

DEPARTMENT OF LABOR**Office of Workers' Compensation Programs****20 CFR Part 30**

RIN 1240-AA08

Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act

AGENCY: Office of Workers' Compensation Programs, Department of Labor.

ACTION: Final rule.

SUMMARY: The Department of Labor initiated this rulemaking to bring clarity to the regulatory description of the claims adjudication process, and to improve the administration of the program. This final rule updates existing regulations to remove obsolete terms, update references and incorporate policy and procedural changes. It also adds necessary controls to allow the Department to better manage the provision of home health care to beneficiaries.

DATES: *Effective Date:* This final rule is effective on April 9, 2019, and will apply to all claims filed on or after that date. This rule will also apply to any claims that are pending on April 9, 2019.

FOR FURTHER INFORMATION CONTACT:

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SUPPLEMENTARY INFORMATION:**I. Background of This Rulemaking**

The Department of Labor (Department) published its Notice of Proposed Rulemaking (NPRM) in the **Federal Register** on November 18, 2015 (80 FR 72296). In its NPRM, the Department proposed amending certain of the existing regulations governing its administration of Parts B and E of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), 42 U.S.C. 7384 *et seq* to conform them to current administrative practice, based on its experience administering the Act since 2001, to bring further clarity to the

regulatory description of the claims adjudication process, and to improve the administration of the Act. The majority of the changes in the NPRM consisted of routine updates to the existing regulations to remove obsolete terms, update references and incorporate policy changes that have already been adopted in the Federal (EEOICPA) Procedure Manual. Most significantly, the Department proposed modifying the existing regulations to describe the increased involvement of the National Institute for Occupational Safety and Health (NIOSH), within the Department of Health and Human Services (HHS), in the Office of Workers' Compensation Programs' (OWCP's) consideration of objections to NIOSH's final radiation dose reconstruction reports. Since the beginning of OWCP's administration of Part B of EEOICPA, Final Adjudication Branch (FAB) reviewers have struggled with their regulatory obligation in existing § 30.318 to consider objections to final dose reconstruction reports that have been prepared by NIOSH during its portion of the adjudication process for radiogenic cancer claims. The experience has also been frustrating for claimants, and convinced the Department that FAB reviewers are ill-suited to address objections that concern matters within the particular scientific expertise of NIOSH. Since NIOSH agreed to consider and address claimant concerns in the final dose reconstruction report it sends to OWCP, and also agreed to provide consultation at the request of FAB reviewers to address any objections raised while the claim is pending before FAB, the Department proposed modifying § 30.318(a). That proposed paragraph describes the potential for NIOSH to provide consultation in FAB's consideration of objections to final dose reconstruction reports, and this consultation process will provide for a more complete consideration of the claimant's objections. In addition, the Department proposed changes in the NPRM to align the processing and payment of medical bills with the system that OWCP currently uses for paying medical bills, updated the process for excluding EEOICPA medical service providers and set out a new process for authorizing home health care.

The Department notes that this final rule is largely an update to the existing regulations to reflect the program's current processes, and incorporates the policy and procedural changes that have been implemented since the existing regulations were issued in 2006, rather

than imposing any new regulatory burdens. However, it puts necessary controls in place to allow the Department to better manage the provision of home health care to beneficiaries, since these costs have been rising over the past decade, and reduces the likelihood of fraudulent practices by some providers of this care. Accordingly, the Department believes that the likely benefits of this rulemaking for both OWCP and the public, in the form of regularized, simplified, and less costly administrative practices of OWCP, and the reduced need for costly overpayment-recovery efforts, will clearly outweigh any unlikely and presumably intangible burdens on businesses and the public at large.

II. Comments on the Proposed Regulations

The Department originally allowed a 60-day period for interested parties to comment on the NPRM that was scheduled to close on January 19, 2016, but on that date it extended the comment period another 30 days through February 18, 2016 (81 FR 2787). In addition, on April 5, 2016, the Department reopened the comment period for the NPRM through May 9, 2016 (81 FR 19518). During these comment periods, the Department received a total of 493 timely comments from the following 474 unique commenters: 272 individuals; 158 unknown persons or organizations; 25 physicians; 6 claimant representatives; 5 advocacy groups; 3 health care providers; 1 congressional representative; 1 labor organization; 1 Federal employee from an agency other than the Department; 1 law firm and the new Advisory Board on Toxic Substances and Worker Health established under section 7385s-16 of EEOICPA. The Department also received one untimely comment from an individual that raised issues that were also raised by the timely commenters.

Of the 493 timely comments, 220 did not address any aspect of the proposed regulatory changes in the NPRM and are not discussed further in this document. This left 273 comments, of which 128 only asked the Department to extend the comment period for the NPRM, but did not discuss any other aspect of the NPRM. The remaining 145 comments referenced at least one change to the existing regulations suggested in the proposed rule; 7 of these 145 also included an extension request. The Department's section-by-section analysis of the 145 timely comments is set forth below (*see* section III). A brief discussion of the total of 135 extension

requests and other ancillary matters related to this rulemaking is also set forth below (see section IV).

III. Section-by-Section Analysis

The analysis in this section provides the Department's response to public comments received on the NPRM. Unless otherwise stated, the section numbers in the text of the analysis refer to the numbering used for the final regulations.

Subpart A—General Provisions

Introduction

In the NPRM, the Department proposed modifying existing § 30.1 to update the Secretary's Order reference and delete the reference to the Assistant Secretary for Employment Standards, since that position, as well as the Employment Standards Administration, no longer exists. A claimant representative agreed with the Department's deletion of those references. An individual commented on other aspects of proposed § 30.1 that are no different from the existing § 30.1. Because the individual's comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

Proposed § 30.2(b) added language to that section to note that HHS delegated its dose reconstruction responsibilities to NIOSH in 42 CFR 82.1. A claimant representative suggested that the Department should retain the reference to HHS that appears in existing § 30.2(b). However, the Department believes that explicitly acknowledging this delegation will promote better public understanding of the fact that this particular portion of the claim adjudication process is performed by and under the exclusive control of another Federal agency. Under these circumstances, no changes were made in the final rule with respect to this comment. An individual commented on other aspects of proposed § 30.2(b) that are no different from the existing § 30.2(b). Because the individual's comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

Definitions

The Department proposed amending the definition of a *beryllium vendor* in existing § 30.5(i) by removing the language indicating that the Department of Energy (DOE) periodically updated a list of beryllium vendors in the **Federal Register**, since DOE no longer has the statutory authority to designate

beryllium vendors, and replaced it with a reference to the final list of beryllium vendors that DOE compiled on December 27, 2002. One individual objected to the proposed language, because he believed that the change did not acknowledge that additional beryllium vendor facilities, *i.e.*, newly identified locations where beryllium vendors performed their work, could still be designated. While DOE's authority to designate new beryllium vendors expired on December 31, 2002 pursuant to 42 U.S.C. 7384m, the Department agrees that there is authority, as the individual pointed out, to designate additional beryllium vendor facilities, and notes that additional beryllium vendor facilities have been designated after December 31, 2002. The Department therefore agrees that the proposed language might cause confusion, and is clarifying it in the final rule by removing the term "facilities" and replacing it with "other entities." This change will acknowledge the continuing authority to designate additional beryllium vendor facilities that are, or have been, owned and operated by either a beryllium vendor identified in section 7384l(6) of EEOICPA or a beryllium vendor designated by DOE prior to December 31, 2002. The same individual also suggested that the Department amend proposed § 30.5(i) to clarify the distinction between corporate beryllium vendors identified in EEOICPA and those designated by DOE prior to December 31, 2002. The Department sees no utility in making the suggested distinction, particularly in the context of claims adjudication, and therefore did not alter the text as desired.

In the NPRM, the Department proposed adding a new paragraph, § 30.5(j), to define the term *beryllium vendor facility*. To accommodate this proposed addition, the Department also proposed redesignating existing paragraphs (j) through (hh) as paragraphs (k) through (ii). Proposed § 30.5(j) defined the term *beryllium vendor facility* as "a facility owned and operated by a beryllium vendor." Two claimant representatives and three advocacy groups objected to proposed § 30.5(j) because they believed that the proposed definition would impermissibly narrow the scope of coverage as set out in EEOICPA for both current and potential covered beryllium employees. These commenters suggested that proposed § 30.5(j) be amended to include the words "occupied by a beryllium vendor" to specifically align the definition with section 7384l(7)(A) of EEOICPA, which

refers to "a facility owned, operated or occupied by a beryllium vendor." While the Department acknowledges that section 7384l(7)(A) refers to "a facility owned, operated or occupied by a beryllium vendor," employees who satisfy that first provision must also show that they were exposed in the performance of duty under section 7384n(a)(2), which refers to "a facility owned and operated by a beryllium vendor." Put simply, an employee must satisfy *both* statutory provisions to be entitled to Part B benefits due to a beryllium illness. Thus, the narrower of those two implicit definitions of a "beryllium vendor facility" controls. The Department notes, however, that the proposed definition did not, nor could it, alter the eligibility of workers at beryllium vendor facilities. Accordingly, no changes were made in the final rule with respect to these comments.

Proposed § 30.5(k)(2) suggested replacing the term "medical doctor" with "licensed physician" in the existing definition of *chronic silicosis* that currently appears in existing § 30.5(j)(2). One claimant representative commented on the language in existing § 30.5(k), which contains a definition of the term *claim*, rather than on the proposed change to the definition of *chronic silicosis*. Since the claimant representative's comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

Proposed § 30.5(w) updated the existing definition of the *Department of Energy* or *DOE* to clarify that DOE's predecessor agencies date back to August 13, 1942, which is the date that the Manhattan Engineer District was established. Two advocacy groups asserted that the start date of DOE's predecessor agencies in proposed § 30.5(w) would prevent some employees who worked on the atomic bomb from applying for benefits, and suggested that the start date should conform with the employment eligibility criteria under section 5 of RECA. However, the Department notes that such a proposal is not legally permissible because section 7384l(10) of EEOICPA provides that the term "Department of Energy" includes the Manhattan Engineer District, which was established on August 13, 1942, not January 1, 1942. Since the proposed regulatory language aligns with section 7384l(10), no change was made to § 30.5(w) in the final rule. One claimant representative also commented on § 30.5(w), but did not comment on a proposed change in that provision. Because the claimant representative's

comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

In proposed § 30.5(x), the Department added § 30.5(x)(2)(iii) to the definition of a *Department of Energy contractor employee* in existing § 30.5(w) to state that a civilian employee of a state or Federal government agency qualifies as a DOE contractor employee if the agency employing that individual is found to have entered into a contract with DOE for the provision of one or more services it was not statutorily obligated to perform and DOE compensated the agency for those services, and also that the delivery or removal of goods from the premises of a DOE facility does not constitute a service for the purposes of determining a worker's coverage under the Act. Four advocacy groups, one claimant representative, two individuals and the labor organization objected to the added language regarding the delivery or removal of goods for the purposes of determining a worker's coverage under the Act. However, that language memorializes a policy that has been followed by OWCP since it issued EEOICPA Bulletin No. 03–27 in 2003, and that policy continues to conform with the eligibility terms of the statute. Because § 30.5(x)(2)(iii) merely updates the current regulations with OWCP's longstanding policy, the requested changes were not made in the final rule. Another claimant representative commented on aspects of existing § 30.5(x), but did not comment on a proposed change in that provision. Since the individual's comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

Proposed § 30.5(ee) amended the definition of a *physician* in existing § 30.5(dd), which states that a “*physician* includes” a list of types of physicians, by stating that a “*physician* means” that same list. Two advocacy groups, one Federal employee, the labor organization and one health care provider suggested that the Department retain the word “includes” so that medical doctors and other medical specialists are included in that definition. The Department agrees with these commenters and acknowledges that the proposed change would have had unintended consequences. Accordingly, the Department is reverting back to using the word “includes” in the final rule. One of those same advocacy groups and another health care provider suggested adding nurse practitioners and/or physician assistants to this regulatory

definition because these practitioners are qualified to prescribe medication in some jurisdictions. However, while the Department acknowledges that nurse practitioners and physician assistants can provide valuable services to patients who reside in remote locations, their written opinions are not widely accepted as probative and persuasive medical evidence. To make that point clear, the Department has added text to this effect to § 30.5(ee) in the final rule. Finally, one claimant representative referred to something that was not changed in proposed § 30.5(ee). Because the claimant representative's comment does not pertain to a change in proposed § 30.5(ee), no change was made in the final rule based on this comment.

Proposed § 30.5(gg) removed references to “RECA” and “EEOICPA” in the existing definition of a *specified cancer* in § 30.5(ff). One claimant representative suggested that the Department should retain those references. However, the Department notes that these two statutory references are clearly surplusage and serve no useful purpose in the regulatory context. Therefore, the suggested change to this paragraph was not adopted in the final rule.

The Department proposed to expand upon the definition of the term *time of injury* in existing § 30.5(hh) by adding text in proposed § 30.5(ii)(2) to explain that the *time of injury* in a survivor's claim is the “date of the employee's death.” Four advocacy groups, a claimant representative, a physician and the labor organization disagreed with the proposed definition, based on their concern that the proposed text could deprive survivors of reimbursement for medical expenses in situations when a covered employee dies after filing a claim, but before such claim is accepted. Section 7385i(a) of EEOICPA is the only place in the statute that Congress used the term “time of injury,” and the Department notes that proposed § 30.5(ii)(2) was intended to clarify how the forfeiture provision in section 7385i(a) works when a survivor, as distinguished from an employee, is convicted of fraud in the application for or receipt of EEOICPA benefits or of Federal or state workers' compensation benefits. It was the Department's intention in the NPRM to give full force and effect to this important fraud prevention provision. Because this definition only impacts those survivors who have committed fraud of the sort that triggers the forfeiture provision of section 7385i(a), and the overwhelming majority of survivors who might be eligible to claim this reimbursement do *not* engage in such fraudulent acts, they

will not be affected in any way by this clarification. Accordingly, no change was made to § 30.5(ii)(2) in the final rule.

In the NPRM, the Department proposed adding new paragraph § 30.5(jj) to define the terms *time of payment* or *payment*. To accommodate this addition, the Department also proposed redesignating existing paragraphs (ii) and (jj) as paragraphs (kk) and (ll). Proposed § 30.5(jj) defined *time of payment* or *payment* as the date that (1) a paper check issued by the Department of the Treasury was received by the payee or by someone who was legally able to act for the payee, or (2) the date the Department of the Treasury made an Electronic Funds Transfer to the payee's financial institution. One claimant representative objected to the proposed definition and argued that the Department should define this term by referring to the time a payment is issued, rather than received. However, the commenter erroneously believes that it is OWCP that issues payments on claims under EEOICPA, when as noted above, it is the Department of the Treasury that performs these ministerial functions. Therefore, since the date a payment is issued is not entirely within OWCP's control, nothing in this final rule could alter when payment by either paper check or Electronic Funds Transfer occurs. Thus, the suggested change to this paragraph was not made in the final rule.

Subpart B—Filing Claims; Evidence and Burden of Proof; Special Procedures for Certain Cancer Claims

Filing Claims for Benefits Under EEOICPA

Proposed § 30.100(a) and (c)(1) removed language that would allow certain persons other than the employee to sign a written claim with OWCP on the employee's behalf, and instead required that the employee sign his or her own claim. Proposed § 30.101(a) and (d)(1) made the same change with respect to survivor claims. Three claimant representatives, three individuals, two health care providers, one advocacy group and the labor organization objected to the Department's change in proposed § 30.100(a) and (c)(1) to require an employee to sign his or her own written claim. The same three claimant representatives, the same three individuals, the same advocacy group and the same labor organization objected to the same change made in proposed § 30.101(a) and (d)(1). These commenters were concerned that the

requirement would cause undue difficulty and delay in the submission of claims by some elderly or otherwise impaired individuals. However, when signing Forms EE-1 and EE-2, a claimant makes certain certifications with possible legal ramifications, and authorizes the release of information to OWCP. Therefore, it is reasonable to require claimants to sign the form, particularly since doing so will be an objective indication that he or she is aware of these matters. The same advocacy group and one of the three individuals suggested that these sections should be written so as to accommodate those claimants who may be unable to sign a claim form. OWCP already accepts, and will continue to accept, claim forms signed by a valid attorney-in-fact or court-appointed representative. An individual other than a claimant may sign the claim form for the claimant if they have the recognized authority to do so, and are not otherwise prohibited under any other provision in these regulations. Therefore, the Department has not made the suggested changes to § 30.100(a) and (c)(1), or to § 30.101(a) and (d)(1), in the final rule.

Also in proposed §§ 30.100 and 30.101, the Department proposed amending language that currently only recognizes postmark dates as evidence of the time a claim is filed to also recognize the date-markings of other carriers, since other delivery options besides the U.S. Mail are widely used. A claimant representative indicated that she did not see any reason for making these proposed changes, and suggested that the additional language be removed. However, since the proposed language at issue in these two sections adds new ways for a claimant to establish the date he or she filed a claim, which is important because the date of filing also marks the date of commencement for the potential payment of medical benefits, the claimant representative's belief is unfounded. Therefore, no change was made in the final rule in response to this comment.

In the NPRM, proposed § 30.102(a) removed the superfluous word "minimum" from the term "minimum impairment rating" in existing § 30.102(a). A claimant representative objected to that change, and pointed out that this word appears in the statutory description of impairment ratings found in section 7385s-2(a)(1)(A)(i) of EEOICPA. However, as the Department explained when it published proposed § 30.102(a), the term "minimum impairment rating" is an artifact left over from an early draft of the legislation that was later enacted as Part

E of EEOICPA and has no intrinsic meaning in the scheme that Congress eventually passed. Since there is no practical difference between a "minimum impairment rating" and an "impairment rating" when a claimant has reached maximum medical improvement, no amendment was made in the final rule in response to this comment.

Evidence and Burden of Proof

In proposed § 30.110(a)(1), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *covered beryllium illness* from § 30.5(o) to § 30.5(p). Also, in proposed § 30.110(a)(4), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *covered uranium employee* from § 30.5(s) to § 30.5(t). Finally, in proposed § 30.110(b), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *covered Part E employee* from § 30.5(p) to § 30.5(q). A claimant representative questioned the need to change these regulatory cross-references in proposed § 30.110(a) and (b), and suggested that the existing cross-references be retained. However, the Department notes that these changes were necessary to reflect the changed location of the specified regulatory provisions. Therefore, no change was made to § 30.110(a) or (b) in the final rule.

In the NPRM, proposed § 30.112(b)(3) removed the term "self-serving" when referring to affidavits submitted to establish covered employment, and also removed language that "OWCP may reject the claim based upon a lack of evidence of covered employment" when DOE or another entity either disagrees, or cannot concur or disagree with the assertion in a written affidavit or declaration of covered employment. In its place, proposed § 30.112(b)(3) explained that OWCP will evaluate such an affidavit in conjunction with the other evidence of employment when DOE or another entity either disagrees, or cannot concur or disagree with the assertion, and "may determine that the claimant has not met his or her burden of proof under § 30.111." A claimant representative agreed with removing the term "self-serving," but stated that the added language in that provision might signify that OWCP will always make a finding of no covered employment based on this type of evidence, and suggested adding language that "objective" evidence such as statements from co-workers, social security records, and payroll records will be considered

as evidence of employment. An advocacy group had the same concern regarding the effect of the changes made in proposed § 30.112(b)(3), and noted that DOE does not have complete employment records. Both commenters asked the Department to clearly define several terms used in the proposed text that explain how OWCP will evaluate affidavit evidence in these situations. However, proposed § 30.112(b)(3) described OWCP's longstanding method of evaluating employment evidence, which necessarily involves a high degree of administrative discretion, and therefore the Department is not persuaded that it would be appropriate to make the above changes in the final rule. An individual mistakenly asserted that OWCP does not accept affidavit evidence to prove covered employment, but did not comment on the proposed change in that provision. Because the individual's comment did not refer to a change that was proposed in the NPRM, no change was made to § 30.112(b)(3) in the final rule with respect to this comment. However, the Department has decided that it needs to conform the regulatory language of § 30.112(b)(3) with the related text of § 30.231(a) in the final rule, by specifying that if the only evidence that the claimant submits to establish covered employment is an affidavit, OWCP will evaluate that affidavit in conjunction with the other available evidence of employment in the record.

