, especially when they do not know who will handle the complaint and/or how the complaint will be handled.

## **2. Process for responding/providing feedback when inappropriate customer conduct is reported**

Claimants often tell us that they do not receive feedback (or receive inadequate feedback) from DEEOIC regarding their complaints of inappropriate customer service. Some claimants interpret this lack of response (or what they perceive as vague responses) as an indication that DEEOIC has little interest in these matters.

Often compounding a claimant’s decision whether to raise a complaint of inappropriate customer service is the fact that claimants generally have little, if any documentation to support their allegations. In many instances, the only account that the claimant can muster is his/her own recollection of the event. This is another reason some claimants decide against raising a complaint. There is a belief that DEEOIC gives little credence to allegations of rude service that claimants cannot support with documentation.

In one instance this year, the claimant was able to document her concerns involving inappropriate customer service. Since the questionable conduct occurred during a hearing (and since this AR was familiar with the hearing process), the AR recognized that the hearing had been transcribed and immediately asked DEEOIC to review the transcript. Following a review of the transcript, DEEOIC informed the AR that they had addressed the matter internally and apologized for any problems this matter may have caused the AR and the claimant. DEEOIC also offered the claimant the opportunity for a new hearing before a different HR. While the AR fully understands that there may be personnel matters that DEEOIC cannot disclose, she nevertheless feels that this response minimizes this documented incident.<sup>76</sup>

Subsequent to this encounter, at least one other claimant with an allegation of inappropriate customer service questioned whether telephone calls to DEEOIC were recorded and if so, whether there was a process by which he/she could obtain this recording. To the extent DEEOIC records telephone conversations (and hearings) claimants believe that, whenever there is an allegation of inappropriate customer service, DEEOIC ought to (and without prompting) review these recordings and provide claimants with a response to the allegation.

<sup>76</sup> Although DEEOIC reviewed the transcript, this AR believes that DEEOIC should have also reviewed the court reporter’s recording of the hearing. Beyond what was said, the AR believes that to fully appreciate the inappropriateness of these comments, a person needs to hear how it was said.

## C. Other common instances where claimants contacted us for assistance

- a. We encountered claimants who endured lengthy delays in receiving a medical benefits card. In one instance, while the covered illness was accepted several years ago, the claimant contacted us this year asserting that he never received a medical benefits card. This claimant assured us that prior to reaching out to our Office, he talked to DEEOIC as well as “the people who made the card,” all to no avail. The issue was only resolved when brought to the attention of the National Office. In another instance, we were contacted when, in spite of numerous promises, a claimant never received his medical benefits card. Following an inquiry, a problem stemming from a previous award was resolved and the claimant received his medical benefits card.
- b. Claimants frequently contact us asking for the status of their claim.<sup>77</sup> When we advise claimants that they can obtain basic claim status information online, some claimants note that they do not have access to the internet, while others inform us that they were hoping to obtain more information than that provided online.<sup>78</sup> This is an instance where claimants often tell us that they would prefer to talk to a “live” person.
- c. We receive inquiries asking why some former employees are entitled to the free medical screenings offered by the DOE Former Worker Program (FWP), while other former employees are not entitled to these screenings.<sup>79</sup> This was the precise question raised by former employees of an AWE when they discovered that they were not entitled to the FWP’s free medical screenings.
- d. In the opinion of some, another problem with this program is that it sometimes appears to assume that every claimant has a working understanding and firm appreciation of EEOICPA policies and procedures. As a result, we find that when claimants are finally made aware of relevant policies and procedures, they sometimes respond by questioning why it took so long for someone to finally apprise them of the policy or procedure. For instance, in questioning whether EEOICPA is in fact claimant-friendly, some claimants point to instances where they were not timely advised of relevant policies and procedures:
  - Claimants frequently complain that it is impossible to respond to requests from DEEOIC within the timeframes (typically 30 days) imposed by DEEOIC. When such concerns are raised with us, we frequently ask if the claimant sought an extension of time. When we inform claimants that it is possible to request an extension of time, they often question why they only learned this from our office, and why those associated with the program never informed them of this option.
  - We are also approached by claimants who want to know the options available to them if they disagree with a final decision. While claimants are usually aware of their right to request reconsideration and/or reopening (as applicable), they often are not aware of their right to seek review in United States District Court. *See* 42 U.S.C. §7385s-6. Claimants question why DEEOIC advises them of their right to seek reconsideration and/

<sup>77</sup> This is another instance where some claimants are unable to take full advantage of an online tool. In addition, other claimants indicated that they turned to us for the status of their claim because the claim status page was “being serviced” and they were unable to access their claim information.