Proposed § 30.113(c) removed the term "self-serving" when referring to documents submitted to establish a covered medical condition, and instead proposed language codifying OWCP's current method of evaluating all medical evidence in a claim when it decides if the claimant has met his or her burden of proof under § 30.111. A claimant representative and a health care provider suggested that the Department further define several terms it used in proposed § 30.113(c). The Department believes that OWCP's evaluation of medical evidence is a matter of administrative discretion and cannot reasonably be further defined. An individual mistakenly asserted that OWCP does not accept the type of medical evidence described in proposed § 30.113(c), but did not comment on the proposed change in that provision. Because the individual's comment did not refer to a change that was proposed in the NPRM, no change was made to § 30.113(c) in the final rule with respect to this comment.

The Department proposed modifying existing § 30.114(b) in the NPRM to clarify that current paragraphs (b)(1) and (b)(2) pertain to medical evidence

needed to establish a compensable medical condition under Part B, and added paragraph (b)(3) to provide that additional medical evidence, as described in other sections of the regulations, is required to establish claims for covered illness(es), impairment benefits and wage-loss benefits under Part E. A claimant representative agreed with the Department's changes in proposed § 30.114(b)(1) and (2), but asserted that proposed § 30.114(b)(3)(ii) wrongly required a claimant to submit additional medical evidence to establish a wage-loss claim, because she believed that the medical evidence already used to accept a covered illness should be enough to support a claim for wage-loss benefits. This belief does not consider that there are, however, additional eligibility requirements for wage-loss benefits in section 7385s-2(a)(2) of EEOICPA beyond those set out in section 7385s-4 of EEOICPA. Therefore, no change was made to § 30.114(b) in the final rule as a result of this comment.

Special Procedures for Certain Radiogenic Cancer Claims

Proposed § 30.115(a) deleted a reference to an obsolete HHS regulation, and proposed § 30.115(a)(2) deleted language stating that HHS may perform further development of the employee's work history and that it will provide DOE with a copy of the final dose reconstruction report for an employee, since HHS does not perform either of those actions. In addition, proposed § 30.115(a) and (b) replaced references to "HHS" with "NIOSH." A claimant representative commented on other aspects of proposed § 30.115(a) that are no different from the existing § 30.115(a). The same claimant representative and the labor organization commented on other aspects of proposed § 30.115(a)(2) that are no different from existing § 30.115(a)(2). Because those commenters did not refer to changes that were proposed in the NPRM, no changes were made to § 30.115(a)(2) in the final rule based on their comments, nor was any change made to § 30.115(b) in the final rule.

Subpart C—Eligibility Criteria

Eligibility Criteria for Claims Relating to Covered Beryllium Illness Under Part B of EEOICPA

In proposed § 30.205(a)(1), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *current or former employee as defined in 5 U.S.C. 8101(1)* from § 30.5(t) to

§ 30.5(u). In proposed § 30.205(a)(3)(i), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *Department of Energy facility* from § 30.5(x) to § 30.5(y). A claimant representative noted those cross-reference changes in proposed § 30.205. However, because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to § 30.205 in the final rule based on this comment.

Proposed § 30.206(a) removed the language "a facility owned, operated, or occupied by a beryllium vendor" from existing § 30.206(a), and instead referenced the definition of a *beryllium vendor facility* in proposed § 30.5(j). An advocacy group, a claimant representative, a health care provider and the Advisory Board suggested that the Department should retain the language in current § 30.206(a), and not reference proposed § 30.5(j) because they believed that proposed § 30.5(j) erroneously excluded facilities that were "occupied by" a beryllium vendor. As explained above, proposed § 30.5(j) did not alter the eligibility of workers at beryllium vendor facilities; rather, it encompassed the narrower of the two definitions at section 7384n(a)(2) of EEOICPA, which all beryllium vendor employees must satisfy to establish their eligibility. Therefore, the suggested change was not adopted in the final rule. The same advocacy group and another advocacy group commented on other aspects of proposed § 30.206(a) that were no different from existing § 30.206(a). Because the comments submitted by the advocacy groups did not refer to changes that were proposed in the NPRM, no amendments were made to § 30.206(a) in the final rule with respect to those comments.

The Department proposed adding paragraph (d) to existing § 30.207 to memorialize its current practices for determining whether to evaluate an employee's medical evidence under either the pre- or post-1993 criteria outlined in section 7384l(13) of EEOICPA. Proposed § 30.207(d)(1) through (3) explained that OWCP will look to the date that the employee was either treated for or diagnosed with a chronic respiratory disorder when determining whether to use either the pre- or post-1993 criteria. One advocacy group took issue with the portion of proposed § 30.207(d) that refers to a diagnosis of a "chronic respiratory disorder," in the belief that the need to establish this diagnosis might conflict with section 7384l(13)(B)(ii)(IV) of EEOICPA. However, no such conflict

exists, since the requirement to establish a diagnosis of a chronic respiratory disorder is one of the ways that would permit the use of the pre-1993 diagnostic criteria (of which the statutory provision referenced above is one of five) for "established chronic beryllium disease" under Part B of EEOICPA, rather than, as the commenter posited, a criterion in and of itself. Therefore, the Department made no change to § 30.207(d) as a result of this comment. A claimant representative suggested that the Department further define the term "chronic" in proposed § 30.207(d), but she did not suggest any changes to the text of the provision. The Department is unaware of any current or past difficulty regarding the use of this term in the claims adjudication process, and is therefore not persuaded that the term requires any further explanation in the regulations. The same claimant representative suggested that the Department add the words "tested for" a chronic respiratory disorder in proposed § 30.207(d)(1) and (2), since that change would be consistent with OWCP's past practice. The Department agrees with this comment; accordingly, text has been added to § 30.207(d)(1) and (2) in the final rule to acknowledge that OWCP will consider whether the employee was "tested positive for" a chronic respiratory disorder when it decides whether the criteria in paragraph (c)(1) in § 30.207 can be used.

Eligibility Criteria for Claims Relating to Radiogenic Cancer Under Parts B and E of EEOICPA

In proposed §§ 30.210(a)(1) and 30.211, the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *specified cancer* from § 30.5(ff) to § 30.5(gg). A claimant representative noted those cross-reference changes in the above sections. However, because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to those sections in the final rule based on this comment.

Proposed § 30.213(a) replaced the words "the employee's radiation dose reconstruction" with "the employee's final dose reconstruction report," and replaced a reference to "HHS" with "NIOSH." A claimant representative commented on other aspects of proposed § 30.213(a) that are no different from existing § 30.213(a). Because the claimant representative's comment did not refer to a change that was proposed in the NPRM, no amendment was made to § 30.213(a) in the final rule with respect to this comment.

Eligibility Criteria for Claims Relating to Chronic Silicosis Under Part B of EEOICPA

In proposed § 30.220(a), the Department updated cross-references to reflect the changed location of the regulatory provisions defining the terms *Department of Energy facility* and *chronic silicosis*, from § 30.5(x) to § 30.5(y) and from § 30.5(j) to § 30.5(k), respectively. A claimant representative noted those cross-reference changes in § 30.220(a). However, because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no changes were made to this section in the final rule based on this comment.

In proposed § 30.222(a), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *chronic silicosis* from § 30.5(j) to § 30.5(k). Also in proposed § 30.222(a), the Department replaced the term “medical doctor” with “licensed physician.” A claimant representative noted the cross-reference change in § 30.222(a). However, because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to those sections in the final rule based on this comment.

Eligibility Criteria for Other Claims Under Part E of EEOICPA

In proposed § 30.230(a) and (d)(1), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *Department of Energy contractor employee* from § 30.5(w) to § 30.5(x). A claimant representative noted the cross-reference changes in § 30.230(a) and (d)(1). However, because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to those paragraphs in the final rule based on this comment.

The Department proposed to amend § 30.231(a) by adding the same language contained in proposed § 30.112(b)(3) to explain its current practice of evaluating affidavit evidence submitted by a claimant as proof of employment, in conjunction with all evidence of employment, to determine if the claimant has met his or her burden of proof. Four advocacy groups, one of whom submitted two different comments, two claimant representatives and the labor organization objected to the proposed language in § 30.231(a). One of those claimant representatives suggested that the Department replace the proposed language entirely with

language stating that it will accept a claimant’s affidavit as evidence of covered employment, absent strong evidence discrediting the affidavit. Also, one of the four advocacy groups questioned whether proposed § 30.231(a) would make it more difficult for claimants to meet their burden of proof. While the Department does not agree with the comment submitted by the claimant representative noted above, it nonetheless has added text (as it did for § 30.112(b)(3)) to clarify that if the only evidence that the claimant submits to establish covered employment is an affidavit, OWCP will evaluate that affidavit in conjunction with the other available evidence of employment when it is unable to verify the alleged covered employment through the processes described in 20 CFR 30.105(a) and 30.106. The Department made that same minor change in the text of § 30.231(a). However, the Department notes that the advocacy group’s concern about the burden of proof is misplaced, since there is nothing in the text of proposed § 30.231(a) that would alter a claimant’s burden of proof to establish covered employment; therefore, no changes were made in § 30.231(a) in the final rule based on this other comment. The other three advocacy groups and the labor organization also asked the Department to define several terms used in the text that explain how OWCP will evaluate affidavit evidence in these situations, while the same three advocacy groups, the two claimant representatives and the first advocacy group discussed above all suggested that neither DOE nor another entity should have any role in OWCP’s evaluation of affidavit evidence. However, as it explained above in response to similar comments to proposed § 30.112(b)(3), the Department is not persuaded that it would be appropriate to make such changes. Therefore, no change was made in § 30.231(a) as a result of those comments.

Proposed § 30.231(b) described sources, in addition to the Site Exposure Matrices that are currently listed in that paragraph, that the Department considers to be reliable sources of information to establish whether an employee was exposed to a toxic substance at a DOE facility or a RECA section 5 facility. An advocacy group disagreed in general terms with proposed § 30.231(b). However, the Department believes that the proposed expansion of the list will be helpful for claimants during the claims adjudication process. Another advocacy group suggested that the Department define several terms used in the text that

explain OWCP’s evaluation of evidence of toxic exposure. However, any such definitions would be unnecessarily specific, and therefore not appropriate for regulatory text. A claimant representative suggested that the Department state in proposed § 30.231(b) that OWCP will only require evidence that the toxic substance was present at a claimed work site and that the employee came in contact with the substance. However, such a change would ignore the explicit requirements of section 7385s–4(c)(1). The Advisory Board requested that the Department include in proposed § 30.231(b) additional potential sources of probative evidence of toxic exposure. Such a change is unnecessary because proposed § 30.231(b)(3) already made clear that OWCP would consider evidence from any entity deemed by OWCP to be a reliable source of information for the purposes of proving toxic exposure information. For the above reasons, the Department did not make any of the suggested changes discussed by these commenters to § 30.231(b) in the final rule.

Proposed § 30.232(a) deleted the former Part D requirements for establishing a covered illness, as Congress abolished Part D and those requirements are now irrelevant. In its place, the Department proposed adding language to describe its current requirements for establishing a covered illness under Part E. A claimant representative questioned why the Department did not retain the requirements stated in § 30.232(a)(2) through (4) of the current regulations. As the Department explained in the preamble to the proposed rule, proposed § 30.232(a) deleted references in that paragraph that referred to the irrelevant requirements in former Part D. The labor organization disagreed with the Department’s removal of the reference to DOE’s Former Worker Program in current § 30.232(a)(3). However, deleting that reference does not mean that evidence from DOE’s Former Worker Program may not be used to establish that a claimant whose employment has been established has been diagnosed with a covered illness under Part E. Thus, the Department did not make any changes to § 30.232(a) based on these comments in the final rule.

Proposed § 30.232(a)(1) required the claimant to submit “[w]ritten medical evidence containing a physician’s diagnosis of the employee’s covered illness (as that term is defined in § 30.5(s)), and the physician’s reasoning for his or her opinion regarding causation” to establish that an employee

has been diagnosed with a covered illness. An advocacy group, two claimant representatives and the Advisory Board disagreed with this general requirement in proposed § 30.232(a)(1). One of those claimant representatives suggested that the Department state instead that any credible sources may be provided to prove causation of a covered illness. The other claimant representative suggested that this provision include the words “aggravating and contributing to.” The advocacy group believed that proposed § 30.232(a)(1) increased the burden necessary to establish a sick worker’s illness by requiring the physician to opine on causation. The Advisory Board had a similar concern, but suggested replacing the proposed text with text that would be essentially identical. However, the Department notes that proposed § 30.232(a)(1) merely recognized a claimant’s burden, as authoritatively stated by the U.S. Supreme Court, to provide evidence to meet the causation standard in section 7385s-4(c) of EEOICPA, and the requirement that the physician diagnosing a condition opine on causation. For those reasons, the Department is not persuaded that any change to § 30.232(a)(1) is needed in the final rule based on these comments. The Department also updated a cross-reference in proposed § 30.232(a)(1) to reflect the changed location of the regulatory provision defining the term *covered illness* from § 30.5(r) to § 30.5(s). A claimant representative noted that change. Because the commenter did not either support or oppose the proposed regulation, or offer ideas for changes, no change was made to that section in the final rule based on this comment.

In addition to the requirement in proposed § 30.232(a)(1), proposed § 30.232(a)(2) stated that a claimant must submit “[a]ny other evidence OWCP may deem necessary to show that the employee has or had an illness that resulted from an exposure to a toxic substance while working at either a DOE facility or a RECA section 5 facility.” One advocacy group and the Advisory Board asserted that proposed § 30.232(a)(2) unreasonably required a claimant to provide evidence beyond a diagnosis of a covered illness. Another advocacy group asked for clarification and further explanation of certain terms used in the text in proposed § 30.232(a)(2). The Department appreciates these comments and understands the underlying concerns. However, because proposed § 30.232(a)(2) is materially identical to

current § 30.232(a)(4) and accurately reflects the claimant’s burden of proof to submit medical evidence of causation, which the Department believes is consistent with the statute, the suggested changes to this provision have not been adopted in the final rule.

In proposed § 30.232(b), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *covered illness* from § 30.5(r) to § 30.5(s). Two advocacy groups and an individual commented on other aspects of proposed § 30.232(b) that are no different from the existing § 30.232(b). Because those commenters did not refer to changes that were proposed in the NPRM, no amendments to § 30.232(b) were made in the final rule with respect to their comments.

Subpart D—Adjudicatory Process

General Provisions

In § 30.300, the Department proposed adding language to explain that a claimant may seek judicial review of a final decision issued by FAB by filing an action in Federal district court, since the current regulations do not provide this explanation. A claimant representative agreed with the Department’s change. An individual, however, suggested that the Department add regulatory language establishing “a process for next-higher appeal within the DOL” in proposed § 30.300. This same suggestion was made by several commenters on this section as it appeared in the first interim final rule governing OWCP’s administration of EEOICPA that was published on May 25, 2001 (66 FR 28948). As it did when it subsequently published the first final rule on December 26, 2002 (67 FR 78874), the Department continues to believe that utilizing administrative law judges or another type of independent review body would unnecessarily complicate and delay the claims adjudication process to the detriment of claimants. The commenter did not present any new reasons not previously considered by the Department when it originally decided to retain the adjudicatory structure described in § 30.300, or any evidence of problems with it since its inception in 2001. Therefore, no change was made to § 30.300 in the final rule based on that comment.

In proposed § 30.301(b)(1), the Department proposed amending language that currently only recognizes postmark dates as evidence of a timely request for the issuance of an administrative subpoena to also recognize the date-markings of other

carriers, since other delivery options besides the U.S. Mail are widely used. A claimant representative stated that “the proposed and the current is the same.” However, since the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to that paragraph in the final rule based on this comment. An advocacy group requested that proposed § 30.301(b)(1) be amended to allow for the submission of subpoena requests through the Energy Document Portal. This suggestion does not pertain to the changes in proposed § 30.301(b)(1). Because the advocacy group’s comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule based on this comment.

Recommended Decisions on Claims

Proposed § 30.305(a) replaced references to “HHS” with “NIOSH.” A claimant representative agreed with that proposed change. Therefore, no change was made to § 30.305(a) in the final rule based on that comment. In addition, the Department proposed modifying the language in § 30.306 to make recommended decisions more understandable by mandating that they include a narrative discussion of the district office’s findings of fact and conclusions of law. A claimant representative asked the Department to explain how OWCP will “enforce the district offices to only list the facts and law in the recommended decisions.” Since proposed § 30.306 merely codified OWCP’s current practice of including a narrative discussion in the recommended decision of the district office’s findings of fact and conclusions of law, the comment addressed a matter of enforcement rather than the substance of the proposed change. Thus, no change was made to § 30.306 in the final rule.

In the NPRM, the Department proposed moving the provisions in current § 30.307 to § 30.308. Newly proposed § 30.307(a) informed readers that in most situations, OWCP will issue a single recommended decision to all survivors who filed claims under Part B and/or Part E of EEOICPA relating to the same deceased employee, while newly proposed § 30.307(b) recognized an exception to that policy when another individual subsequently files a claim seeking the same award referenced in § 30.307(a). A claimant representative commented that the proposed language was confusing and would deny a subsequent survivor the opportunity to file a claim. However, proposed § 30.307(b) did not state that OWCP will deny a subsequently claiming survivor

the opportunity to file such a claim, but instead explained that in circumstances where a district office recommends that a subsequently filed claim be denied, the same recommended decision will not address the entitlement of the earlier claimants. Therefore, no change was made to this section in the final rule.

Hearings and Final Decisions on Claims

In the NPRM, proposed § 30.310(a) replaced references to “HHS” with “NIOSH.” In addition, the Department proposed amending the language in § 30.310(b) that only recognizes postmark dates as evidence of the time a written objection is filed to also recognize the date-markings of other carriers, since other delivery options besides the U.S. Mail are widely used. The Department also changed the wording in proposed § 30.310(b) to reflect recent changes in how the program receives and processes mail. A claimant representative had “no objections” to the proposed changes in § 30.310. An advocacy group suggested that proposed § 30.310(b) be amended to allow claimants to submit hearing requests through the Energy Document Portal. As stated above in response to this same request in relation to proposed § 30.301(b)(1), this suggestion does not address the proposed change in that provision. Because the advocacy group’s comment did not refer to a change that was proposed in the NPRM, no amendment was made to this paragraph in the final rule based on that comment.

Proposed § 30.313(c) in the NPRM replaced references to “HHS” with “NIOSH.” A claimant representative and an individual commented on other aspects of proposed § 30.313(c) that were no different from the existing § 30.313(c). Because those comments did not refer to changes that were proposed in the NPRM, no changes to § 30.313(c) were made in the final rule with respect to those comments.

The Department also proposed amending § 30.314(a), which currently provides a FAB reviewer with the discretion to conduct hearings by telephone or teleconference, to also allow the FAB reviewer to conduct hearings by videoconference or other electronic means. A claimant representative stated that there was “no change” from the current regulations. Because the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to that paragraph in the final rule based on this comment. Proposed § 30.314(b) included new language to provide the FAB reviewer with the discretion to mail a hearing

notice less than 30 days prior to the hearing if the claimant and/or representative waives the 30-day notice period in writing. A claimant representative agreed with the change in proposed § 30.314(b). An advocacy group suggested that OWCP allow claimants more time to prepare for a hearing if needed, and more time to present evidence at hearings. However, the advocacy group’s comments did not pertain to any of the changes made in proposed § 30.314(b). Because the advocacy group’s comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule based on this comment.

Proposed § 30.315(a) added a provision prohibiting a claimant or representative from making more than one request to reschedule a hearing, since repeated requests to cancel and reschedule hearings can have a negative impact on the claim adjudication process for other claimants. A claimant representative agreed with the change. The labor organization asked whether and how OWCP will notify claimants of this provision prior to their hearing date. The Department does not believe that the issue of notification suggested by the latter comment is appropriate for a regulation, since it involves a purely internal procedure. Thus, no change was made to § 30.315(a) in the final rule.

As the Department explained above in the “Background of This Rulemaking,” it proposed to modify § 30.318(a) to describe the potential for NIOSH to provide consultation in FAB’s consideration of objections to final dose reconstruction reports. This consultation process will provide for a more complete consideration of the claimant’s objections. The Department also proposed to clarify OWCP’s obligation to consider objections to how it calculates the probability of causation in new § 30.318(b). One claimant representative commented that the changes in proposed § 30.318 were unnecessary. However, the Department believes that the changes to that section will alleviate the frustration experienced by claimants and FAB reviewers in determining whether an objection to NIOSH’s final dose reconstruction report concerned “methodology” or “application.” The Department further believes that NIOSH’s increased involvement in FAB’s consideration of objections to NIOSH’s final dose reconstruction reports will make this process more efficient and transparent. For those reasons, no changes were made to § 30.318 in the final rule based on this comment. Another claimant representative suggested that NIOSH

should indicate in its final dose reconstruction report the calculated recommended probability of causation. While the Department agrees that this suggestion has merit, it is nonetheless contrary to how the President assigned responsibility for this task in E.O. 13179, and the suggested change was not made to § 30.318(b) in the final rule.

In the NPRM, the Department proposed to add language in § 30.319(b), which currently only recognizes postmark dates as evidence of the time a request for reconsideration is filed, to also recognize the date-markings of other carriers, since other delivery options besides the U.S. Mail are widely used. The Department also changed the wording in proposed § 30.319(b) to reflect recent changes in how the program receives and processes mail. A claimant representative commented that the changes in proposed § 30.319(b) were unnecessary. However, as stated above, other carrier’s date markings besides postmarks exist and therefore the Department believes that it is necessary to recognize them for timeliness purposes. Also, since the program now receives and processes mail through a central mail room, the reference in current § 30.319(b) that FAB receives mail is no longer accurate. Thus, no changes were made to § 30.319(b) in the final rule based on this comment.

Reopening Claims

Proposed § 30.320(b) allowed claimants to request a reopening based on new medical evidence diagnosing a medical condition. Two advocacy groups and a health care provider suggested that the new language proposed in § 30.320(b) be amended to state that the Director for Energy Employees Occupational Illness Compensation will reopen any claim in instances when it failed to take into account all relevant evidence in reaching their determination on eligibility. Another advocacy group asserted that the Department’s change in proposed § 30.320(b) was unnecessary because the Director has the discretion to reopen a claim at any time. Both of those comments go beyond the proposed change in § 30.320(b). Because those commenters referred to something that was not changed in the NPRM, no amendment to § 30.320(b) was made in the final rule with respect to their comments. A claimant representative commented that she was unsure whether OWCP will grant a reopening request based on new medical evidence. Proposed § 30.320(b) answered this question in the affirmative by explicitly stating that the Director will reopen a

claim in instances when, in her discretion, she determines that a claimant has submitted new medical evidence that diagnoses a medical condition and is material to the claim. Under these circumstances, no amendment was made to § 30.320(b) in the final rule as a result of those comments.

Subpart E—Medical and Related Benefits

Medical Treatment and Related Issues

In the NPRM, the Department proposed to move language in current § 30.400(a) regarding the payment to reimburse out-of-pocket costs of obtaining covered medical treatment to survivors to a new paragraph. It also proposed to add a new statement to that paragraph clarifying that if there is any doubt about whether a contemplated service, appliance or supply is or will be necessary to treat an accepted illness, the employee should consult OWCP's bill processing agent prior to obtaining it. An advocacy group suggested that the new language in proposed § 30.400(a) be amended to state that employees may contact OWCP directly to ascertain whether a contemplated medical treatment is considered to be necessary. However, such questions are more efficiently answered by contacting OWCP's bill processing agent, as is the current practice. Therefore, no change was made to § 30.400(a) in the final rule as a result of this comment. Also, a claimant representative and the labor organization commented on aspects of proposed § 30.400(a) that did not relate to the proposed changes in that paragraph. Because those comments did not refer to a change that was proposed in the NPRM, no amendment was made to § 30.400(a) in the final rule with respect to them.

The Department also proposed to make a number of changes to § 30.400(c). First, the Department proposed adding new language in that paragraph to explain the current qualifications that must be met before hospitals and providers of medical services or supplies may furnish appropriate services, drugs, supplies and appliances to covered employees. A claimant representative agreed with the Department's change in that paragraph. Two health care providers believed that the proposed language in § 30.400(c) indicating that specified providers must possess "all applicable licenses required under State law" would obligate OWCP to monitor providers' licensure. One of those same two health care providers proposed amending that provision to specify that a provider must possess all

applicable licenses required under state law "as determined by the applicable State regulatory body." However, the only occasions when OWCP is concerned with a provider's possession of state-required licenses is either at the time of enrollment or exclusion. The Department believes that no further specificity is required in this provision since the proposed language explicitly states that state law governs licensure requirements. Therefore, the above suggestions have not been adopted in the final rule.

In addition, the NPRM proposed adding language in § 30.400(c) authorizing OWCP to offset the cost of prior rental payments against the future purchase of an appliance or supply. A claimant representative objected to this provision, and suggested that OWCP had other means available to it to control its costs in this area. However, this practice has been in effect since EEOICPA Bulletin No. 13-03 was issued in 2013, and has not proved problematic. Accordingly, no changes were made in the final rule as a result of this comment. The Department also proposed adding authority in § 30.400(c) for it to provide refurbished equipment where appropriate. The same claimant representative and a health care provider objected to this provision, and commented that it should be removed because such appliances may not work properly. However, these comments presumed that refurbished appliances would be unreliable without providing any data in support of that position. Therefore, no changes were made in the final rule in response to these comments. Lastly, in proposed § 30.400(c), the NPRM proposed codifying OWCP's inherent authority to contract with specific providers to provide non-physician services and appliances to beneficiaries. Three health care providers, two advocacy groups and a claimant representative objected to this provision. All of these commenters, except one of the two advocacy groups, questioned the Department's statutory authority for this proposed change, while the remaining advocacy group believed that the proposal was too vague. However, section 7384t(b)(2) of EEOICPA states that a physician initially selected by a beneficiary must "provide medical services, appliances, and supplies under this section in accordance with such regulations and instructions as the President considers necessary." Since OWCP has been delegated the President's authority under section 7384t(b)(2), it clearly has the authority to regulate in this manner. Accordingly,

no changes were made to § 30.400(c) in the final rule as a result of any of these comments.

As stated above, the Department proposed to move language in current § 30.400(a) regarding payments to reimburse out-of-pocket costs of obtaining covered medical treatment to survivors to a new paragraph, proposed § 30.400(d), in order to bring attention to that longstanding policy. A claimant representative agreed with the Department's new proposed § 30.400(d). Accordingly, no changes were made to this paragraph in the final rule.

In the NPRM, the Department proposed reorganizing existing § 30.403 into three separate paragraphs to better focus the section on OWCP's current methods for pre-authorization of and payment for claims under section 7384t of EEOICPA for home health care, nursing home, and assisted living services, which comprise the vast bulk of services of this type being provided. Proposed § 30.403(a) incorporated the descriptive text in current § 30.403 with minor modifications, and proposed § 30.403(b) described OWCP's general requirements for payment of a claim for nursing home and assisted living services. A claimant representative generally agreed with the Department's changes in proposed § 30.403(a) and (b), but that same claimant representative and a health care provider objected to the new language in those paragraphs stating that authorization and payment for home health care services are "subject to the pre-authorization requirements described" in proposed § 30.403(c). For the reasons described below in response to comments in proposed § 30.403(c), the Department is not persuaded that it is necessary to remove that language in § 30.403(a) and (b) in the final rule.

Proposed § 30.403(c) set out the particular pre-authorization process used to file an initial claim for home health care, nursing home, and assisted living services. The Department received 39 comments on this proposed paragraph (24 comments were from physicians, eight comments were from individuals, four comments were from three health care providers, two comments were from an advocacy group and one comment was from a claimant representative). While one of the individuals and the claimant representative agreed with the Department's changes in proposed § 30.403(c), the remainder of the commenters requested that the Department retain the language in current § 30.403 because they believe that the new procedures would be too burdensome for claimants and

providers, and would cause unnecessary delays in the medical treatment of EEOICPA beneficiaries. However, the processes set forth in proposed § 30.403(c) were merely a compilation of the current processes for pre-authorization, and will improve communications between the program and the beneficiary, and between the program and the treating physician. Currently, OWCP does not require beneficiaries to identify the name of their treating physician at the time that home health care is requested, and believes that obtaining this information up front will greatly enhance efficiency because it will be able to communicate with the physician directly, if needed. Furthermore, OWCP currently requires that the beneficiary's physician submit a letter of medical necessity and verify that a timely face-to-face physical examination of the beneficiary took place, and proposed § 30.403(c) merely recognizes this current process. Thus, no changes were made to § 30.403(c) based on these comments.

In the NPRM, proposed § 30.405(b) and (c) clarified OWCP's policy for approving or denying an employee's request to change treating physicians. The language in current § 30.405(b) and (c) states that OWCP may approve or deny a certain type of request to *change* physicians based on the "sufficiency" of the request, while the proposed language in those paragraphs stated that OWCP will approve or deny such a request based on the credibility of the request, and whether it is supported by minimally persuasive evidence. The Department received 102 comments that objected to the proposed changes in § 30.405 (from 90 individuals, three advocacy groups, three claimant representatives, two health care providers, two unknown persons or organizations, one labor organization and the Advisory Board). Out of these, 54 comments interpreted proposed § 30.405(b) and (c) to mean that a beneficiary's right to *change* physicians was being eliminated, 26 other comments interpreted those paragraphs to mean that a beneficiary's right to *initially choose* a physician was being eliminated, another 14 comments believed that those paragraphs eliminated *both* of those rights, and the final group of eight comments opposed the proposed language without further explanation.

The Department notes that section 7384t(b)(2) of EEOICPA allows a beneficiary the opportunity to *initially choose* a physician to provide medical services, appliances and supplies, and that statutory provision is reflected in the text of existing § 30.405(a). Nothing

in proposed § 30.405(b) and (c) changed existing § 30.405(a), which also recognizes that treating physicians may, and often do, refer their patients to specialists for further medical care. Proposed § 30.405(b) and (c) merely clarified the standards that OWCP may use under its existing authority to approve or deny certain requests to *change* a treating physician. Although most of the 102 comments submitted a general objection to the changes in proposed § 30.405(b) and (c), the following commenters submitted comments with specific suggestions on those proposed provisions. One of the three advocacy groups, one of the three claimant representatives and both of the health care providers suggested that the Department further define the terms and circumstances under which it would deny a beneficiary's request to change a treating physician. However, the Department believes that these are properly matters of administrative discretion and would be too confusing to define and of little utility to beneficiaries. A different claimant representative suggested that the proposed language in these paragraphs be replaced with language stating that a beneficiary may select and utilize any physician, at any time, so long as that physician is an approved provider under the program. Consistent with the above explanation, such a proposal goes well beyond the right of initial choice found in section 7384t(b)(2) of EEOICPA, and was not proposed in the NPRM. The Advisory Board suggested that the Department eliminate the changes in proposed § 30.405(b) and (c), and instead state in those paragraphs that "The claimant may cite personal preference as a valid reason to change physicians." However, this suggestion goes beyond the change proposed, which clarified that OWCP will approve or deny a request to change physicians based on the credibility of the request and whether it is supported by minimally persuasive evidence, instead of the "sufficiency" of the request, as is stated in the existing regulation. In light of the above discussion, no changes were made to this section in the final rule as a result of these 102 comments.

Directed Medical Examinations

The Department proposed to amend §§ 30.410(c) and 30.411(d) to memorialize OWCP's existing authority to administratively close an employee's claim when he or she refuses to attend a second opinion examination or a referee medical examination, respectively. A claimant representative agreed with the changes in proposed §§ 30.410(c) and 30.411(d). Another

claimant representative suggested that the Department amend proposed §§ 30.410(c) and 30.411(d) to state that a claimant may utilize the adjudicatory process described in subpart D of the regulations if their claim is administratively closed, and include provisions allowing the claimant to cancel and request rescheduling of those examinations upon a showing of good cause. Two health care providers questioned the propriety of proposed §§ 30.410(c) and 30.411(d) and suggested amending these provisions to state that OWCP will pay for reasonable travel accommodations, will hold examinations in facilities which accommodate the medical needs of beneficiaries, allow for adjudication under subpart D and include in the provisions language that OWCP will give 30 days notice of an examination and limit the employee's travel to a 100-mile radius, prior to assessing if the employee "refused" an examination. OWCP notes that its procedures and other regulations not part of this rulemaking already provide that OWCP will pay for the cost of these examinations, including travel and accommodations, allow their cancellation for good cause, and direct that these examinations be held in facilities that accommodate the individual's medical needs and are within a reasonable distance from the individual's residence (almost always within a 100-mile radius). It is not always possible to schedule examinations at locations within that radius, such as cases involving individuals who reside in remote areas, but the examination must still be within a reasonable distance and these same protections apply. Nevertheless, in situations when a directed medical examination is necessary, OWCP is unable to make a determination on a claimant's eligibility for benefits until completion of such examination. Accordingly, administratively closing the claim until that essential development step takes place is a reasonable action that can be resolved by employee cooperation. The Department further notes that the decision whether or not to administratively close a claim properly involves a question of administrative discretion, and that as such, the Department has decided not to identify specific factors for such circumstances in the regulations. For those reasons, the suggested changes were not made to §§ 30.410(c) and 30.411(d) in the final rule. Finally, an advocacy group asked the Department to clarify what it means by "pending matters" in proposed

§§ 30.410(c) and 30.411(d). The Department believes that the term must be broad enough to retain maximum administrative discretion because the matters that OWCP may need to suspend under these sections will likely be unique to the case at hand. Thus, the Department has not made this last suggested change to §§ 30.410(c) and 30.411(d) in the final rule.

Medical Reports

In the NPRM, proposed § 30.416(a) removed language that a physician's stamp will be accepted in lieu of his or her signature on a medical report, and specified that the physician's handwritten or electronic signature should be on his or her medical report. Two claimant representatives suggested that it was unreasonable for OWCP to require a physician's handwritten or electronic signature on a medical report. However, this change was made to align with the requirements of other programs administered by OWCP, as well as the requirements of the Centers for Medicare and Medicaid Services (CMS) within HHS. Thus, no change was made to § 30.416(a) in this final rule based on those comments. A third claimant representative mistakenly asserted that proposed § 30.416(a) was identical to existing § 30.416(a), and therefore questioned why it appeared in the NPRM. However, because the claimant representative's comment did not pertain to something that was changed in the NPRM, no amendment was made in the final rule with respect to this comment.

Subpart F—Survivors; Payments and Offsets; Overpayments

Survivors

In the NPRM, the Department proposed amending the first sentence in § 30.500(a)(2) to memorialize OWCP's policy determination that a "child" under Parts B and E of EEOICPA means only a biological child, a stepchild or an adopted child of a deceased covered Part B or Part E employee. Also, the Department proposed to move the statutory definition of a "covered child" found in the second sentence of existing § 30.500(a)(2) to its own new paragraph. A claimant representative asserted that the changes in proposed § 30.500(a)(2) were unnecessary. However, since the Department believes that these changes are substantive in nature and add clarity, no change was made to § 30.500(a)(2) in the final rule as a result of this comment.

As noted above, the Department proposed in the NPRM to move the statutory definition of a "covered child"

in current § 30.500(a)(2) to a new paragraph, proposed § 30.500(c)(1), in order to increase the understandability of this important definition. The Department also proposed adding a sentence in proposed § 30.500(c)(1) to explain that a child's marital status or dependency on the covered employee for support is irrelevant to his or her eligibility for benefits as a "covered child" under Part E. A claimant representative agreed with the changes in proposed § 30.500(c)(1). Therefore, no change was made to § 30.500(c)(1) in the final rule. In addition, proposed § 30.500(c)(2) further defined the statutory term *incapable of self-support* to mean that the child must have been physically and/or mentally incapable of self-support at the time of the covered employee's death. An individual objected to the Department's proposed definition as too vague. The Department does not agree that the proposed definition at issue is vague, however, and believes that the text added to this definition in proposed § 30.500(c)(2) highlights that determinations made on this point will focus on objective factual and/or medical evidence, while still permitting OWCP to retain the maximum amount of discretion needed for it to adjudicate these sorts of claims on their individual facts. Furthermore, the Department notes that this approach has met with judicial approval. See *Watson v. Solis*, 693 F.3d 620 (6th Cir. 2012). Accordingly, no change was made to § 30.500(c)(2) in the final rule.

In proposed § 30.501(a) and (b), the Department updated a cross-reference to reflect the changed location of the regulatory provision defining the term *survivor* from § 30.5(gg) to § 30.5(hh). In proposed § 30.502, the Department updated a cross-reference to reflect the changed location of the statutory definition of a "covered child" from § 30.500(a)(2) to § 30.500(c)(1). A claimant representative noted both of these updated cross-references. However, because the commenter did not either support or oppose the proposed regulations or offer ideas for changes, no change was made to either section in the final rule based on her comments.

Payment of Claims and Offset for Certain Payments

In the NPRM, the Department proposed amending current § 30.509(c), which references the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (AMA's *Guides*) to specifically reference the 5th Edition of the AMA's *Guides*. Both a claimant representative and the Advisory Board questioned the wisdom

of amending current § 30.509(c) to specifically reference the 5th Edition, since this would reduce the ability to change this in the future absent another rulemaking. The Department agrees with these commenters and acknowledges that OWCP may wish to move to another edition in the future. Accordingly, this change in proposed § 30.509(c) was not made in this final rule. An individual commented on other aspects of proposed § 30.509(c) that are no different from the existing § 30.509(c). Because the individual's comment did not refer to a change that was proposed in the NPRM, no amendment was made to § 30.509(c) in the final rule with respect to this comment.

Subpart G—Special Provisions

Representation

In the NPRM, the Department proposed amending § 30.600 to state that a representative does not have the authority to sign either Form EE-1 or Form EE-2, to be consistent with proposed §§ 30.100 and 30.101. Four claimant representatives and one advocacy group suggested that it was unreasonable for the Department to eliminate a representative's authority to sign these initial claim forms in proposed § 30.600(c)(2), citing reasons such as convenience and contractual arrangements. One of those same claimant representatives asserted instead that a properly appointed authorized representative ought to have the authority to sign *all* documents relating to a claim. The Department discussed above, in its response to comments it received on proposed §§ 30.100 and 30.101, the reasons why it believes that a claimant's signature is needed on his or her claim form. Because those same reasons apply here, the Department did not make any change to proposed § 30.600(c)(2) as a result of these comments. The same one of these four claimant representatives and the same advocacy group noted that there was no provision in proposed § 30.600(c)(2) allowing an attorney-in-fact to sign a claim form on a claimant's behalf. As discussed above in relation to proposed §§ 30.100 and 30.101, OWCP has and will continue to accept claim forms signed by a valid attorney-in-fact. Any individual other than a claimant may sign the claim form if they have the legal authority to do so, and have not otherwise been excluded under proposed § 30.600(c)(2) of the regulations. Therefore, no change was made to this section as a result of this second group of comments.

Proposed § 30.601 added language to provide that a representative must comply with OWCP's conflict of interest policy. Three advocacy groups, two health care providers and a claimant representative disagreed with this requirement in proposed § 30.601. One of those advocacy groups asserted that such policy removes a class of potential authorized representatives without proof of any wrongdoing, restricts home health care workers from being appointed as authorized representatives in situations when home health care benefits would not be available (such as for survivors), and that the Department should address its fraud concerns in other ways. That same advocacy group and the second advocacy group believed that some elderly sick workers only have their nurses to represent them, and any limitation on who they may select to represent them would be unreasonable or would negatively affect their health. The third advocacy group stated that the Department's proposal to limit a claimant's ability to designate a representative creates an unnecessary burden on claimants since it is already difficult for claimants to find representatives willing to provide assistance, and that OWCP did not provide any rationale for the change. Both of the health care providers disagreed with the conflict of interest policy because the prohibition against representatives having outside financial interests unreasonably bars health care providers (who have experience navigating complex Federal benefit programs) from advocating for a claimant, and suggested addressing this in the regulations or removing it. Two of the advocacy groups and one of the health care providers believed that other health benefit programs are not as restrictive. Finally, the claimant representative did not offer any reasons for her disagreement with this proposed change, nor did she suggest any changes. The two health care providers, the claimant representative and one of the advocacy groups asked the Department to specifically state in the regulations the standards it has adopted. The Department is not persuaded by any of the reasons given by these commenters to abandon the proposed application of the conflict-of-interest policy in this context, because the aim of the policy is to keep providers from straying outside of their proper roles as providers of medical treatment. Also, the Department believes that its policy will help it safeguard our vulnerable, often aged, claimant population by lessening the chance that an outside financial interest of an authorized

representative could interfere with, or be contrary to, the best interests of the claimant. The Department agrees, however, with the commenters' suggestion that a basic statement of such policy should be incorporated in this provision. The Department has therefore added a basic statement of OWCP's conflict of interest policy to § 30.601 in the final rule.

Proposed § 30.603(a) clarified that a representative may charge a claimant for costs and expenses related to a claim in addition to a fee for his or her services within the limitations specified in § 30.603(b). A claimant representative agreed with this change in proposed § 30.603(a). Under these circumstances, no change was made to that provision in the final rule.