<sup>78</sup> DEEOIC’s website contains a link entitled, “Claimant Status Page (Check on the status of your claim).”

<sup>79</sup> Medical screenings by the FWP are available to former DOE federal, contractor and subcontractor employees. These screenings are not available to current DOE federal, contractor, or subcontractor employees and are not available to employees of Atomic Weapons Employers or Beryllium Vendors.

or reopening, but does not advise them of their statutory right to seek review in district court.<sup>80</sup>

- While in the Spokane, Washington area, we talked to former uranium miners who indicated that soon after the creation of EEOICPA representatives from the government came to the area and encouraged them to file EEOICPA claims. Many of the EEOICPA claims filed by these former miners were denied. Thereafter, some of these former miners filed claims under Section 5 of RECA that were accepted. It concerned these former miners that no one informed them that following the acceptance of their RECA Section 5 claim, they should again file an EEOICPA claim.<sup>81</sup> Note: DOJ routinely informs RECA Section 5 awardees that they should file EEOICPA claims.

Claimants find it frustrating when they first become aware of a policy or procedure after their case is well into the claims process and, after the point when knowledge of the policy or procedure would help. We also receive complaints suggesting that some policies and procedures are “buried” among pages of documents. Claimants question the extent to which they should be expected to find (and know) policies and procedures that are “buried” among pages of documents, especially if EEOICPA is intended to be claimant-friendly. We also encounter claimants who believe that they sometimes overlook policies and procedures because these policies and procedures were initially brought to their attention at a time during the adjudication process when the policy or procedure had no relevance. As an alternative, claimants suggest that it would be preferable to inform (or reiterate) policies and procedures at the point when the policy or procedure has relevance – i.e., informing claimants of their right to request an extension of time in the same letter that sets the time in which they must respond, and informing claimants of their right to appeal to district court at the time the final decision is issued to them.

<sup>80</sup> There are specific deadlines for appealing to district courts. We encounter claimants who only became aware of their right to appeal to district court after the deadline had passed.

<sup>81</sup> An individual with an approved Section 5 RECA claim is automatically entitled to a lump sum of \$50,000 and medical benefits under Part B of EEOICPA.

# Issues Involving Authorized Representatives and Home Health Providers

Not all of the complaints that we receive pertain to agencies involved in the administration of this program. This year, we also received complaints addressing the conduct of some ARs, as well as some home health care providers.

## A. Issues involving ARs

There were three (3) concerns involving ARs brought to our attention over the course of 2014: (1) whether some ARs were adequately forwarding information to claimants; (2) issues arising because some ARs only represented claimants for certain matters; and (3) whether some ARs adhere to the statute when seeking their fee for services.

### 1. Are ARs adequately forwarding claim information to claimants?

There were instances this year when claimants complained that without prior notice, they were informed by a provider that their home health care services would be discontinued.<sup>82</sup> In contacting us, these claimants usually asked why DEEOIC had not notified them of any pending problems with their home health care. In several instances, DEEOIC responded by informing us that since the AR had only provided DEEOIC with his/her contact information (and no contact information for the claimant), all correspondence, including correspondence that might have alerted the claimant to the pending problem, was forwarded only to the AR. While we have not pursued these matters with these ARs, most of these claimants continue to insist that, prior to receiving direct notice from the provider they never received any of the correspondence from DEEOIC.<sup>83</sup>

The fact that some claimants maintain that they were never apprised of documents forwarded to their AR further explains the crisis that often surrounds issues related to medical benefits. In some situations, claimants first learn of a problem when they receive a notice informing them that the provider is about to discontinue service. This often initiates a scramble by claimant to talk to someone as quickly as he/she can in an effort to resolve the problem.

### 2. Issues arising because some ARs only represent claimants for certain matters

A claimant may appoint one individual to represent his or her interests. *See* 20 C.F.R. §30.600(a). There were occasions this year when non-AR family members (or others on behalf of claimants) contacted us to complain that DEEOIC would not provide them with information related to a claim. Ordinarily, such problems can be resolved if the claimant is willing to appoint this person as their AR. However, in some

<sup>82</sup> In many of the instances, the notice of the discontinuation of service came from the company providing the home health care services.

<sup>83</sup> Claimants are often insistent that if they were aware of problems with unpaid bills or documentation that needed to be submitted, they would have immediately acted to resolve these matters.

instances brought to our attention, the claimant already had an AR. When we asked why the claimant did not utilize the AR to address the issue at hand, we were sometimes told that the AR only represented the claimant on certain matters related to the claim.<sup>84</sup> Since a claimant can only appoint one authorized representative at a time, where the AR is only representing the claimant on certain matters, the other people trying to assist the claimant sometimes find themselves significantly limited in their ability to assist the claimant. *See* PM Chapter 2-400.2(b).

- We talked to family members who asserted that they only became involved with the claim due to the incapacity of the claimant. Some of these family members confided to us that they while more information was necessary in order to properly assist the claimant, since they knew so little about EEOICPA they were hesitant to suggest that the claimant dismiss their current AR. Accordingly, we encounter family members who seek as much guidance as they can in the hope that they will be able to resolve any outstanding issues related to EEOICPA not addressed by the AR.<sup>85</sup>

### **3. Is there adherence to the statute in seeking attorney fees from claimants**

Pursuant to §7385g and as incorporated by §7385s-9, a representative may not receive more than the following percentages of compensation 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. *See* 42 U.S.C. §§ 7385g and 7385s-9.

Comments that we hear question whether there are some ARs who charge fees for services that exceed the limits outlined in these statutory provisions. To date, these comments have come from third parties – i.e., individuals contacting us to suggest that they fear this is occurring. As of yet, we have not heard from a claimant asserting that he/she was charged a fee that exceeded the statutory limits.

Nevertheless, those who raise these issues wonder if there is a procedure for reporting such conduct to DEEOIC and/or another appropriate agency.

Those who fear that overcharging may occur also believe the scarcity of people willing to assist claimants may help to explain why claimants do not complain. There is a belief that some claimants may feel so overwhelmed with the claims process, they are willing pay more than the statutory limits for help.

<sup>84</sup> Based on our observations, it appears that some ARs agree to represent claimants on issues related to establishing entitlement to compensation and benefits, but do not assist claimants with issues related to medical or home health care benefits.

<sup>85</sup> Moreover, family members often tell us that in assisting the claimant they endeavor to make as few significant changes as possible. In this vein, family members often view it as drastic to dismiss the AR.

## B. Home Health Care Providers

We receive complaints concerning some of the practices carried out by certain staff of health care providers. In particular we hear complaints that:

- Certain home health care representatives make statements that give the impression that their companies are affiliated with, or endorsed by DOL. For instance, enrollment as an “EEOICP Medical Provider” does not signify DEEOIC’s endorsement of that provider. Rather, a provider must be enrolled with DEEOIC in order to be paid for covered services. Nevertheless, we routinely hear allegations suggesting that some representatives refer to their companies as “preferred EEOICP Medical Providers” or use other similar terms that give the impression that the company is affiliated with (or endorsed by) DOL.
- There are instances where representatives affiliated with some home health care providers encouraged (or attempted to encourage) claimants to file claims for illnesses that claimants were well aware were not related to covered employment.
- There were also assertions made to our Office that unbeknownst to claimants, certain providers and/or representatives made efforts to seek compensation (or coverage) for additional illnesses without the claimant’s express consent. We were told of instances where in the course of a discussion concerning the plan of care for home health care services, the claimant discovered that someone had included illnesses that he/she never authorized to be claimed under EEOICPA. In some of these instances, the claimant asserted that he/she was able to trace the inclusion of these additional illnesses to staff associated with a home health care provider. Similarly, we were told of instances where inquiries from the physician alerted the claimant that persons affiliated with the home health care provider had, without authorization, sought to extend coverage to additional illnesses.