Effect of Tort Suits Against Beryllium Vendors and Atomic Weapons Employers

In the NPRM, proposed §§ 30.617(b)(2) and 30.618(c)(2) replaced references to "HHS" with "NIOSH." A claimant representative asserted that the changes to these two sections were unnecessary. The Department, however, has replaced the term "HHS" with "NIOSH" throughout the NPRM to correctly reflect HHS's delegation of its exclusive control of the portion of the claims process for radiogenic cancer to NIOSH in 42 CFR 82.1. Accordingly, no changes were made in the final rule with respect to this comment.

Subpart H—Information for Medical Providers

Medical Records and Bills

In the NPRM, the Department proposed amending § 30.700 to describe, for the first time, OWCP's process for enrolling providers with its bill processing agent, as well as the agent's automated bill processing and authorization systems. Proposed § 30.700(a) required that a provider seeking to enroll certify that it has satisfied all applicable Federal and state licensure and regulatory requirements, that it will maintain documentation showing that it satisfies those requirements, and that it will notify OWCP immediately if any such information changes. A claimant representative questioned whether the Department's changes in proposed § 30.700(a) were necessary and argued that they placed undue hardship on providers. The Department does not agree that the changes in proposed § 30.700(a) cause any hardship, given that providers have been adhering to the described requirements since the

inception of the program in 2001. While these requirements have been in existence since that time, the Department continues to prefer describing its current provider processes in a regulatory format. A health care provider suggested amending proposed § 30.700(a) to specify that Federal and state license requirements are to be determined by the applicable Federal or state regulatory body. However, the fact that the requirements are determined by the applicable Federal or state regulatory body is irrelevant to this provision. As explained in the Department's discussion of a similar comment received in connection with proposed § 30.400(c), the only occasions when OWCP is concerned with a provider's possession of required licenses is either at the time of enrollment or exclusion. The Department believes that no further specificity is required in this provision since the proposed language explicitly states that Federal and state law governs any pertinent licensure requirements. Therefore, no changes to § 30.700(a) were made in the final rule based on these comments.

Proposed § 30.700(b) recognized OWCP's current practice of requiring providers to seek pre-authorization for certain services. A health care provider felt that proposed § 30.700(b) should be removed because it conflicted with unspecified provisions in EEOICPA, would result in delayed care, and presented the likelihood that health care providers seeking pre-authorization might violate unspecified state laws. The Department is not persuaded by this vague and unspecific comment, which appears to be based on pure speculation. A second health care provider, an advocacy group and a claimant representative suggested that the Department provide more detail in proposed § 30.700(b) to describe the pre-authorization process, and list the specific procedures that require pre-authorization. However, the requested level of specificity in these comments is not appropriate for regulations, and the processes and procedures at issue are more appropriately addressed through provider manuals, the bill processing agent's web page and other explanatory materials. For the above reasons, no changes were made to § 30.700(b) in the final rule.

Proposed § 30.700(c) required that a provider submit "all medical bills" to OWCP through its bill processing portal. A health care provider asked the Department to clarify whether it intended to use electronic billing as the sole billing method in proposed § 30.700(c). The commenter was

concerned that supporting medical evidence can be voluminous, and asserted that it could be more efficiently submitted via U.S. Mail. The Department notes, however, that the regulatory requirement to support all bills for medical treatment with supporting medical reports or office/treatment notes has been in existence since 2001 in existing § 30.701(a). As to whether OWCP and/or its bill processing agent will allow exceptions to this requirement for case-specific circumstances is beyond the scope of proposed § 30.700(c), and thus no change was made to this paragraph in the final rule based on this comment.

In the NPRM, proposed § 30.701(a) recognized that OWCP may withhold payment for services until the required medical evidence described in proposed § 30.700 is provided, and clarified that charges for medicinal drugs dispensed in a physician's office must be reported on Form OWCP-1500 or CMS-1500. An advocacy group and a claimant representative were concerned that the language in proposed § 30.701(a) might force beneficiaries to pay bills that OWCP refuses to pay, and might ultimately leave beneficiaries without necessary care. This scenario appears to be dependent upon the particular contractual relationships between providers and their clients, and does not therefore involve OWCP in a meaningful way. The same claimant representative also suggested that proposed § 30.701(a) include a provision allowing providers to obtain administrative and/or judicial review if OWCP withholds payment, and allow providers to receive interest on a service that was provided, yet not paid for in a timely manner. The Department notes that a provider already has the ability to seek judicial review of OWCP's decision to withhold payment for services, and therefore does not require a regulatory acknowledgment of that ability. As for the payment of interest, the Department notes that any such payment would be governed by the Prompt Payment Act and is thus not within the purview of this rulemaking. Accordingly, no changes were made to § 30.701(a) in the final rule based on these comments.

Proposed § 30.701(b) described OWCP's existing discretion to determine which codes to use in the automated billing process managed by its agent, and to create and supply specific codes to be used by providers when either seeking authorization or submitting a bill for payment. In addition, proposed § 30.701(b) noted that OWCP will return and/or deny payment for a bill if no code is submitted. A claimant representative feared that the language

in proposed § 30.701(b) recognizing this discretion might create inconsistencies and delays. This comment is merely conjectural, however, and is not consistent with OWCP's experience. The same claimant representative objected to the proposed language that OWCP will return and/or deny payment for a bill if no code is submitted, and felt that this action would be statutorily impermissible. On the contrary, this reasonable and fiscally prudent practice has been in place since the beginning of the program in 2001, and the Department is not persuaded by the commenter that it should be changed. Accordingly, no changes were made to this paragraph in the final rule.

Proposed § 30.701(c)(1)(ii) alerted providers that in the future, OWCP may adopt certain provisions contained within the Home Health Prospective Payment System, which was devised by CMS. Three health care providers, three advocacy groups and an individual objected to the possible adoption of any aspect of that system, alleging that it would not be a good fit for the EEOICPA beneficiary population, while one claimant representative agreed with that proposed change. The Department notes that this provision merely stated that OWCP *may* adopt the system, or parts of that system, in the future. Since CMS currently uses the system, providers should already be prepared for these changes if they are ultimately implemented by OWCP. Therefore, no change was made to proposed § 30.701(c)(1)(ii) in the final rule as a result of these comments. In proposed § 30.701(c)(3), the Department stated that nursing home charges for appliances, supplies or services "shall be subject to any applicable OWCP fee schedule." A claimant representative agreed with the Department that a fee schedule for nursing home charges would probably be necessary. An advocacy group suggested instead that the Department initiate a new rulemaking at the point in time that it decides to implement such a fee schedule. However, it is within OWCP's discretion to use such a fee schedule, and proposed § 30.701(c)(3) merely announces that OWCP may subject nursing home charges to a fee schedule in the future. Therefore, no amendments were made to § 30.701(c)(3) in the final rule.

Proposed § 30.701(d) clarified that providers must adhere to accepted industry standards when billing, and that billing practices such as upcoding and unbundling are not in accord with those industry standards. A claimant representative agreed with the Department's proposal in § 30.701(d) to

use "industry standards" for billing of services, and commented that "industry standards" should be mandated for all medical benefits. Accordingly, no change was needed for § 30.701(d) in the final rule.

Proposed § 30.701(e) described OWCP's current practice of rejecting a bill that does not conform to the requirements in § 30.701, after which the rejected bill is returned to the provider to be corrected and resubmitted. Proposed § 30.701(e) also clarified OWCP's policy that a bill must contain the provider's handwritten or electronic signature when required by the pertinent billing form, and removed language that a provider's stamp will be accepted in lieu of his or her signature on the bill. An advocacy group was concerned that the proposed language in § 30.701(e) that OWCP may deny a non-conforming bill could force beneficiaries to pay bills that OWCP refuses to pay, and will ultimately leave the beneficiary without necessary care. However, as noted above, this scenario appears to be dependent upon the particular contractual relationships between providers and their clients, and does not therefore involve OWCP in a meaningful way. A claimant representative suggested that the Department state in proposed § 30.701(e) that a provider may seek review of a disputed bill by an administrative law judge. Once again, the Department notes that a provider has the ability to seek judicial review of a disputed bill, and a regulatory acknowledgment of that ability is not necessary. Two other claimant representatives argued that it was unreasonable for the Department to amend § 30.701(e) to require a physician's handwritten or electronic signature, and no longer accept signature stamps. However, as explained in the Department's discussion on similar comments received in connection with proposed § 30.416(a), this change was made to conform with the requirements in other programs within OWCP, and with the requirements of CMS. Thus, no change was made to § 30.701(e) as a result of these comments.

In the NPRM, proposed § 30.702 clarified how an employee can seek reimbursement for out-of-pocket expenses incurred for the medical treatment of an accepted illness. Proposed § 30.702(a) added a reference to Forms OWCP-04 and UB-04 to clarify that those forms must be used to request reimbursement of hospital charges. An advocacy group felt that the current requirement in existing § 30.702(a) that an employee submit Form OWCP-1500 or CMS-1500 to

request reimbursement for professional medical services is too burdensome. However, this comment does not refer to a change in proposed § 30.702(a). Because the advocacy group's comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment. The Department also added language in proposed § 30.702(a)(1) to provide that OWCP will reject a reimbursement request if a provider does not indicate the code or a description of the service on the billing form, after which the beneficiary would have to resubmit a corrected bill. An advocacy group and a claimant representative objected to this provision, but did not suggest a change to the proposed language in the NPRM. This requirement has been in effect since the beginning of the program, and the Department sees no reason to change this established practice based on these comments.

Proposed § 30.702(d) stated that billing forms submitted by beneficiaries with their requests for reimbursement must bear the handwritten or electronic signature of the provider. The Department also proposed to amend language in existing § 30.702(d), which currently provides that OWCP's decision regarding reimbursement to a beneficiary for out-of-pocket expenses is final, to instead provide that OWCP will issue a letter decision in such circumstances. An advocacy group and two claimant representatives objected to the new language in proposed § 30.702(d) concerning a provider's signature. However, this change was made to conform with similar requirements in other programs administered by OWCP, and with the requirements of CMS, as discussed above in connection with the comments received by the Department on proposed § 30.416(a). Another claimant representative agreed with the change in proposed § 30.702(d) regarding OWCP's issuance of a letter decision. Therefore, no changes were made to proposed § 30.702(d) as a result of these four comments.

Medical Fee Schedule

In the NPRM, the Department proposed amending existing § 30.705(a) to provide that "devices and supplies," in addition to "health services" as currently stated in that paragraph, are covered by the OWCP fee schedule. A claimant representative agreed with the Department's change in proposed § 30.705(a). Therefore, no changes were made to that paragraph in the final rule. The Department also proposed modifying existing § 30.705(b) to

provide that OWCP may require nursing homes to abide by a fee schedule. A claimant representative and two advocacy groups asserted that it was premature for the Department to add that language to proposed § 30.705(b). The same claimant representative and one of those advocacy groups suggested that the Department initiate a separate rulemaking if it decides to adopt this fee schedule. The Department notes, however, that it is within OWCP's discretion to adopt such a fee schedule, and proposed § 30.705(b) merely announces that OWCP may decide that nursing homes will be covered by a fee schedule in the future. Accordingly, no amendment was made to § 30.705(b) in the final rule. In proposed §§ 30.706 and 30.707, the Department proposed updating the indices used to determine maximum fees. A claimant representative agreed with the changes to those provisions. Therefore, no changes were made to those sections in the final rule.

In the introductory text in proposed § 30.709, the Department added language that payment will be made for medicinal drugs "[u]nless otherwise specified by OWCP." Also in the introductory text in proposed § 30.709, the Department added language that OWCP may contract for, or require the use of, specific providers for medicinal drugs. A claimant representative felt that the new language "[u]nless otherwise specified by OWCP" is ambiguous and requires further explanation. The Department added that language to clarify its discretionary authority in this unsettled area of medical costs, and is not persuaded that any change to that section is required in the final rule. The same claimant representative also felt that the proposed language in the introductory text noting that OWCP may contract for, or require the use of, specific providers for certain medications was a violation of a claimant's right to obtain his or her own physician. However, the proposed language only stated that OWCP may contract with or require the use of specific providers for certain medications; it did not state that beneficiaries could be required to obtain treatment from specific physicians. Thus, no change was made to the introductory text of § 30.709 in the final rule.

In the NPRM, proposed § 30.709(a) clarified that the fee schedule for medicinal drugs applies whether the drugs are dispensed by a pharmacy or by a doctor in his office. A claimant representative commented that she generally agreed with the proposed language in § 30.709(a), but asked that

the dispensing fee be unbiased and unambiguous, and consistent with the CMS fee schedule. The Department is unaware of any objective evidence of bias regarding the dispensing fee for medical drugs and this comment is outside the scope of the proposed change in § 30.709(a). Because the claimant representative's comment goes beyond the change in the NPRM, no amendment was made in the final rule with respect to this comment.

Proposed § 30.709(c) codified OWCP's authority to require the use of generic drugs, where appropriate. A claimant representative generally agreed with the proposed addition, as long as a beneficiary can petition for "ungeneric" equivalents if recommended by the provider. An advocacy group disagreed with the Department's proposed change because it believes that a beneficiary's physician, not OWCP, must decide what medications are best for the beneficiary. However, OWCP has required the use of generic equivalents where available since the beginning of the program in 2001, and sees no reason to alter this established requirement. Therefore, no change made to § 30.709(c) in the final rule as a result of this comment.

Proposed § 30.710(a) removed the terminology in existing § 30.710(a) that refers to the obsolete "Prospective Payment System," and instead referred to the "Inpatient Prospective Payment System" devised by CMS. A claimant representative noted the change in proposed § 30.710(a). However, since the commenter did not either support or oppose the proposed regulation or offer ideas for changes, no change was made to § 30.710(a) in the final rule based on this comment. The same claimant representative commented on existing § 30.710(b), but the Department did not propose any changes to this paragraph in the NPRM. Because the claimant representative's second comment did not refer to a change that was proposed in the NPRM, no amendment was made in the final rule with respect to this comment.

In the NPRM, the Department added a new section, proposed § 30.711, to explain its current practice of paying hospitals for outpatient medical services according to Ambulatory Payment Classifications based on the Outpatient Prospective Payment System devised by CMS. To accommodate the addition of that new section, existing §§ 30.711, 30.712 and 30.713 appeared in the NPRM as proposed §§ 30.712, 30.713 and 30.714. A claimant representative generally agreed with proposed § 30.711, and suggested adding a provision in proposed § 30.711 to state that an aggrieved party may petition for

judicial review if OWCP denies payment for outpatient medical services. The Department notes that a claimant already has the ability to seek judicial review of such a denial, and does not require a regulatory acknowledgment of that ability. For that reason, no change was made to § 30.711 in the final rule based on that comment.

Proposed § 30.712(a) clearly stated that OWCP will not correct procedure or diagnosis codes on submitted bills. Rather, those bills will be returned to the provider for correction because the responsibility for proper submission of bills lies with the provider. A claimant representative commented that the Department's proposed change in § 30.712(a) may cause unnecessary delay. This requirement, however, is not new to this rulemaking and has been in existence since the beginning of the program. Therefore, since the Department sees no reason to alter this requirement, no change was made to this paragraph in the final rule. The same claimant representative commented on both proposed §§ 30.712(b) and 30.713(a), but the Department did not propose any changes to those provisions in the NPRM. Because the claimant representative's latter comments referred to regulatory text that was not changed in the NPRM, no amendment was made in the final rule with respect to those comments.

Proposed § 30.713(a)(1) clarified that the provider should make a request for reconsideration of a fee determination to the district office with jurisdiction of the employee's claim. A claimant representative agreed with that change. Accordingly, no change was needed for § 30.713(a)(1) in the final rule. In addition, proposed § 30.713(b) provided that a Regional Director's decision on a reduction in a provider's fee is final. A claimant representative objected to the Department's addition in proposed § 30.713(b), and suggested adding language stating that the provider has the right to file an objection with an administrative law judge or in Federal district court. The Department added the provision concerning the finality of the Regional Director's decision to § 30.713(b) to conform with similar regulations in another program administered by OWCP, and is not persuaded to deviate from those similar regulations. For that reason, no change was made to § 30.713(b) in the final rule.

Exclusion of Providers

In the NPRM, the Department proposed adding two new paragraphs, proposed § 30.715(i) and (j), to existing

§ 30.715 to set out two new reasonable bases for excluding providers. In proposed § 30.715(i), a provider may be excluded for failing to inform OWCP of any change in its provider status, and in proposed § 30.715(j), a provider may be excluded for engaging in conduct related to care found by OWCP to be misleading, deceptive or unfair. A claimant representative suggested that the Department add text, presumably in the introductory paragraph of existing § 30.715, to state that OWCP will exclude providers based on "substantial relevant evidence," and that providers have the right to seek administrative review. These suggestions, however, do not relate to the proposed changes in existing § 30.715. Further, the Department notes that an excluded provider already has the ability to request a hearing before an administrative law judge as outlined in existing §§ 30.720 through 30.723, and to seek judicial review of such a decision excluding them from the program. Thus, the suggested changes to existing § 30.715 suggested by the commenter were not made in the final rule.

With respect to proposed § 30.715(i), two health care providers relayed their fears that the language in that proposed paragraph might cause a provider to be excluded for something as inadvertent as a mere administrative mishap. In addition, both of those health care providers and an advocacy group requested that the Department clearly define the terms used in the text of that paragraph. The Department believes that a provider's failure to inform OWCP that it no longer satisfies all applicable Federal and state licensure and regulatory requirements is significant, rather than a mere administrative mishap, and thus a valid basis for exclusion. Also, the Department firmly believes that the grounds upon which it may exclude a provider involve matters of administrative discretion that need not be further defined. Therefore, the Department is not persuaded that proposed § 30.715(i) should be modified in the final rule as requested by these commenters.

As for proposed § 30.715(j), four individuals, one health care provider and a law firm believed that the wording in proposed § 30.715(j) was overbroad and arbitrary. Two advocacy groups, the same and one other health care provider and the law firm suggested that the Department clearly define the terms used in the text of that paragraph. As it noted above, the Department firmly believes that the grounds upon which it may exclude a provider involve matters of

administrative discretion that need not be further defined. Two of the individual commenters asserted that proposed § 30.715(j) will infringe on a state's authority to regulate licensed health care providers. However, OWCP is not now, and will not in the future, monitoring a provider's compliance with state licensing and other regulatory requirements, and therefore no such infringement exists. Accordingly, no change was made to § 30.715(j) in the final rule based on these comments.

In the NPRM, the Department added a new paragraph, proposed § 30.716(c), to clarify that a provider may voluntarily choose to be excluded without undergoing the exclusion process. That clarification was meant to address situations where providers may simply agree to be excluded, and thereby avoid a possibly burdensome administrative exclusion process when, for example, they are facing criminal charges unrelated to the provision of services to any EEOICPA beneficiaries. A claimant representative suggested that the Department should state in proposed § 30.716(c) that a provider may voluntarily exclude themselves from the program. Such clarification is unnecessary since the language in proposed § 30.716(c) states exactly what the commenter suggested. Therefore, no change was made to that paragraph in the final rule.

Proposed § 30.717 reorganized existing § 30.717 into three separate paragraphs to provide that the Department's Office of Inspector General (DOL OIG) will be primarily responsible for investigating all potential exclusions of providers, instead of the Regional Director as provided in existing § 30.717. Proposed § 30.717(a) stated that OWCP will forward exclusion-related information to the DOL OIG. A claimant representative agreed with the changes in proposed § 30.717(a). Another claimant representative commented that exclusion matters should be handled by the Regional Director, not the DOL OIG, since the current regulations state that the Regional Director will handle those matters. The Department acknowledged in the preamble to the proposed rule that this function was previously handled by OWCP; however, OWCP has no investigatory arm and lacks resources to carry out this responsibility. The Department continues to believe that the DOL OIG is in the best position to handle such investigations. A health care provider commented that referral to the DOL OIG will result in significant and expensive adverse impacts on legitimate providers. This commenter did not provide any proof to validate the

fear that such problems will occur, nor has this been OWCP's experience in its administration of another compensation program that already uses this contemplated process. Another health care provider commented that proposed § 30.717(a) lacked necessary details. However, that paragraph merely announced that the DOL OIG will be responsible for investigating all possible exclusions of providers, and therefore any further explanation of the process involved would be superfluous. For the reasons stated above, the Department is not persuaded that any change is needed in § 30.717(a); therefore, no change was made in the final rule.