To date, the complaints alleging that a home health care provider initiated actions without a claimant’s express consent were brought to our attention by a third party – i.e., someone other than the claimant.

# Other Complaints In 2014

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

In our 2013 annual report we discussed concerns involving the DEEOIC policy prohibiting an individual from serving as a claimant's AR and also providing medical services to the claimant. Subsequently, on July 1, 2014, DEEOIC reduced this to writing by issuing Bulletin No. 14-04 Authorized Representative Conflicts of Interest.

Claimants find it troubling when DEEOIC starts to implement a policy, and it is weeks (or months) later before this policy is formally announced in writing. Prior to the formal announcement of the policy, claimants can find it difficult to develop a challenge (or to know what to challenge). Such situations often cause some to describe the adjudication of claims as a “moving target.”

While claimants understand, and some even applaud this bulletin as it applies to law firms and/or health care companies, there is a concern that this bulletin may be too broad. In particular, claimants question the application of this bulletin to situations where a family member, especially a family member living with the claimant, is serving as the AR and is being paid to provide unskilled, attendant home health care.

It is noted that in some instances, family members are serving as both the AR and the unskilled home health attendant not for the money, but out of necessity. For example, it is noted that since DEEOIC will only talk about a claim to the claimant or the AR, family members must be appointed as the AR if claimant wishes for them to obtain any claim related information. Oftentimes it is those claimants who are elderly, non-English speaking, quite sick, and/or living in remote areas of the country who find themselves in the position where a family member who is their AR and thus, their only way of communicating with DEEOIC, is also the only person they trust taking care of them in their home on a day-to-day basis. In order to avoid any appearance of a conflict of interest, a couple of ARs noted that they were willing to waive any entitlement to attorney fees, but complained that neither Bulletin No. 14-04, nor any other DEEOIC provision provided for such action or offered an alternative remedy to this situation.

In addition, since DEEOIC does not permit unskilled, attendant home health care providers to have input into the plan of care for home health care services, claimants question the impact that the unskilled provider might have on a claim and question whether the potential of a conflict of interest justifies such a strict rule. Consequently, claimants question why DEEOIC chose to impose such a strict rule. Some claimants also see this as another instance of inconsistency. While on one hand, DEEOIC maintains that claimants are free to choose who they want as their AR and home health provider, on the other hand, DEEOIC imposes very strict rules limiting these choices.

## **B. The impact of forwarding decisions by mail**

During this calendar year, claimants complained that DEEOIC's use of the mail to deliver documents often limited the amount of time that they had to respond to these documents. While this concern relates to various documents mailed by DEEOIC, it was frequently directed at final decisions. According to 20 C.F.R. § 30.319(a) claimants have 30 days from the date of the issuance of the final decision to request reconsideration. Claimants contend that since final decisions are forwarded by mail, by the time they receive the final decision, there is already less than 30 days remaining to respond. This scenario is often cited as one of the reasons claimants become so upset when they cannot immediately talk to the HR. It only adds to the anxiety of having less than 30 days to respond when the claimant is unable to immediately talk to someone who can answer the questions that will help him/her decide how to respond to the final decision.

## **C. FOIA Requests**

We received complaints addressing the fees imposed by DEEOIC to respond to certain FOIA requests. Many of the FOIA requests brought to our attention were made by an advocacy group that contends it is the only group currently providing independent oversight of EEOICPA. In its requests, this group often asserts that a review of the requested documents is necessary to ensure the fair adjudication of claims. This group believes that because of its efforts to provide independent oversight, it should be afforded a waiver of any potential fee.

With respect to at least one FOIA, this group took exception with what it calculated to be a fee that amounted to an hourly rate of \$184.50 to have a DOL contractor search for documents. This group felt that this was an exorbitant fee to charge for work performed by a government contractor.

# Summary

The agencies involved with the administration of EEOICPA have developed a variety of tools and resources to assist with the processing of claims. Yet, this Office continues to encounter claimants who only recently became aware of the program, as well as others who tell us that they found it difficult to access and/or utilize the various tools and resources designed to assist them. Similarly, while this program has, since its inception, paid out over \$11 billion in compensation and benefits, we routinely encounter claimants who take issue with the adjudication of their claim. We realize that it might be tempting to conclude that this Office is primarily contacted by individuals who take exception with the outcome of their claim, especially those who take exception with a denial of a claim. Yet, the complaints that we receive do not necessarily come from individuals with denied claims. More importantly, many of the concerns expressed to us address matters that go beyond the mere disagreement with a decision. Thus, in an effort to assess the complaints, grievances, and requests for assistance received by this Office in 2014 we focused on: (1) identifying the claimants who contacted the Office; and (2) identifying the issues that formed the basis of the complaints, grievances, and requests for assistance that we received.

## **The claimants who contact the Office**

While we are approached by claimants who disagree with the denial of their claim, we are also contacted by: (1) individuals who just heard of the program and are seeking more information; (2) individuals who develop questions or encounter difficulties while pursuing a claim; as well as (3) individuals found eligible for compensation and/or benefits who thereafter have questions concerning matters such as impairment, wage loss, or medical benefits and home health care. Moreover, there are occasions when claimants with accepted claims nevertheless approach us to tell of the difficulties they encountered with the program. This frequently occurs at outreach events where, in support of the concerns raised by others, individuals who have already received compensation will share the difficulties they encountered while pursuing their claim for benefits.

In addition, it is not just claimants and potential claimants who contact our Office. We are also contacted by family members; ARs; medical personnel and health care providers; congressional staff members; as well as individuals advocating on behalf of the workers covered by EEOICPA.

## **The issues underlying the complaints, grievances, and requests for assistance**

To some extent, every complaint presents a unique set of facts and thus raises unique concerns. Yet, there are some common themes/concerns that arise from the complaints, grievances, and requests for assistance we receive:

- Some claimants find it troubling that although Part B was created in 2000 and Part E was created in 2004, they are just learning of the program. Claimants find it even more troubling when they first learn of the program years after its creation and then only learn of the program because of a passing comment made by a relative or friend. Some claimants continue to question why efforts were never undertaken to directly inform them of this program.
- We continue to receive complaints that address the statute, especially the limitations in coverage outlined in the statute. Specifically, claimants question why: (1) some employees who worked at covered facilities are covered under the Act while others are not; (2) some employees are covered under both Part B and Part E, while others are only covered under Part B; and (3) why some

employees covered under Part B are covered for cancers caused by radiation, CBD, beryllium sensitivity, and chronic silicosis, while other employees covered under Part B are covered for some but not all of these illnesses.