In proposed § 30.717(c), the Department described the contents of the written report that the DOL OIG would need to prepare for OWCP if it determined that there was reasonable cause to believe that any violations enumerated in proposed § 30.715 had occurred. The law firm and a health care provider suggested wording changes to proposed § 30.717(c), but those changes would inadvisably limit the amount of discretion that the Department feels is necessary in this process. Therefore, the suggested changes to this paragraph were not made in the final rule.

Proposed § 30.718(a) through (f) contained minor wording changes to the existing language in those paragraphs with respect to how OWCP will notify a provider of its intent to exclude them, in order to conform the existing regulatory language with similar regulations in another program administered by OWCP. A health care provider asked the Department to add specific details in proposed § 30.718 about what will happen to the clients of excluded providers, and whether OWCP will alert other home health care providers that a specific provider was excluded from the program. However, the above comment was outside the scope of the changes in proposed § 30.718. Because the comment goes beyond the change in the NPRM, no amendment was made in the final rule with respect to this comment. In proposed § 30.718(e), the Department proposed allowing a provider 60 days, instead of 30 days as stated in current § 30.718(e), to respond to a letter of intent. A claimant representative agreed with that provision. Under these circumstances, no changes were made in § 30.718(e) based on the comment.

Proposed § 30.719(c) stated that “[t]he provider may inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent,” while existing § 30.719(c) does not

contain any time requirements. Two health care providers commented that this language was confusing, and both of those commenters suggested that no timeframe for requesting information should be imposed. The Department is not persuaded that the proposed regulation is confusing, because both of these commenters have read it properly regarding the 20-day period for requesting access. Regarding the suggestion that no timeframe should be imposed, the Department thinks that it is reasonable for a provider to decide, within 20 days of receiving the letter of intent, whether or not it wants to review any information in the record. Allowing these requests to be made at any time would likely result in an inefficient and slower administrative review process, which would benefit neither the provider nor OWCP. Thus, no amendments were made to those provisions in the final rule. In the NPRM, the Department added a new paragraph, proposed § 30.719(d), to allow OWCP 30 days to answer the provider's response to OWCP's letter of intent, and to allow the provider 15 days to reply to OWCP's answer. A claimant representative suggested that the Department allow OWCP 60 days, instead of 30 days, to answer a provider's response in proposed § 30.719(d). However, the Department made this change to conform with similar regulations in another program administered by OWCP. For that reason, and since the claimant representative gave no reason for her suggestion, no changes were made in § 30.719 in the final rule based on her comment.

In proposed §§ 30.720 through 30.723, the Department made minor wording changes to the existing language in those sections that addresses how an excluded provider can request a hearing, how hearings are assigned and scheduled, how subpoenas or advisory opinions are obtained and how an administrative law judge will conduct a hearing and issue a recommended decision, respectively. A claimant representative suggested that the Department's changes in those proposed sections were unnecessary. However, these sections were amended to conform with similar regulations in another program administered by OWCP. Thus, the proposed changes are necessary, and no changes were made to those sections in the final rule as a result of this comment.

Proposed § 30.724(a) through (h) modified the manner in which the administrative law judge's recommended decision on exclusion becomes final. In particular, proposed § 30.724(h) stated that no recommended

decision regarding exclusion will become final until the Director for Energy Employees Occupational Illness Compensation issues the decision in final form, while existing § 30.724(a) provides that an administrative law judge's recommended decision on exclusion becomes final if no objection is filed. A claimant representative and a health care provider commented that they did not understand why the Department modified this section in the NPRM. That same health care provider objected to the language in proposed § 30.724(h) and argued that it gave the Director authority over administrative law judges and the DOL OIG. The Department disagrees that the proposed changes will give the Director any managerial authority over administrative law judges and/or the DOL OIG, and notes again that it added that language in order to conform the provision to similar regulations in another program administered by OWCP. Therefore, no changes were made to that paragraph in the final rule.

In the NPRM, the Department proposed adding paragraph (a)(4) to existing § 30.725 to state that OWCP will notify the state or local authority responsible for licensing or certifying the excluded party of the exclusion. A claimant representative questioned whether OWCP has the authority to do so; the Department is confident that OWCP has such authority, as would any member of the public with knowledge relevant to the professional deficiencies of any licensed provider. A health care provider asked the Department to explain the difference between automatic and non-automatic exclusion, but this comment does not pertain to the change proposed in § 30.725(a)(4). Because the health care provider's comment did not refer to a change that was proposed in the NPRM, no amendment was made to § 30.725(a)(4) in the final rule.

Proposed § 30.726(c) corrected outdated terminology by replacing the word “argument” with “presentation.” A claimant representative commented that the change was unnecessary. The Department agrees that this change is minor; however, it was made to conform to similar regulations in another program administered by OWCP. For that reason, no changes were made to § 30.726(c) in the final rule in response to this single comment.

Subpart I—Wage-Loss Determinations Under Part E of EEOICPA

General Provisions

In proposed § 30.800(c), the Department updated a cross-reference to

reflect the changed location of the regulatory provision defining the term *covered illness* from § 30.5(r) to § 30.5(s). A claimant representative commented that the cross-reference change in § 30.800(c) was unnecessary. Nonetheless, because this change was needed to reflect the changed location of the regulatory provision, no change was made to § 30.800(c) in the final rule. The Department proposed slight modifications and additions to the definitions related to wage-loss benefits available under Part E contained in proposed § 30.801. A claimant representative generally agreed with those changes, and specifically asserted that the regulatory definition of *wages* in proposed § 30.801(g) should refer explicitly to the “time of injury.” However, because the term “time of injury” is only relevant to a determination whether an individual has forfeited his or her entitlement under section 7385(a) of EEOICPA, and because the definition of *wages* needs to be applicable to potentially multiple points of time in a single claim, no change to § 30.801 was made in the final rule.

Evidence of Wage-Loss

Proposed § 30.805(a) set out in detail the criteria, derived from the statute at section 7385s–2(a)(2)(A) of EEOICPA that claimants must establish in order to be eligible for wage-loss benefits under Part E. A claimant representative suggested that proposed § 30.805(a) wrongly placed the burden of proof on claimants to establish their entitlement to wage-loss benefits, because she believed that once OWCP determines that a claimant is a covered employee who contracted a covered illness, “then the employee claimant is mandated to receive wage-loss” benefits. However, this comment does not recognize that there are clearly discernable eligibility requirements for wage-loss benefits in section 7385s–2(a)(2)(A) beyond those set out in section 7385s–4 of EEOICPA, and that it is the claimant’s burden, as stated by the U.S. Supreme Court, to provide evidence to meet the requirements in *both* of those sections of EEOICPA. Therefore, no change was made to § 30.805(a) in the final rule as a result of this comment.

Proposed § 30.805(b) explained that OWCP may discontinue development of a covered Part E employee’s request for wage-loss benefits at any point when the claimant is unable to meet his or her burden of proof to submit factual and/or medical evidence to establish the criteria specified in proposed § 30.805(a). Two claimant representatives and four advocacy

groups objected to proposed § 30.805(b), because they were concerned that the decision to discontinue development would not be subject to administrative review if OWCP administratively closed such a claim for wage-loss benefits without issuing recommended and final decisions. However, the text of proposed § 30.805(b) nowhere suggested that this would occur. The Department has added text to § 30.805(b) in the final rule to make clear that a decision would issue.

In the NPRM, proposed § 30.806 was substantially similar to current § 30.805(b), except that it provided an explanation of what OWCP would consider to be “rationalized” medical evidence, *i.e.*, medical evidence based on a physician’s fully explained and reasoned decision, which a covered Part E employee must submit in order to establish that the claimed wage-loss at issue was causally related to the employee’s covered illness. Additionally, proposed § 30.806 memorialized OWCP’s established policy and Federal case law that wage-loss sustained due to something other than a covered illness is not compensable under Part E of EEOICPA. *See Trego v. U.S. Dep’t of Labor*, 681 F.Supp. 2d 894 (E.D. Tenn. 2009). Two advocacy groups, one claimant representative and the Advisory Board suggested that several terms used in the text describing the type of medical evidence a claimant must submit to prove that he or she lost wages in the alleged trigger month needed to be defined further or eliminated, and suggested that the type of medical evidence described in proposed § 30.806 would be difficult for claimants to obtain. It should be noted, however, that proposed § 30.806 does not alter or increase the existing requirement for the submission of this medical evidence in current § 30.805(b). Rather, it gives a fuller and more helpful description of the type of medical evidence necessary, which is useful to claimants seeking to obtain these benefits. Accordingly, no changes were made to § 30.806 in the final rule.

Proposed new § 30.807 was added to accommodate the changes described above in proposed § 30.806. Proposed § 30.807(a) was substantially similar to existing § 30.805(a), except that the provision stated that OWCP may rely upon annual, as well as quarterly, wage information that has been reported to the Social Security Administration. Also, the Department sought to move language defining “wages” that appears in current § 30.805(a) to a new § 30.801(g). And finally, proposed § 30.807(b) was substantially similar to

existing § 30.806, which describes the submission of factual evidence of wage-loss by claimants. A claimant representative submitted a comment in which she questioned whether the changes in proposed § 30.807 were necessary. These regulatory changes not only reorganize and clarify the existing regulatory description of the process for developing wage-loss claims, but also explain how OWCP has interpreted and applied the complex provisions of the statute. Because of this, and also because the commenter did not suggest a viable alternative, no change to § 30.807 was made in the final rule in response to this comment.

Determinations of Average Annual Wage and Percentages of Loss

In the NPRM, the Department proposed revising existing § 30.810 to state that it will calculate the average annual wage of a covered Part E employee using months instead of quarters, to be consistent with proposed § 30.801(a). Also, proposed § 30.811(a) combined the text from paragraphs (a) and (b) in existing § 30.811, since the current text in those paragraphs is repetitive. A claimant representative questioned the need for the admittedly minor conforming changes in proposed §§ 30.810 and 30.811. However, the proposed minor changes to existing § 30.810 were needed to conform with other proposed changes in subpart I, and repetitive text was removed from proposed § 30.811 to make it clearer. Under these circumstances, the Department did not make any changes to §§ 30.810 and 30.811 in the final rule with respect to this comment.

Subpart J—Impairment Benefits Under Part E of EEOICPA

General Provisions

In the NPRM, proposed § 30.901(a) deleted the word “minimum” from the statutory term “minimum impairment rating” that appears in the existing paragraph, and proposed § 30.901(b) deleted the same statutory term entirely. In addition, the Department proposed deleting the statement that appears in existing § 30.901(b) that OWCP will determine impairment ratings under EEOICPA in accordance with the AMA’s *Guides*. A claimant representative and an advocacy group objected to the deletion of the word “minimum” in proposed § 30.901(a), and to the deletion of the term “minimum impairment rating” in (b), and pointed out that this language appears in the statutory description of impairment ratings found in 42 U.S.C. 7385s–2(a)(1)(A)(i). However, as the

Department pointed out when it published proposed § 30.901(a) and (b), the word “minimum” has no actual meaning in the context of rating permanent impairment, nor does it meaningfully describe or further modify “impairment rating.” Put simply, there is no difference between a “minimum impairment rating” and an “impairment rating” when a claimant has reached maximum medical improvement. The same advocacy group, a second advocacy group, a claimant representative and a health care provider also objected to the deletion of the statement that OWCP will determine impairment ratings under EEOICPA in accordance with the AMA’s *Guides*, and asserted that this change was confusing and contrary to section 7385s–2(b). The Department agrees, but notes that the deletion in question was made at the insistence of the Office of the Federal Register, which deemed it to be a prohibited incorporation of material by reference. Accordingly, for the reasons stated above, no changes were made to § 30.901(a) and (b) in the final rule based on the above comments.

Proposed new § 30.902(b) added text to describe OWCP’s longstanding policy of proportionately reducing an impairment award in circumstances when such award is payable based on a whole person impairment rating, and at least one of the elements of the award is subject to a reduction under existing §§ 30.505(b) and/or 30.626. A claimant representative objected to the new paragraph, and mistakenly assumed that these reductions would be made without providing a claimant with notice and an opportunity to respond. Appropriate process will be provided, and therefore no changes were made to § 30.902(b) in the final rule.

Medical Evidence of Impairment

Proposed § 30.908(b) and (c) replaced the term “minimum impairment rating” with “impairment rating,” to be consistent with the changes in proposed §§ 30.102(a), 30.901 and 30.902. A claimant representative objected to that change, for the same reasons she gave in support of her comments regarding proposed § 30.901. However, and as noted above regarding those comments, the word “minimum” serves no actual purpose in the determination of a claimant’s impairment rating. Accordingly, and as it did above in connection with proposed § 30.901, the Department did not make any changes to § 30.908(b) and (c) in the final rule based on this comment. The same claimant representative, as well as a health care provider and two advocacy groups, commented on other aspects of

proposed § 30.908(b) and (c) in the NPRM that were no different from existing § 30.908(b) and (c). Since the only change to the existing paragraphs that were made in proposed § 30.908(b) and (c) was the deletion of the words “minimum,” none of the changes suggested by this second group of comments were made to § 30.908(b) and (c) in the final rule.

IV. Miscellaneous Rulemaking Issues

During this rulemaking process, several extraneous issues arose that are not addressed in the above section-by-section analysis. The Department’s analysis of the requests it received to extend the comment periods, the comment it received from the Advisory Board on issues that were either outside the Advisory Board’s scope of duties under section 7385s–16(b)(1) of EEOICPA or not addressed in any aspect of the proposed changes, and its communications with interested parties about the NPRM outside of the rulemaking process follows:

Requests To Extend the Comment Period

Prior to expiration of the original January 19, 2016 deadline to submit comments concerning the NPRM, the Department received 33 timely comments that requested that the Department extend the comment period, but did not otherwise comment on any aspect of the proposed rule (24 from different individuals, 1 of whom submitted 2 separate comments, 3 from advocacy groups, 2 from claimant representatives, 1 from a health care provider and 1 from a member of Congress), while an additional 3 timely comments requested that the Department extend the comment period and also commented on aspects of the proposed rule (2 from individuals and 1 from a health care provider). Most of the commenters asked that the comment period be extended to allow the Advisory Board to be seated and have the opportunity to comment on the proposed rule. The remainder of these requesters asked for an extension for reasons such as the comment period was disrupted by several holidays, and because the elderly and sick population interested in the program needed more time to review the proposed changes.

On January 19, 2016, the Department extended the comment period another 30 days through February 18, 2016. During the 30-day extended period, the Department received requests that the comment period be extended yet further from 99 commenters. Of those 99 commenters, 95 requested that the Department extend the comment period

but did not otherwise comment on any aspect of the proposed rule (92 from individuals, 2 from unknown persons or organizations, and 1 from a health care provider), while an additional 4 timely commenters requested that the Department extend the comment period and also commented on aspects of the proposed rule (1 from the same health care provider and 1 from another health care provider, 1 from an individual and 1 from a labor organization). The Department also received 1 untimely request from an individual requesting an extension. A significant portion of these requests were identical or nearly identical “form letters” that generally asked for more time for physicians to review the proposed regulations, and some asked the Department to hold Town Hall meetings. The few remaining requesters asked the Department to wait until the Advisory Board was seated before issuing final regulations.

Comments From the Advisory Board on Toxic Substances and Worker Health

On April 5, 2016, the Department reopened the comment period for the NPRM through May 9, 2016, to afford interested parties the opportunity to further review the NPRM, and to afford the new Advisory Board the opportunity to review the NPRM at its public meeting held April 26, 27 and 28, 2016. Prior to the meeting, the Advisory Board received legal guidance with respect to which of the sections of the NPRM were within the scope of its duties, as specified in § 7385s–16(b)(1) of EEOICPA, and which other sections fell outside its scope of duties. During the reopened comment period, the Department received 180 comments, including 1 from the Advisory Board.

The Department thanks the Advisory Board for its work. The Advisory Board addressed a number of aspects of the proposed regulations in its comment. Section 7385s–16(b)(1) of EEOICPA sets out the scope of the Board’s advisory duties and, consequently, the Department’s bounds on formal consideration of that advice. Some of the issues raised by the Board addressed sections of the regulation that fell within its duties: §§ 30.206(a), 30.231(b), 30.232(a)(1) and (2), 30.405(b) and (c), 30.509(c) and 30.806. The Department discussed these comments in the section-by-section analysis set forth above. The Advisory Board also went outside its statutory mandate to submit comments on proposed §§ 30.5(j), 30.5(x)(2)(iii), 30.5(ee), 30.112(b)(3), 30.231(a) and 30.805(a)(3). Although the Department did not discuss this second set of Advisory Board comments in the section-by-

section analysis, the issues raised in those comments were also raised in other timely comments and thus were fully addressed. Lastly, the Advisory Board commented on existing § 30.230(d)(2)(iii) and aspects of proposed § 30.231(b) that were not included in the NPRM, and therefore no discussion of that comment was included in the Department's section-by-section analysis.

Communications Outside of the Rulemaking Process

Meetings or discussions with one or more parties about NPRMs can take place outside of the comment process, provided that the agency properly documents the particulars of those communications. However, such discussions are not a substitute for submission of public comments, and the content of those communications cannot be considered in preparation of the final rule.

During the comment periods for this NPRM, DOL personnel had a total of 16 instances wherein they discussed aspects of the NPRM with interested individuals and groups outside of the formal comment process. Specifically, DOL personnel attended four face-to-face meetings with congressional staff at the request of the staffers and spoke with a member of the press on two separate occasions. In addition, three advocacy groups, two claimant representatives, two NIOSH employees and one health care provider contacted DOL personnel on matters relating to the NPRM. Also, on April 4, 2016, DOL personnel provided a briefing on the NPRM to all members of the Advisory Board, and the Advisory Board discussed the NPRM at its public meeting held April 26, 27 and 28, 2016. Although those specific discussions were not considered in preparation of this final rule, the subjects and sections of the NPRM that were discussed in those communications were addressed by the timely comments that are discussed above.

V. Publication in Final

The Department has determined, pursuant to 5 U.S.C. 553(b)(B), that good cause exists for waiving public comment on this final rule with respect to the following changes: (1) Corrections of typographical errors; and (2) minor wording changes and clarifications that do not affect the substance of the regulations. For these changes, publication of a proposed rule and solicitation of comments would be neither necessary nor fruitful.

VI. Statutory Authority

Section 7384d of EEOICPA provides general statutory authority, which E.O. 13179 allocates to the Secretary, to prescribe rules and regulations necessary for administration of Part B of the Act. Section 7385s–10 provides the Secretary with the general statutory authority to administer Part E of the Act. Sections 7384t, 7384u and 7385s8 provide the specific authority regarding medical treatment and care, including authority to determine the appropriateness of charges. The Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et seq.*), authorizes imposition of interest charges and collection of debts by withholding funds due the debtor.

VII. Executive Orders 12866 and 13563

E.O. 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including distributive impacts, equity, and potential economic, environmental, public health and safety effects). E.O. 13563 is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in E.O. 12866.

This rule has been designated a “significant regulatory action” although not economically significant under section 3(f) of E.O. 12866. The rule is not economically significant because it will not have an annual effect on the economy of \$100 million or more. The Department believes that this rule is merely an update to the existing regulations to reflect the program's current processes, and to incorporate the policy and procedural changes that have been implemented since the existing regulations were issued in 2006.

Thus, the Department does not believe that any of the above significant policies in the final rule will result in increased or decreased administrative costs to either the program or the public, or any increase in benefits paid. This rule has been reviewed by the Office of Management and Budget.

VIII. Regulatory Flexibility Act

This rule has been reviewed in accordance with the Regulatory Flexibility Act of 1980, as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, 5 U.S.C. 601–612. The Department has concluded that the rule does not involve regulatory and informational requirements regarding businesses, organizations and governmental jurisdictions subject to the regulation.

IX. Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (PRA), 44 U.S.C. 3501 *et seq.*, and its implementing regulations, 5 CFR part 1320, require that the Department consider the impact of paperwork and other information collection burdens imposed on the public. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by the Office of Management and Budget (OMB) under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person may generally be subject to penalty for failing to comply with a collection of information that does not display a valid Control Number. *See* 5 CFR 1320.5(a) and 1320.6.