- We encounter claimants who are not aware of the various tools/resources developed by DEEOIC and/or do not know the various agencies involved in the administration of EEOICPA. These claimants often question why more is not done to inform them of the existence of these tools. Claimants find it especially troubling when, in spite of numerous conversations with the staff of DEEOIC involving a particular issue, they were never advised of the existence of a relevant tool or resource. We also find that even when they are aware of these tools/resources, some claimants find it difficult to access and/or utilize these tools/resources. Claimants often contend that it would be helpful if the agencies were more forthcoming in offering assistance (and letting claimants know that the agencies will provide assistance).
- A frequent concern that we hear suggests that while this program is often characterized as claimant-friendly, there are many instances where DEEOIC appears to assume that claimants have a working knowledge of the program. We encounter claimants who stress that they know very little about this program. These claimants contend that it would be very helpful, and would be consistent with a claimant-friendly program if the program advised claimants of relevant policies and procedures and advised them of these policies and procedures when this information had some relevance in their case. For instance, advising a claimant of his/her right to request a copy of the report of a specialist when DEEOIC obtains the report.
- Claimants question whether the government is fully meeting its requirement to provide assistance in connection with a claim. We especially hear this concern in connection with the development of evidence, as well as in connection with the delivery of durable medical equipment and the resolution of medical billing issues. This concern is also frequently raised in instances where claimants believe that the government is in a much better position to locate evidence.
- Claimants continue to approach us with complaints concerning DEEOIC's weighing of evidence. In particular, we continue to receive complaints asserting that DEEOIC does not always explain why evidence is or is not credited, and/or does not always provide a reasoned and documented explanation of its decisions. In addition, there continues to be those who contend that DEEOIC's expectations are sometimes unrealistic when it comes to the evidence that claimants must submit in order to meet their burden of proof.
- This year, there were instances where claimants question whether they were afforded due process. In particular, there were instances where provisions of the PM, a bulletin, or a circular were given the weight of law, and thus cited as the basis for resolving a claim. Without the documentation used to support these provisions, claimants often found it difficult, if not impossible, to develop a credible challenge to these provisions.
- There is a belief that DEEOIC needs to outline specific procedures for reporting inappropriate customer service, and that these procedures should be sensitive to the fears that claimants have regarding retaliation.
- Claimants are excited that Congress approved the creation of an Advisory Board on Toxic Substances and Worker Health. The hope is that this board will help resolve many of the concerns that arise with issues related to exposure and causation under Part E of the EEOICPA. Nevertheless,

we continue to hear from claimants who believe that it would help if there was an independent review of the decisions of DEEOIC. While DEEOIC maintains that the Final Adjudication Branch provides an independent review of recommended decisions, we talk to claimants who question the extent of FAB's independence and the adequacy of its review.

# Acronyms (Abbreviations) Used in this Report

ACS	.....	Affiliated Computer Services
AEC	.....	Atomic Energy Commission
AR	.....	Authorized Representative
AWE	.....	Atomic Weapons Employer
BeLPT	.....	Beryllium lymphocyte proliferation test
Blockson	.....	Blockson Chemical Co.
CBD	.....	Chronic beryllium disease
CE	.....	Claims examiner
CLL	.....	Chronic lymphocytic leukemia
CMC	.....	Contract Medical Consultant (formerly known as District Medical Consultant)
CPWR	.....	The Center for Construction Research and Training
DEEOIC	.....	Division of Energy Employees Occupational Illness Compensation
DME	.....	Durable medical equipment
DOD	.....	Department of Defense
DOE	.....	Department of Energy
DOJ	.....	Department of Justice
DOL	.....	Department of Labor
EEOICPA	.....	Energy Employees Occupational Illness Compensation Program Act
ERDA	.....	Energy Research & Development Administration
FAB	.....	Final Adjudication Branch
FECA	.....	Federal Employees Compensation Act
FOIA	.....	Freedom of Information Act
FWP	.....	Former Worker Medical Screening Program

FY .....Fiscal year

HHS .....Department of Health and Human Services

HR .....Hearing Representative

IOP .....Iowa Ordnance Plant

IH .....Industrial hygienist

IOM .....Institute Of Medicine of the National Academies

JOTG .....Joint Outreach Task Group

MED .....U.S. Army Corps of Engineers Manhattan Engineer District

NDAA .....National Defense Authorization Act

NIOSH .....National Institute for Occupational Safety and Health

NO .....National Office

PM .....Procedure Manual

PoC .....Probability of causation

RECA .....Radiation Exposure Compensation Act

RESEP .....The Radiation Employees Screening and Education Program

SEC .....Special Exposure Cohort

SEM .....Site Exposure Matrix

SERT .....Secure Electronic Records Transfer system

SSA .....Social Security Administration

The Act .....The Energy Employees Occupational Illness Compensation Program Act

The Office .....The Office of the Ombudsman, Energy Employees Occupational Illness Compensation









**UNITED STATES DEPARTMENT OF LABOR**

Office of the Ombudsman  
Energy Employees Occupational Illness Compensation Program

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