This final rule contains information collection requirements subject to the PRA. The information collection requirements in §§ 30.700, 30.701 and 30.702 of this final rule, which relate to information required to be submitted by claimants and medical providers in connection with the processing of bills, were both submitted to and approved by OMB under the PRA, and the currently approved collections in OMB Control Nos. 1240–0007, 1240–0019, 1240–0021, 1240–0044 and 1240–0050 will not be affected by any of the changes made in this final rule. No comments were received concerning the information collection burdens in this first group of sections, and therefore no changes relating to those burdens were made in this final rule. The information collection requirements in §§ 30.100, 30.101, 30.102, 30.103, 30.112, 30.113, 30.206, 30.207, 30.213, 30.222, 30.231, 30.232 and 30.416 of this final rule were also previously submitted to and approved by OMB under the PRA, and were assigned OMB Control No. 1240–0002. The information collection requirements in this second group of sections will not be affected by any of the substantive changes made in this final rule; no comments concerning the information collection burdens in this second group were received, and therefore no changes relating to those burdens were made in this final rule.

However, in the NPRM, the Department noted that proposed sections 30.114(b)(3) and 30.403, which, as discussed above, require parties to submit information OWCP needs before it can accept and then provide medical benefits for a claim, constituted collections of information within the meaning of the PRA that were being added to OMB Control No. 1240–0002.

80 FR 72302–72304. The NPRM specifically invited comments regarding the information collections and notified the public of their opportunity to file such comments with both OMB and the Department. *Id.* On the same date the NPRM was published, the Department submitted a series of Information Collection Requests (ICRs) to OMB for approval in order to update the information collections to be consistent with the proposed rule. On January 19, 2016, OMB concluded its reviews by asking the Department to submit a summary of all comments received on the proposed information collections and identify any changes made in response to these comments. *Id.*

The Department received comments on the substance of proposed sections 30.114(b)(3) and 30.403; those comments are fully addressed in the above section-by-section analysis entitled “Comments on the Proposed Regulations.” The Department also received 18 comments about the information collections in proposed section 30.403, but no comments on the information collections in proposed § 30.114(b)(3) were received. The comments regarding proposed § 30.403 were submitted by 17 different commenters (one of whom submitted two separate comments). Ten physicians, two individuals, three health care providers and one claimant representative submitted comments in which they stated that the information collection burdens of the proposed Form EE–17A (which asks the claimant to provide OWCP with the name and contact information for their treating physician) and Form EE–17B (which asks the treating physician to verify that a timely a face-to-face examination took place and to submit a Letter of Medical Necessity supporting the requested services) were excessive. However, the Department notes that these comments are based on the erroneous supposition that these two new forms will add *additional* burdens on the public and delay the provision of necessary services, when in fact they are intended to standardize and thus *replace* the current individualized method (currently not accounted for under the PRA) for OWCP’s required pre-authorization process which can, and often does, take longer than all parties would wish. One individual commenter praised the idea behind the creation of proposed Forms EE–17A and EE–17B, noting that standardizing the process would likely bring a measure of order to an otherwise often chaotic process. The Department is in agreement with this last commenter, and made no changes to

the information collection instruments at issue. The Department is submitting ICRs to OMB for the information collections to revise and update them for this final rule.

The information collections in this rule may be summarized as follows. The number of responses and burden estimates listed are not specific to the Energy program; instead, the estimates are cumulative for all OWCP-administered compensation programs that collect this information.

1. *Title of Collection:* Energy Employees Occupational Illness Compensation Program Act Forms.

OMB Control Number: 1240–0002.

Total Estimated Number of Responses: 60,294.

Total Estimated Annual Time Burden: 20,359 hours.

Total Estimated Annual Other Costs Burden: \$28,989.48.

2. *Title of Collection:* Claim for Medical Reimbursement Form.

OMB Control Number: 1240–0007.

Total Estimated Number of Responses: 34,564.

Total Estimated Annual Time Burden: 5,738 hours.

Total Estimated Annual Other Costs Burden: \$59,450.

3. *Title of Collection:* Uniform Billing Form (OWCP–04).

OMB Control Number: 1240–0019.

Total Estimated Number of Responses: 259,865.

Total Estimated Annual Time Burden: 29,466.

Total Estimated Annual Other Costs Burden: \$0.

4. *Title of Collection:* Provider Enrollment Form.

OMB Control Number: 1240–0021.

Total Estimated Number of Responses: 64,325.

Total Estimated Annual Time Burden: 8,555 hours.

Total Estimated Annual Other Costs Burden: \$33,449.

5. *Title of Collection:* Health Insurance Claim Form.

OMB Control Number: 1240–0044.

Total Estimated Number of Responses: 3,381,232.

Total Estimated Annual Time Burden: 321,455 hours.

Total Estimated Annual Other Costs Burden: \$0.

6. *Title of Collection:* Pharmacy Billing Requirements.

OMB Control Number: 1240–0050.

Total Estimated Number of Responses: 1,381,903.

Total Estimated Annual Time Burden: 24,203 hours.

Total Estimated Annual Other Costs Burden: \$0.

X. Unfunded Mandates Reform Act

Title II of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1531 *et seq.*) directs agencies to assess the effects of Federal regulatory actions on state, local, and tribal governments, and the private sector, “other than to the extent that such regulations incorporate requirements specifically set forth in law.” For purposes of the Unfunded Mandates Reform Act, this final rule does not include any Federal mandate that may result in increased annual expenditures in excess of \$100 million by state, local or tribal governments in the aggregate, or by the private sector.

XI. Executive Order 13132 (Federalism)

The Department has reviewed this final rule in accordance with E.O. 13132 regarding federalism, and has determined that it does not have “federalism implications.” The final rule does not “have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government.”

XII. Executive Order 13175 (Consultation and Coordination With Indian Tribal Governments)

The Department has reviewed this final rule in accordance with E.O. 13175 and has determined that it does not have “tribal implications.” The final rule does not “have substantial direct effects on one or more Indian tribes, on the relationship between the Federal government and Indian tribes, or on the distribution of power and responsibilities between the Federal government and Indian tribes.”

XIII. Executive Order 12988 (Civil Justice Reform)

This final rule has been drafted and reviewed in accordance with E.O. 12988 and will not unduly burden the Federal court system. The regulation has been written so as to minimize litigation and provide a clear legal standard for affected conduct, and has been reviewed carefully to eliminate drafting errors and ambiguities.

XIV. Executive Order 13045 (Protection of Children From Environmental, Health Risks and Safety Risks)

In accordance with E.O. 13045, the Department has evaluated the environmental health and safety effects of this rule on children, and has determined that the final rule will have no effect on children.

XV. Executive Order 13211 (Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use)

In accordance with E.O. 13211, the Department has evaluated the effects of this final rule on energy supply, distribution or use, and has determined that it is not likely to have a significant adverse effect on them.

XVI. Executive Order 13771 (Reducing Regulation and Controlling Regulatory Costs)

This rule is not subject to the requirements of E.O. 13771 because this rule results in no more than de minimis costs. This final rule simply updates some of the provisions governing EEOICPA transfers to ensure the program operates properly and efficiently.

List of Subjects in 20 CFR Part 30

Administrative practice and procedure, Cancer, Claims, Kidney diseases, Leukemia, Lung diseases, Miners, Radioactive materials, Tort claims, Underground mining, Uranium, Workers' compensation.

Text of the Rule

For the reasons stated in the preamble, the Department of Labor amends 20 CFR part 30 as follows:

PART 30—CLAIMS FOR COMPENSATION UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT OF 2000, AS AMENDED

■ 1. The authority citation for part 30 is revised to read as follows:

Authority: 5 U.S.C. 301; 31 U.S.C. 3716 and 3717; 42 U.S.C. 7384d, 7384t, 7384u and 7385s-10; Executive Order 13179, 65 FR 77487, 3 CFR, 2000 Comp., p. 321; Secretary of Labor's Order No. 10-2009, 74 FR 58834.

■ 2. Revise § 30.1 to read as follows:

§ 30.1 What rules govern the administration of EEOICPA and this chapter?

In accordance with EEOICPA, Executive Order 13179 and Secretary's Order No. 10-2009, the primary responsibility for administering the Act, except for those activities assigned to the Secretary of Health and Human Services (HHS), the Secretary of Energy and the Attorney General, has been delegated to the Director of the Office of Workers' Compensation Programs (OWCP). Except as otherwise provided by law, the Director of OWCP and his or her designees have the exclusive authority to administer, interpret and enforce the provisions of the Act.

■ 3. Amend § 30.2 by revising paragraph (b) to read as follows:

§ 30.2 In general, how have the tasks associated with the administration of EEOICPA claims process been assigned?

(b) However, HHS has exclusive control of the portion of the claims process under which it provides reconstructed doses for certain radiogenic cancer claims (see § 30.115), which it delegated to the National Institute for Occupational Safety and Health (NIOSH) in 42 CFR part 82. HHS also has exclusive control of the process for designating classes of employees to be added to the Special Exposure Cohort under Part B of the Act, and has promulgated regulations governing that process at 42 CFR part 83. Finally, HHS has promulgated regulations at 42 CFR part 81 that set out guidelines that OWCP follows when it assesses the compensability of an employee's radiogenic cancer (see § 30.213). DOE and DOJ must, among other things, notify potential claimants and submit evidence that OWCP deems necessary for its adjudication of claims under EEOICPA (see §§ 30.105, 30.112, 30.206, 30.212 and 30.221).

- 4. Amend § 30.5 as follows:
- a. Revise paragraphs (c)(2)(i) and (i);
- b. Redesignate paragraphs (ii) and (jj) as paragraphs (kk) and (ll) and paragraphs (j) through (hh) as paragraphs (k) through (ii) and, respectively;
- c. Add new paragraphs (j) and (jj);
- d. Revise newly redesignated paragraphs (k)(2) introductory text, (w), (x)(2), (ee), (gg) introductory text; and (ii).

The revisions and additions read as follows:

§ 30.5 What are the definitions used in this part?

(c) * * *

(2)(i) An individual employed at a facility that NIOSH reported had a potential for significant residual contamination outside of the period described in paragraph (c)(1) of this section;

(i) *Beryllium vendor* means the specific corporations and named predecessor corporations listed in section 7384l(6) of the Act and any other entities designated as such by DOE on December 27, 2002.

(j) *Beryllium vendor facility* means a facility owned and operated by a beryllium vendor.

(k) * * *

(2) A written diagnosis of silicosis is made by a licensed physician and is accompanied by:

* * * * *

(w) *Department of Energy* or *DOE* includes the predecessor agencies of DOE back to the establishment of the Manhattan Engineer District on August 13, 1942.

(x) * * *

(2) An individual who is or was employed at a DOE facility by:

(i) An entity that contracted with the DOE to provide management and operating, management and integration, or environmental remediation at the facility;

(ii) A contractor or subcontractor that provided services, including construction and maintenance, at the facility; or

(iii) A civilian employee of a state or Federal government agency if the agency employing that individual is found to have entered into a contract with DOE for the provision of one or more services it was not statutorily obligated to perform, and DOE compensated the agency for those services. The delivery or removal of goods from the premises of a DOE facility does not constitute a service for the purposes of determining a worker's coverage under this paragraph (x).

* * * * *

(ee) *Physician* includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law. Physician assistants and nurse practitioners are excluded from this definition. The services of chiropractors that may be reimbursed are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

* * * * *

(gg) *Specified cancer* means:

* * * * *

(ii) *Time of injury* is defined as follows:

(1) For an employee's claim, this term means:

(i) In regard to a claim arising out of exposure to beryllium or silica, the last date on which a covered Part B employee was exposed to such substance in the performance of duty in accordance with sections 7384n(a) or 7384r(c) of the Act;

(ii) In regard to a claim arising out of exposure to radiation under Part B, the last date on which a covered Part B employee was exposed to radiation in the performance of duty in accordance

with section 7384n(b) of the Act or, in the case of a member of the Special Exposure Cohort, the last date on which the member of the Special Exposure Cohort was employed at the Department of Energy facility or the atomic weapons employer facility at which the member was exposed to radiation; or

(iii) In regard to a claim arising out of exposure to a toxic substance, the last date on which a covered Part E employee was employed at the Department of Energy facility or RECA section 5 facility, as appropriate, at which the exposure took place.

(2) For a survivor's claim, the date of the employee's death is the time of injury.

(jj) *Time of payment or payment* means the date that a paper check issued by the Department of the Treasury was received by the payee or by someone who was legally able to act for the payee, or the date the Department of the Treasury made an Electronic Funds Transfer to the payee's financial institution.

* * * * *

■ 5. Amend § 30.100 by revising paragraphs (a), (c) introductory text, (c)(1) and (d) to read as follows:

§ 30.100 In general, how does an employee file an initial claim for benefits?

(a) To claim benefits under EEOICPA, an employee must file a claim in writing with OWCP. Form EE-1 should be used for this purpose, but any written communication that requests benefits under EEOICPA will be considered a claim. It will, however, be necessary for an employee to submit a Form EE-1 for OWCP to fully develop the claim. Copies of Form EE-1 may be obtained from OWCP or on the internet at <http://www.dol.gov/owcp/energy/index.htm>. The employee must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the employee's behalf.

* * * * *

(c) Except as provided in paragraph (d) of this section, a claim is considered to be "filed" on the date that the employee mails his or her claim to OWCP, as determined by postmark or other carrier's date marking, or on the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a claim under Part B of EEOICPA be considered to be "filed" earlier than July 31, 2001, nor will a claim under Part E of EEOICPA be considered to be "filed" earlier than October 30, 2000.

(1) The employee shall affirm that the information provided on the Form EE-

1 is true, and must inform OWCP of any subsequent changes to that information.

* * * * *

(d) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be "filed" on the date that the employee mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be "filed" earlier than October 30, 2000.

■ 6. Amend § 30.101 by revising paragraphs (a), (d) introductory text, (d)(1) and (e) to read as follows:

§ 30.101 In general, how is a survivor's claim filed?

(a) A survivor of an employee must file a claim for compensation in writing with OWCP. Form EE-2 should be used for this purpose, but any written communication that requests survivor benefits under the Act will be considered a claim. It will, however, be necessary for a survivor to submit a Form EE-2 for OWCP to fully develop the claim. Copies of Form EE-2 may be obtained from OWCP or on the internet at <http://www.dol.gov/owcp/energy/index.htm>. The survivor must sign the written claim that is filed with OWCP, but another person may present the claim to OWCP on the survivor's behalf. Although only one survivor needs to file a claim under this section to initiate the development process, OWCP will distribute any monetary benefits payable on the claim among all eligible surviving beneficiaries who have filed claims with OWCP.

* * * * *

(d) Except as provided in paragraph (e) of this section, a survivor's claim is considered to be "filed" on the date that the survivor mails his or her claim to OWCP, as determined by postmark or other carrier's date marking, or the date that the claim is received by OWCP, whichever is the earliest determinable date. However, in no event will a survivor's claim under Part B of the Act be considered to be "filed" earlier than July 31, 2001, nor will a survivor's claim under Part E of the Act be considered to be "filed" earlier than October 30, 2000.

(1) The survivor shall affirm that the information provided on the Form EE-2 is true, and must inform OWCP of any subsequent changes to that information.

* * * * *

(e) For those claims under Part E of EEOICPA that were originally filed with DOE as claims for assistance under former section 7385o of EEOICPA (which was repealed on October 28, 2004), a claim is considered to be "filed" on the date that the survivor mailed his or her claim to DOE, as determined by postmark or other carrier's date marking, or on the date that the claim was received by DOE, whichever is the earliest determinable date. However, in no event will a claim referred to in this paragraph be considered to be "filed" earlier than October 30, 2000.

* * * * *

■ 7. Amend § 30.102 by revising paragraph (a) to read as follows:

§ 30.102 In general, how does an employee file a claim for additional impairment or wage-loss under Part E of EEOICPA?

(a) An employee previously awarded impairment benefits by OWCP may file a claim for additional impairment benefits. Such claim must be based on an increase in the employee's impairment rating attributable to the covered illness or illnesses from the impairment rating that formed the basis for the last award of such benefits by OWCP. OWCP will only adjudicate claims for such an increased rating that are filed at least two years from the date of the last award of impairment benefits. However, OWCP will not wait two years before it will adjudicate a claim for additional impairment that is based on an allegation that the employee sustained a new covered illness.

* * * * *

■ 8. Amend § 30.103 by revising paragraph (b) to read as follows:

§ 30.103 How does a claimant make sure that OWCP has the evidence necessary to process the claim?

* * * * *

(b) Copies of the forms listed in this section are available for public inspection at the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210. They may also be obtained from OWCP district offices and on the internet at <http://www.dol.gov/owcp/energy/index.htm>.

■ 9. Amend § 30.110 by revising paragraphs (a)(1) and (4) and (b) to read as follows:

§ 30.110 Who is entitled to compensation under the Act?

(a) * * *
 (1) A "covered beryllium employee" (as described in § 30.205(a)) with a covered beryllium illness (as defined in § 30.5(p)) who was exposed to beryllium

in the performance of duty (in accordance with § 30.206).

* * * * *

(4) A "covered uranium employee" (as defined in § 30.5(t)).

(b) Under Part E of EEOICPA, compensation is payable to a "covered Part E employee" (as defined in § 30.5(q)), or his or her survivors.

* * * * *

■ 10. Amend § 30.112 by revising paragraph (b)(3) to read as follows:

§ 30.112 What kind of evidence is needed to establish covered employment and how will that evidence be evaluated?

* * * * *

(b) * * *

(3) If the only evidence of covered employment submitted by the claimant is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under § 30.111.

■ 11. Amend § 30.113 by revising paragraph (c) to read as follows:

§ 30.113 What are the requirements for written medical documentation, contemporaneous records, and other records or documents?

* * * * *

(c) If a claimant submits a certified statement, by a person with knowledge of the facts, that the medical records containing a diagnosis and date of diagnosis of a covered medical condition no longer exist, then OWCP may consider other evidence to establish a diagnosis and date of diagnosis of a covered medical condition. However, OWCP will evaluate the probative value of such other evidence to determine whether it is sufficient proof of a covered medical condition.

■ 12. Amend § 30.114 as follows:

■ a. Revise paragraphs (b)(1) and (2);

■ b. Redesignate paragraph (b)(3) as paragraph (b)(4); and

■ c. Add new paragraph (b)(3).

The revisions and addition read as follows:

§ 30.114 What kind of evidence is needed to establish a compensable medical condition and how will that evidence be evaluated?

* * * * *

(b) * * *

(1) For covered beryllium illnesses under Part B of EEOICPA, additional medical evidence, as set forth in § 30.207, is required to establish a beryllium illness.

(2) For chronic silicosis under Part B of EEOICPA, additional medical evidence, as set forth in § 30.222, is required to establish chronic silicosis.

(3) For covered illnesses under Part E of EEOICPA, additional medical evidence, as set forth in § 30.232, is required to establish a covered illness.

(i) For impairment benefits under Part E of EEOICPA, additional medical evidence, as set forth in § 30.901, is required to establish an impairment that is the result of a covered illness referred to in § 30.900.

(ii) For wage-loss benefits under Part E of EEOICPA, additional medical evidence, as set forth in § 30.806, is required to establish wage-loss that is the result of a covered illness referred to in § 30.800.

* * * * *

■ 13. Amend § 30.115 by revising paragraphs (a) introductory text, (a)(2), and (b) to read as follows:

§ 30.115 For those radiogenic cancer claims that do not seek benefits under Part B of the Act pursuant to the Special Exposure Cohort provisions, what will OWCP do once it determines that an employee contracted cancer?

(a) Other than claims seeking benefits under Part E of the Act that have previously been accepted under section 7384u of the Act or claims previously accepted under Part B pursuant to the Special Exposure Cohort provisions, OWCP will forward the claim package (including, but not limited to, Forms EE-1, EE-2, EE-3, EE-4 and EE-5, as appropriate) to NIOSH for dose reconstruction. At that point in time, development of the claim by OWCP may be suspended.

* * * * *

(2) NIOSH will then reconstruct the radiation dose of the employee and provide the claimant and OWCP with the final dose reconstruction report. The final dose reconstruction record will be delivered to OWCP with the final dose reconstruction report and to the claimant upon request.

(b) Following its receipt of the final dose reconstruction report from NIOSH, OWCP will resume its adjudication of the cancer claim and consider whether the claimant has met the eligibility criteria set forth in subpart C of this part. However, during the period before it receives a reconstructed dose from NIOSH, OWCP may continue to develop other aspects of a claim, to the extent

that it deems such development to be appropriate.

■ 14. Amend § 30.205 by revising paragraphs (a)(1) and (a)(3)(i) to read as follows:

§ 30.205 What are the criteria for eligibility for benefits relating to beryllium illnesses covered under Part B of EEOICPA?

* * * * *

(a) * * *

(1) The employee is a "current or former employee as defined in 5 U.S.C. 8101(1)" (see § 30.5(u)) who may have been exposed to beryllium at a DOE facility or at a facility owned, operated or occupied by a beryllium vendor; or

* * * * *

(3) * * *

(i) Employed at a DOE facility (as defined in § 30.5(y)); or

* * * * *

■ 15. Amend § 30.206 by revising paragraph (a) to read as follows:

§ 30.206 How does a claimant prove that the employee was a "covered beryllium employee" exposed to beryllium dust, particles or vapor in the performance of duty?

(a) Proof of employment or physical presence at a DOE facility, or a beryllium vendor facility as defined in § 30.5(j), because of employment by the United States, a beryllium vendor, or a contractor or subcontractor of a beryllium vendor during a period when beryllium dust, particles or vapor may have been present at such facility, may be made by the submission of any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was employed or present at a covered facility and the time period of such employment or presence.

* * * * *

■ 16. Amend § 30.207 as follows:

■ a. Revise paragraph (a);

■ b. Redesignate paragraph (d) as paragraph (e); and

■ c. Add new paragraph (d).

The revision and addition read as follows:

§ 30.207 How does a claimant prove a diagnosis of a beryllium disease covered under Part B?

(a) Written medical documentation is required in all cases to prove that the employee developed a covered beryllium illness. Proof that the employee developed a covered beryllium illness must be made by using the procedures outlined in paragraph (b), (c), (d) or (e) of this section.

* * * * *

(d) OWCP will use the criteria in either paragraph (c)(1) or (2) of this

section to establish that the employee developed chronic beryllium disease as follows:

(1) If the earliest dated medical evidence shows that the employee was either treated for, tested positive for, or diagnosed with a chronic respiratory disorder before January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used;

(2) If the earliest dated medical evidence shows that the employee was either treated for, tested positive for, or diagnosed with a chronic respiratory disorder on or after January 1, 1993, the criteria set forth in paragraph (c)(1) of this section must be used; and

(3) If the employee was treated for a chronic respiratory disorder before January 1, 1993 and medical evidence verifies that such treatment was performed before January 1, 1993, but the medical evidence is dated on or after January 1, 1993, the criteria set forth in paragraph (c)(2) of this section may be used.

* * * * *

■ 17. Amend § 30.210 by revising paragraph (a)(1) to read as follows:

§ 30.210 What are the criteria for eligibility for benefits relating to radiogenic cancer?

(a) * * *

(1) The employee has been diagnosed with one of the forms of cancer specified in § 30.5(gg); and

* * * * *

■ 18. Revise § 30.211 to read as follows:

§ 30.211 How does a claimant establish that the employee has or had contracted cancer?

A claimant establishes that the employee has or had contracted a specified cancer (as defined in § 30.5(gg)) or other cancer with medical evidence that sets forth an explicit diagnosis of cancer and the date on which that diagnosis was first made.

■ 19. Amend § 30.213 by revising paragraph (a) to read as follows:

§ 30.213 How does a claimant establish that the radiogenic cancer was at least as likely as not related to employment at the DOE facility, the atomic weapons employer facility, or the RECA section 5 facility?

(a) HHS, with the advice of the Advisory Board on Radiation and Worker Health, has issued regulatory guidelines at 42 CFR part 81 that OWCP uses to determine whether radiogenic cancers claimed under Parts B and E were at least as likely as not related to employment at a DOE facility, an atomic weapons employer facility, or a RECA section 5 facility. Persons should consult HHS's regulations for information regarding the factual

evidence that will be considered by OWCP, in addition to the employee's final dose reconstruction report that will be provided to OWCP by NIOSH, in making this particular factual determination.

* * * * *

■ 20. Amend § 30.220 by revising paragraph (a) to read as follows:

§ 30.220 What are the criteria for eligibility for benefits relating to chronic silicosis?

* * * * *

(a) The employee is a civilian DOE employee, or a civilian DOE contractor employee, who was present for a number of workdays aggregating at least 250 workdays during the mining of tunnels at a DOE facility (as defined in § 30.5(y)) located in Nevada or Alaska for tests or experiments related to an atomic weapon, and has been diagnosed with chronic silicosis (as defined in § 30.5(k)); or

* * * * *

■ 21. Amend § 30.222 by revising paragraph (a) introductory text to read as follows:

§ 30.222 How does a claimant establish that the employee has been diagnosed with chronic silicosis or has sustained a consequential injury, illness, impairment or disease?

(a) A written diagnosis of the employee's chronic silicosis (as defined in § 30.5(k)) shall be made by a licensed physician and accompanied by one of the following:

* * * * *

■ 22. Amend § 30.230 by revising paragraphs (a) and (d)(1) introductory text to read as follows:

§ 30.230 What are the criteria necessary to establish that an employee contracted a covered illness under Part E of EEOICPA?

* * * * *

(a) That OWCP has determined under Part B of EEOICPA that the employee is a DOE contractor employee as defined in § 30.5(x), and that he or she has been awarded compensation under that Part of the Act for an occupational illness;

* * * * *

(d)(1) That the employee is a civilian DOE contractor employee as defined in § 30.5(x), or a civilian who was employed in a uranium mine or mill located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon or Texas at any time during the period from January 1, 1942 through December 31, 1971, or was employed in the transport of uranium ore or vanadium-uranium ore from such a

mine or mill during that same period, and that he or she:

* * * * *

■ 23. Amend § 30.231 by revising paragraphs (a) and (b) to read as follows:

§ 30.231 How does a claimant prove employment-related exposure to a toxic substance at a DOE facility or a RECA section 5 facility?

* * * * *

(a) Proof of employment may be established by any trustworthy records that, on their face or in conjunction with other such records, establish that the employee was so employed and the time period(s) of such employment. If the only evidence of covered employment submitted by the claimant is a written affidavit or declaration subject to penalty of perjury by the employee, survivor or any other person, and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP will evaluate the probative value of the affidavit in conjunction with the other evidence of employment, and may determine that the claimant has not met his or her burden of proof under § 30.111.

(b) For claimants who have established proof of employment, proof of exposure to a toxic substance may be established by the submission of any appropriate document or information that is evidence that such substance was present at the facility where the employee was employed and that the employee came into contact with such substance. Information from the following sources may be considered as probative factual evidence for purposes of establishing an employee's exposure to a toxic substance at a DOE facility or a RECA section 5 facility:

(1) To the extent practicable and appropriate, from DOE, a DOE-sponsored Former Worker Program, or an entity that acted as a contractor or subcontractor to DOE;

(2) OWCP's Site Exposure Matrices; or

(3) Any other entity deemed by OWCP to be a reliable source of information necessary to establish that the employee was exposed to a toxic substance at a DOE facility or RECA section 5 facility.

■ 24. Amend § 30.232 as follows:

■ a. Revise paragraphs (a)(1) and (2);

■ b. Remove paragraphs (a)(3) and (4) and (b); and

■ c. Redesignate paragraph (c) as paragraph (b) and revise newly designated paragraph (b).

The revisions read as follows:

§ 30.232 How does a claimant establish that the employee has been diagnosed with a covered illness, or sustained an injury, illness, impairment or disease as a consequence of a covered illness?

(a) * * *

(1) Written medical evidence containing a physician's diagnosis of the employee's covered illness (as that term is defined in § 30.5(s)), and the physician's reasoning for his or her opinion regarding causation; and

(2) Any other evidence OWCP may deem necessary to show that the employee has or had an illness that resulted from an exposure to a toxic substance while working at either a DOE facility or a RECA section 5 facility.

(b) An injury, illness, impairment or disease sustained as a consequence of a covered illness (as defined in § 30.5(s)) must be established with a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the covered illness. Neither the fact that the injury, illness, impairment or disease manifests itself after a diagnosis of a covered illness, nor the belief of the claimant that the injury, illness, impairment or disease was caused by the covered illness, is sufficient in itself to prove a causal relationship.

■ 25. Add an undesignated center heading immediately preceding § 30.300 and revise § 30.300 to read as follows:

General Provisions

§ 30.300 What administrative process will OWCP use to decide claims for entitlement, and how can claimants obtain judicial review of final decisions on their claims?

OWCP district offices will issue recommended decisions with respect to most claims for entitlement under Part B and/or Part E of EEOICPA that are filed pursuant to the regulations set forth in subpart B of this part. In circumstances where a claim is made for more than one benefit available under Part B and/or Part E of the Act, OWCP may issue a recommended decision on only part of that particular claim in order to adjudicate that portion of the claim as quickly as possible. Should this occur, OWCP will issue one or more recommended decisions on the deferred portions of the claim when the adjudication of those portions is completed. All recommended decisions granting and/or denying claims for entitlement under Part B and/or Part E of the Act will be forwarded to the Final Adjudication Branch (FAB). Claimants will be given an opportunity to object to all or part of the recommended decision before the FAB. The FAB will consider objections filed by a claimant and

conduct a hearing, if requested to do so by the claimant, before issuing a final decision on the claim for entitlement. Claimants may request judicial review of a final decision of FAB by filing an action in Federal district court.

■ 26. Amend § 30.301 by revising paragraph (b)(1) to read as follows:

§ 30.301 May subpoenas be issued for witnesses and documents in connection with a claim under Part B of EEOICPA?

* * * * *

(b) * * *

(1) Submit the request in writing and send it to the FAB reviewer as early as possible, but no later than 30 days (as evidenced by postmark or other carrier's date marking) after the date of the original hearing request;

* * * * *

■ 27. Amend § 30.305 by revising paragraph (a) to read as follows:

§ 30.305 How does OWCP determine entitlement to EEOICPA compensation?

(a) In reaching a recommended decision with respect to EEOICPA compensation, OWCP considers the claim presented by the claimant, the factual and medical evidence of record, the dose reconstruction report prepared by NIOSH (if any), any report submitted by DOE and the results of such investigation as OWCP may deem necessary.

* * * * *

■ 28. Revise § 30.306 to read as follows:

§ 30.306 What does the recommended decision include?

The recommended decision shall include a discussion of the district office's findings of fact and conclusions of law in support of the recommendation. The recommended decision may recommend acceptance or rejection of the claim in its entirety, or of a portion of the claim presented. It is accompanied by a notice of the claimant's right to file objections with, and request a hearing before, the FAB.

§ 30.307 [Redesignated as § 30.308]

■ 29a. Redesignate § 30.307 as § 30.308.

■ 29b. Add new § 30.307 to read as follows:

§ 30.307 Can one recommended decision address the entitlement of multiple claimants?

(a) When multiple individuals have filed survivor claims under Part B and/or Part E of EEOICPA relating to the same deceased employee, the entitlement of all of those individuals shall be determined in the same recommended decision, except as

described in paragraph (b) of this section.

(b) If another individual subsequently files a survivor claim for the same award, the recommended decision on that claim will not address the entitlement of the earlier claimants if the district office recommended that the later survivor claim be denied.

■ 30. Revise § 30.310 to read as follows:

§ 30.310 What must the claimant do if he or she objects to the recommended decision or wants to request a hearing?

(a) Within 60 days from the date the recommended decision is issued, the claimant must state, in writing, whether he or she objects to any of the findings of fact and/or conclusions of law discussed in such decision, including NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), and whether a hearing is desired. This written statement should be filed with the FAB at the address indicated in the notice accompanying the recommended decision.

(b) For purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the FAB, the statement will be considered to be "filed" on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written statement is actually received, whichever is the earliest determinable date.

■ 31. Amend § 30.313 by revising paragraph (c) to read as follows:

§ 30.313 How is a review of the written record conducted?

* * * * *

(c) Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

■ 32. Amend § 30.314 by revising paragraphs (a) introductory text and (b) to read as follows:

§ 30.314 How is a hearing conducted?

(a) The FAB reviewer retains complete discretion to set the time and place of the hearing, including the amount of time allotted for the hearing, considering the issues to be resolved. At the discretion of the reviewer, the hearing may be conducted by telephone, teleconference, videoconference or other electronic means. As part of the hearing

process, the FAB reviewer will consider the written record forwarded by the district office and any additional evidence and/or argument submitted by the claimant. The reviewer may also conduct whatever investigation is deemed necessary.

* * * * *

(b) The FAB reviewer will mail a notice of the time and place of the hearing to the claimant and any representative at least 30 days before the scheduled hearing date. The FAB reviewer may mail a hearing notice less than 30 days prior to the hearing if the claimant and/or representative waives the above 30-day notice period in writing. If the claimant only objects to part of the recommended decision, the FAB reviewer may issue a final decision accepting the remaining part of the recommendation of the district office without first holding a hearing (see § 30.316). Any objection that is not presented to the FAB reviewer, including any objection to NIOSH's reconstruction of the radiation dose to which the employee was exposed (if any), whether or not the pertinent issue was previously presented to the district office, is deemed waived for all purposes.

* * * * *

■ 33. Amend § 30.315 by revising paragraph (a) to read as follows:

§ 30.315 May a claimant postpone a hearing?

(a) The FAB will entertain any reasonable request for scheduling the time and place of the hearing, but such requests should be made at the time that the hearing is requested. Scheduling is at the discretion of the FAB, and is not reviewable. In most instances, once the hearing has been scheduled and appropriate written notice has been mailed, it cannot be postponed at the claimant's request for any reason except those stated in paragraph (b) of this section, unless the FAB reviewer can reschedule the hearing on the same docket (that is, during the same hearing trip). If a request to postpone a scheduled hearing does not meet one of the tests of paragraph (b) of this section and cannot be accommodated on the same docket, or if the claimant and/or representative cancels or fails to attend a scheduled hearing, no further opportunity for a hearing will be provided. Instead, the FAB will consider the claimant's objections by means of a review of the written record. In the alternative, a teleconference may be substituted for the hearing at the discretion of the reviewer.

* * * * *

■ 34. Revise § 30.318 to read as follows:

§ 30.318 How will FAB consider objections to NIOSH's reconstruction of a radiation dose, or to OWCP's calculation of the recommended probability of causation, in a Part B claim for radiogenic cancer?

(a) If the claimant objects to NIOSH's reconstruction of the radiation dose to which the employee was exposed, either in writing or at the oral hearing, the FAB reviewer has the discretion to consult with NIOSH as part of his or her consideration of any objection. However, the HHS dose reconstruction regulation, which provides guidance for the technical methods developed and used by NIOSH to provide a reasonable estimate of the radiation dose received by an employee, is binding on FAB. Should this consultation take place, the FAB reviewer will properly document it in the case. Whether or not NIOSH is consulted, and as provided for in § 30.317, the FAB reviewer may decide to return the case to the district office for referral to NIOSH for such further action as may be appropriate.

(b) If the claimant objects to OWCP's calculation of the recommended probability of causation in a Part B radiogenic cancer claim, the FAB reviewer has the discretion to consider if OWCP used incorrect factual information when it performed this calculation. However, the statute requires that OWCP use a particular methodology, established by regulations issued by HHS at 42 CFR part 81, when it calculates the recommended probability of causation.

■ 35. Amend § 30.319 by revising paragraph (b) to read as follows:

§ 30.319 May a claimant request reconsideration of a final decision of the FAB?

* * * * *

(b) For purposes of determining whether the written request referred to in paragraph (a) of this section has been timely filed with the FAB, the request will be considered to be "filed" on the date that the claimant mails it to the FAB, as determined by postmark or other carrier's date marking, or on the date that such written request is actually received, whichever is the earliest determinable date.

* * * * *

■ 36. Amend § 30.320 by revising paragraph (b) to read as follows:

§ 30.320 Can a claim be reopened after the FAB has issued a final decision?

* * * * *

(b) At any time after the FAB has issued a final decision pursuant to § 30.316, a claimant may file a written

request that the Director for Energy Employees Occupational Illness Compensation reopen his or her claim, provided that the claimant also submits new evidence of a diagnosed medical condition, covered employment, or exposure to a toxic substance. A written request to reopen a claim may also be supported by identifying either a change in the PoC guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort. If the Director concludes that the evidence submitted or matter identified in support of the claimant's request is material to the claim, the Director will reopen the claim and return it to the district office for such further development as may be necessary, to be followed by a new recommended decision.

* * * * *

■ 37. Amend § 30.400 by revising paragraphs (a) and (c) and adding paragraph (d) to read as follows:

§ 30.400 What are the basic rules for obtaining medical treatment?

(a) A covered Part B employee or a covered Part E employee who fits into at least one of the compensable claim categories described in subpart C of this part is entitled to receive all medical services, appliances or supplies that a qualified physician prescribes or recommends and that OWCP considers necessary to treat his or her occupational illness or covered illness, retroactive to the date the claim for benefits for that occupational illness or covered illness under Part B or Part E of EEOICPA was filed. The employee need not be disabled to receive such treatment. If there is any doubt as to whether a specific service, appliance or supply is necessary to treat the occupational illness or covered illness, the employee should consult OWCP prior to obtaining it through the automated authorization process described in § 30.700. In situations where the occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer; however, payment for medical treatment of the underlying primary cancer under these circumstances does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of EEOICPA.

* * * * *

(c) Any qualified physician may provide medical services, appliances and supplies to the covered Part B employee or the covered Part E

employee. A hospital or a provider of medical services or supplies may furnish appropriate services, drugs, supplies and appliances, so long as such provider possesses all applicable licenses required under State law and has not been excluded from participation in the program under subpart H of this part. OWCP may apply a test of cost-effectiveness when it decides if appliances and supplies are necessary to treat an occupational illness or covered illness, may offset the cost of prior rental payments against a future purchase price, and may provide refurbished appliances where appropriate. Also, OWCP may authorize payment for durable medical equipment and modifications to a home or vehicle, to the extent that OWCP deems it necessary and reasonable. With respect to prescribed medications, OWCP may require the use of generic equivalents where they are available. OWCP may contract with a specific provider or providers to supply non-physician medical services or supplies.

(d) In circumstances when a covered employee dies after filing a claim but before such claim is accepted, OWCP will pay for medical treatment for all accepted illnesses, retroactive to the date that the employee filed the claim, if the deceased employee's survivor(s) files a claim that is accepted under Part B and/or Part E of EEOICPA. If this occurs, OWCP shall only pay either the provider(s) or the employee's estate for medical treatment that the employee obtained after filing his or her claim.

■ 38. Revise § 30.403 to read as follows:

§ 30.403 Will OWCP pay for home health care, nursing home, and assisted living services?

(a) OWCP will authorize and pay for home health care claimed under section 7384t of the Act, whether or not such care constitutes skilled nursing care, so long as the care has been determined to be medically necessary. OWCP will pay for approved periods of care by a registered nurse, licensed practical nurse, home health aide or similarly trained individual, subject to the pre-authorization requirements described in paragraph (c) of this section.

(b) OWCP will also authorize and pay for periods of nursing home and assisted living services claimed under section 7384t of the Act, so long as such services have been determined to be medically necessary, subject to the pre-authorization requirements described in paragraph (c) of this section.

(c) To file an initial claim for home health care, nursing home, or assisted living services, the beneficiary must submit Form EE-17A to OWCP and

identify his or her treating physician. OWCP then provides the treating physician with Form EE-17B, which asks the physician to submit a letter of medical necessity and verify that a timely face-to-face physical examination of the beneficiary took place. This particular pre-authorization process must be followed only for the initial claim for home health care, nursing home, and assisted living services; any subsequent request for pre-authorization must satisfy OWCP's usual medical necessity requirements. If a claimant disagrees with the decision of OWCP that the claimed services are not medically necessary, he or she may utilize the adjudicatory process described in subpart D of this part.

■ 39. Amend § 30.405 by revising paragraphs (b) and (c) to read as follows:

§ 30.405 After selecting a treating physician, may an employee choose to be treated by another physician instead?

* * * * *

(b) OWCP will approve the request if it determines that the reasons submitted are credible and supported by probative factual and/or medical evidence, as appropriate. Requests that are often approved include those for transfer of care from a general practitioner to a physician who specializes in treating the occupational illnesses or covered illnesses covered by EEOICPA, or the need for a new physician when an employee has moved.

(c) OWCP may deny a requested change of physician if it determines that the reasons submitted are not both credible and supported by probative evidence. If a claimant disagrees with such an informal denial, he or she may utilize the adjudicatory process described in subpart D of this part.

■ 40. Amend § 30.410 by adding paragraph (c) to read as follows:

§ 30.410 Can OWCP require an employee to be examined by another physician?

* * * * *

(c) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a second opinion examination.

■ 41. Amend § 30.411 by adding paragraph (d) to read as follows:

§ 30.411 What happens if the opinion of the physician selected by OWCP differs from the opinion of the physician selected by the employee?

* * * * *

(d) OWCP may administratively close the claim and suspend adjudication of any pending matters if the employee refuses to attend a referee medical examination.

■ 42. Amend § 30.416 by revising paragraph (a) to read as follows:

§ 30.416 How and when should medical reports be submitted?

(a) The initial medical report (and any subsequent reports) should be made in narrative form on the physician's letterhead stationery. The physician should use the Form EE-7 as a guide for the preparation of his or her initial medical report in support of a claim under Part B and/or Part E of EEOICPA. The report should bear the physician's handwritten or electronic signature. OWCP may require an original signature on the report.

* * * * *

■ 43. Amend § 30.500 by revising paragraph (a)(2) and adding paragraph (c) to read as follows:

§ 30.500 What special statutory definitions apply to survivors under EEOICPA?

(a) * * *

(2) *Child* of a deceased covered Part B employee or deceased covered Part E employee means only a biological child, a stepchild or an adopted child of that individual.

* * * * *

(c) For the purposes of paying compensation to survivors under Part E of EEOICPA, OWCP will use the following additional definitions:

(1) *Covered child* means a child that is, as of the date of the deceased covered Part E employee's death, either under the age of 18 years, or under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support. A child's marital status or dependency on the covered employee for support is irrelevant to his or her eligibility for benefits as a covered child under Part E.

(2) *Incapable of self-support* means that the child must have been physically and/or mentally incapable of self-support at the time of the covered employee's death.

■ 44. Amend § 30.501 by revising paragraphs (a) introductory text and (b) introductory text to read as follows:

§ 30.501 What order of precedence will OWCP use to determine which survivors are entitled to receive compensation under EEOICPA?

(a) Under Part B of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part B employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as

follows, subject to the qualifications set forth in § 30.5(hh)(3):

* * * * *

(b) Under Part E of the Act, if OWCP determines that a survivor or survivors are entitled to receive compensation under EEOICPA because a covered Part E employee who would otherwise have been entitled to benefits is deceased, that compensation will be disbursed as follows, subject to the qualifications set forth in § 30.5(hh)(3):

* * * * *

■ 45. Revise § 30.502 to read as follows:

§ 30.502 When is entitlement for survivors determined for purposes of EEOICPA?

Entitlement to any lump-sum payment for survivors under the EEOICPA, other than for “covered” children under Part E, will be determined as of the time OWCP makes such a payment. As noted in § 30.500(c)(1), a child of a deceased Part E employee will only qualify as a “covered” child of that individual if he or she satisfied one of the additional statutory criteria for a “covered” child as of the date of the deceased Part E employee’s death.

■ 46. Amend § 30.509 by revising paragraph (c) to read as follows:

§ 30.509 Under what circumstances may a survivor claiming under Part E of the Act choose to receive the benefits that would otherwise be payable to a covered Part E employee who is deceased?

* * * * *

(c) OWCP only makes impairment determinations based on rationalized medical evidence in the case file that is sufficiently detailed and meets the various requirements for the many different types of impairment determinations possible under the American Medical Association’s *Guides to the Evaluation of Permanent Impairment* (AMA’s *Guides*). Therefore, OWCP will only make an impairment determination for a deceased covered Part E employee pursuant to this section if the medical evidence of record is sufficient to satisfy the pertinent requirements in the AMA’s *Guides* and subpart J of this part.

■ 47. Amend § 30.600 by revising paragraph (c)(2) to read as follows:

§ 30.600 May a claimant designate a representative?

* * * * *

(c) * * *

(2) A representative does not have authority to sign the Form EE–1 (described in § 30.100(a)) or the Form EE–2 (described in § 30.101(a)) for his or her client. A representative also does not have authority to sign the Form EN–

20 (described in § 30.505(c)) for his or her client

■ 48. Amend § 30.601 by revising the introductory text to read as follows:

§ 30.601 Who may serve as a representative?

A claimant may authorize any individual to represent him or her in regard to a claim under EEOICPA, unless that individual’s service as a representative would violate any applicable provision of law (such as 18 U.S.C. 205 and 208) or the standards regarding conflicts of interest adopted by OWCP. Under those standards, authorized representatives are prohibited from having private, non-representational financial interests with respect to their client’s EEOICPA claims. This does not include their fee for serving as a representative. A Federal employee may act as a representative only:

* * * * *

■ 49. Amend § 30.603 by revising paragraph (a) to read as follows:

§ 30.603 Are there any limitations on what the representative may charge the claimant for his or her services?

(a) Notwithstanding any contract, the representative may not receive, for services rendered in connection with a claim pending before OWCP, more than the percentages of the lump-sum payment made to the claimant set out in paragraph (b) of this section, exclusive of costs and expenses.

* * * * *

■ 50. Amend § 30.617 by revising paragraph (b)(2) to read as follows:

§ 30.617 What happens if this type of tort suit was filed during the period from October 30, 2000 through December 28, 2001?

* * * * *

(b) * * *

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, “the date the claimant or claimants first became aware” will be deemed to be the date they received either a reconstructed dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

■ 51. Amend § 30.618 by revising paragraph (c)(2) to read as follows:

§ 30.618 What happens if this type of tort suit was filed after December 28, 2001?

* * * * *

(c) * * *

(2) The date that is 30 months after the date the claimant or claimants first became aware that an illness of the covered Part B employee may be connected to his or her exposure to beryllium or radiation covered by EEOICPA. For purposes of determining when this 30-month period begins, “the date the claimant or claimants first became aware” will be deemed to be the date they received either a reconstructed dose from NIOSH, or a diagnosis of a covered beryllium illness, as applicable.

■ 52. Revise §§ 30.700 through 30.702 to read as follows:

§ 30.700 In general, what responsibilities do providers have with respect to enrolling with OWCP, seeking authorization to provide services, billing, and retaining medical records?

(a) All providers must enroll with OWCP or its designated bill processing agent (hereinafter OWCP in this subpart) to have access to the automated authorization system and to submit medical bills to OWCP. To enroll, the provider must complete and submit a Form OWCP–1168 to the appropriate location noted on that form. By completing and submitting this form, providers certify that they satisfy all applicable Federal and state licensure and regulatory requirements that apply to their specific provider or supplier type. The provider must maintain documentary evidence indicating that it satisfies those requirements. The provider is also required to notify OWCP immediately if any information provided to OWCP in the enrollment process changes. Federal government medical officers, private physicians and hospitals are also required to keep records of all cases treated by them under EEOICPA so they can supply OWCP with a history of the claimed occupational illness or covered illness, a description of the nature and extent of the claimed occupational illness or covered illness, the results of any diagnostic studies performed and the nature of the treatment rendered. This requirement terminates after a provider has supplied OWCP with the above-noted information, and otherwise terminates ten years after the record was created.

(b) Where a medical provider intends to bill for a procedure where prior authorization is required, authorization must be requested from OWCP.

(c) After enrollment, a provider must submit all medical bills to OWCP through its bill processing portal and include the Provider Number/ID obtained through enrollment or other identifying number required by OWCP.

§ 30.701 How are medical bills to be submitted?

(a) All charges for medical and surgical treatment, appliances or supplies furnished to employees, except for treatment and supplies provided by nursing homes, shall be supported by medical evidence as provided in § 30.700. OWCP may withhold payment for services until such report or evidence is provided. The physician or provider shall itemize the charges on Form OWCP-1500 or CMS-1500 (for professional charges or medicinal drugs dispensed in the office), Form OWCP-04 or UB-04 (for hospitals), an electronic or paper-based bill that includes required data elements (for pharmacies) or other form as warranted, and submit the form or bill promptly to OWCP.

(b) The provider shall identify each service performed using the Physician's Current Procedural Terminology (CPT) code, the Healthcare Common Procedure Coding System (HCPCS) code, the National Drug Code (NDC) number, or the Revenue Center Code (RCC), with a brief narrative description. OWCP has discretion to determine which of these codes may be utilized in the billing process. OWCP also has the authority to create and supply specific procedure codes that will be used by OWCP to better describe and allow specific payments for special services. These OWCP-created codes will be issued to providers by OWCP as appropriate and may only be used as authorized by OWCP. For example, a physician conducting a referee or second opinion examination as described in §§ 30.410 through 30.412 will be furnished an OWCP-created code. A provider may not use an OWCP-created code for other types of medical examinations or services. When no code is submitted to identify the services performed, the bill will be returned to the provider and/or denied.

(c) For professional charges billed on Form OWCP-1500 or CMS-1500, the provider shall also state each diagnosed condition and furnish the corresponding diagnostic code using the "International Classification of Disease, 9th Edition, Clinical Modification" (ICD-9-CM), or as revised. A separate bill shall be submitted when the employee is discharged from treatment or monthly, if treatment for the occupational illness or covered illness is necessary for more than 30 days.

(1)(i) Hospitals shall submit charges for both inpatient and outpatient medical and surgical treatment or supplies promptly to OWCP on Form OWCP-04 or UB-04.

(ii) OWCP may adopt a Home Health Prospective Payment System (HHPPS), as developed and implemented by the Centers for Medicare and Medicaid Services (CMS) within HHS for Medicare, while modifying the allowable costs under Medicare to account for deductibles and other additional costs that are covered by EEOICPA. If adopted, home health care providers will be required to submit bills on Form OWCP-04 or UB-04 and to use Health Insurance Prospective Payment System codes and other coding schemes.

(2) Pharmacies shall itemize charges for prescription medications, appliances or supplies on electronic or paper-based bills and submit them promptly to OWCP. Bills for prescription medications must include all required data elements, including the NDC number assigned to the product, the generic or trade name of the drug provided, the prescription number, the quantity provided, and the date the prescription was filled.

(3) Nursing homes shall itemize charges for appliances, supplies or services on the provider's billhead stationery and submit them promptly to OWCP. Such charges shall be subject to any applicable OWCP fee schedule.

(d) By submitting a bill and/or accepting payment, the provider signifies that the service for which payment is sought was performed as described and was necessary, appropriate and properly billed in accordance with accepted industry standards. For example, accepted industry standards preclude upcoding billed services for extended medical appointments when the employee actually had a brief routine appointment, or charging for the services of a professional when a paraprofessional or aide performed the service. Also, industry standards prohibit unbundling services to charge separately for services that should be billed as a single charge. In addition, the provider thereby agrees to comply with all regulations set forth in this subpart concerning the rendering of treatment and/or the process for seeking payment for medical services, including the limitation imposed on the amount to be paid for such services.

(e) In summary, bills submitted by providers must: Be itemized on Form OWCP-1500 or CMS-1500 (for physicians), Form OWCP-04 or UB-04 (for hospitals), or an electronic or paper-based bill that includes required data elements (for pharmacies); contain the handwritten or electronic signature of the provider when required; and identify the procedures using HCPCS/

CPT codes, RCCs or NDC numbers. Otherwise, OWCP may deny the bill, and the provider must correct and resubmit the bill. The decision of OWCP whether to pay a provider's bill is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.702 How should an employee prepare and submit requests for reimbursement for medical expenses, transportation costs, loss of wages, and incidental expenses?

(a) If an employee has paid bills for medical, surgical or other services, supplies or appliances provided by a professional due to an occupational illness or a covered illness, he or she must submit a request for reimbursement on Form OWCP-915, together with an itemized bill on Form OWCP-1500 or CMS-1500 prepared by the provider, or Form OWCP-04 or UB-04 prepared by the provider, and a medical report as provided in § 30.700, to OWCP for consideration.

(1) The provider of such service shall state each diagnosed condition and furnish the applicable ICD-9-CM code, or as revised, and identify each service performed using the applicable HCPCS/CPT code, with a brief narrative description of the service performed, or, where no code is applicable, a detailed description of that service. If no code or description is received, OWCP will deny the reimbursement request, and correction and resubmission will be required.

(2) The reimbursement request must be accompanied by evidence that the provider received payment for the service from the employee and a statement of the amount paid. Acceptable evidence that payment was received includes, but is not limited to, a signed statement by the provider, a mechanical stamp or other device showing receipt of payment, a copy of the employee's canceled check (both front and back), a copy of the employee's credit card receipt or a provider billing form indicating a zero balance due.

(b) If a pharmacy or nursing home provided services for which the employee paid, the employee must also use Form OWCP-915 to request reimbursement and should submit the request in accordance with the provisions of § 30.701(a). Any such request for reimbursement must be accompanied by evidence, as described in paragraph (a)(2) of this section, that the provider received payment for the service from the employee and a statement of the amount paid.

(c) OWCP may waive the requirements of paragraphs (a) and (b) of

this section if extensive delays in the filing or the adjudication of a claim make it unusually difficult for the employee to obtain the required information.

(d) Copies of bills submitted for reimbursement must bear the handwritten or electronic signature of the provider when required, with evidence of payment. Payment for medical and surgical treatment, appliances or supplies shall in general be no greater than the maximum allowable charge for such service determined by OWCP, as set forth in § 30.705. OWCP will issue a letter decision on whether to reimburse an employee for out-of-pocket medical expenses, and the amount of any reimbursement. A claimant who disagrees with OWCP's letter decision may request a formal recommended decision and utilize the adjudicatory process described in subpart D of this part.

(e) An employee will be only partially reimbursed for a medical expense if the amount he or she paid to a provider for the service exceeds the maximum allowable charge set by OWCP's schedule. If this happens, OWCP shall advise the employee of the maximum allowable charge for the service in question and of his or her responsibility to ask the provider to refund to the employee, or credit to the employee's account, the amount he or she paid which exceeds the maximum allowable charge. The provider that the employee paid, but not the employee, may request reconsideration of the fee determination as set forth in § 30.712.

(f) If the provider fails to make appropriate refund to the employee, or to credit the employee's account, within 60 days after the employee requests a refund of any excess amount, or the date of a subsequent reconsideration decision which continues to disallow all or a portion of the disputed amount, OWCP will initiate exclusion procedures as provided by § 30.715.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the charge which OWCP allows, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

■ 53. Revise §§ 30.705 through 30.707 to read as follows:

§ 30.705 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services, devices and supplies furnished by physicians, hospitals and other providers for occupational illnesses or covered illnesses shall not exceed a maximum allowable charge for such service as determined by OWCP, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional. In the future, OWCP may also decide to implement a fee schedule for services provided in nursing homes.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 30.706 How are the maximum fees for professional medical services defined?

For professional medical services, OWCP shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a Relative Value Unit (RVU) to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an assignment of Geographic Practice Cost Index (GPCI) values which represent the relative work, practice expenses and malpractice expenses relative to other localities throughout the country; and a monetary value assignment (conversion factor) for one unit of value for each coded service.

§ 30.707 How are payments to providers calculated?

Payment for a procedure, service or device identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the RVU values for that procedure by the GPCI values for services in that area and by the conversion factor to arrive at a dollar amount assigned to one unit in that category of service.

(a) The "locality" which serves as a basis for the determination of cost is defined by the Bureau of Census Metropolitan Statistical Areas. OWCP shall base the determination of the relative per capita cost of medical care in a locality using information about

enrollment and medical cost per county, provided by CMS.

(b) OWCP shall assign the RVUs published by CMS to all services for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, OWCP may develop and assign any RVUs it considers appropriate. The geographic adjustment factor shall be that designated by GPCI values for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for each category of service as appropriate using OWCP's processing experience and internal data.

(c) For example, if the RVUs for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the conversion factor assigned to one unit in that category of service (surgery) is \$61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding GPCI values for the locality times the conversion factor. If the GPCI values for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20 \\ [2.45 + 3.44 + .56] \times \$61.20 \\ 6.45 \times \$61.20 = \$394.74$$

■ 54. Revise §§ 30.709 and 30.710 to read as follows:

§ 30.709 How are payments for medicinal drugs determined?

Unless otherwise specified by OWCP, payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee. OWCP may, in its discretion, contract for or require the use of specific providers for certain medications.

(a) All prescription medications identified by NDC number will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. OWCP will establish the dispensing fee, which will not be affected by the location or type of provider dispensing the medication.

(b) The NDC numbers, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

(c) With respect to prescribed medications, OWCP may require the use

of generic equivalents where they are available.

§ 30.710 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Inpatient Prospective Payment System (IPPS) devised by CMS. Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All inpatient hospital discharges will be classified according to the DRGs prescribed by CMS in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their IPPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by CMS to determine the specific rate for a hospital discharge under their IPPS. OWCP may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS's IPPS on consideration of detailed medical reports and other evidence.

(4) OWCP shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

(b) OWCP shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when OWCP deems it necessary or appropriate.

§§ 30.711 through 30.713 [Redesignated as § 30.712 through 30.714]

■ 55a. Redesignate §§ 30.711 through 30.713 as §§ 30.712 through 30.714.

■ 55b. Add new § 30.711 to read as follows:

§ 30.711 How are payments for outpatient medical services determined?

(a) OWCP will pay for outpatient medical services according to Ambulatory Payment Classifications (APC) based on the Outpatient Prospective Payment System devised by CMS.

(b) All outpatient medical services will be classified according to the APC

prescribed by CMS for that service in the form of the Outpatient Prospective Payment System Grouper software program. Each payment is derived by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor to arrive at a national unadjusted payment rate for the APC. The labor portion of the national unadjusted payment rate is further adjusted by the hospital wage index for the area where payment is being made.

(c) If a payable service has no assigned APC, the payment will be derived from the OWCP Medical Fee Schedule.

(d) OWCP shall review the pre-determined outpatient hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

■ 55c. Revise newly redesignated §§ 30.712 and 30.713 to read as follows:

§ 30.712 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and other evidence, and will pay no more than the maximum allowable fee for that procedure. If the code is not consistent with the medical and other evidence or where no code is supplied, the bill will be returned to the provider for correction and resubmission.

(b) If the charge submitted for a service supplied to an employee exceeds the maximum amount determined to be reasonable according to the schedule, OWCP shall pay the amount allowed by the schedule for that service and shall notify the provider in writing that payment was reduced for that service in accordance with the schedule. OWCP shall also notify the provider of the method for requesting reconsideration of the balance of the charge. The decision of OWCP to pay less than the charged amount is final when issued and is not subject to the adjudicatory process described in subpart D of this part.

§ 30.713 If OWCP reduces a fee, may a provider request reconsideration of the reduction?

(a) A physician or other provider whose charge for service is only partially paid because it exceeds a maximum allowable amount set by OWCP may, within 30 days, request reconsideration of the fee determination.

(1) The provider should make such a request to the district office with jurisdiction over the employee's claim. The request must be accompanied by

documentary evidence that the procedure performed was either incorrectly identified by the original code, that the presence of a severe or concomitant medical condition made treatment especially difficult, or that the provider possessed unusual qualifications. In itself, board certification in a specialty is not sufficient evidence of unusual qualifications to justify a charge in excess of the maximum allowable amount set by OWCP. These are the only three circumstances that will justify reevaluation of the paid amount.

(2) A list of district offices and their respective areas of jurisdiction is available upon request from the U.S. Department of Labor, Office of Workers' Compensation Programs, Washington, DC 20210, or at <http://www.dol.gov/owcp/energy/index.htm>. Within 30 days of receiving the request for reconsideration, the district office shall respond in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted.

(b) If the district office issues a decision that continues to disallow a contested amount, the provider may apply to the Regional Director of the region with jurisdiction over the district office. The application must be filed within 30 days of the date of such decision, and it may be accompanied by additional evidence. Within 60 days of receipt of such application, the Regional Director shall issue a decision in writing stating whether or not an additional amount will be allowed as reasonable, considering the evidence submitted. This decision is final, and shall not be subject to further review.

■ 56. Revise § 30.715 to read as follows:

§ 30.715 What are the grounds for excluding a provider from payment under this part?

A physician, hospital, or provider of medical services or supplies shall be excluded from payment under this part if such physician, hospital or provider has:

(a) Been convicted under any criminal statute of fraudulent activities in connection with any Federal or state program for which payments are made to providers for similar medical, surgical or hospital services, appliances or supplies;

(b) Been excluded or suspended, or has resigned in lieu of exclusion or suspension, from participation in any Federal or state program referred to in paragraph (a) of this section;

(c) Knowingly made, or caused to be made, any false statement or misrepresentation of a material fact in

connection with a determination of the right to reimbursement under this part, or in connection with a request for payment;

(d) Submitted, or caused to be submitted, three or more bills or requests for payment within a 12-month period under this subpart containing charges which OWCP finds to be substantially in excess of such provider's customary charges, unless OWCP finds there is good cause for the bills or requests containing such charges;

(e) Knowingly failed to timely reimburse employees for treatment, services or supplies furnished under this subpart and paid for by OWCP;

(f) Failed, neglected or refused on three or more occasions during a 12-month period to submit full and accurate medical reports, or to respond to requests by OWCP for additional reports or information, as required by § 30.700;

(g) Knowingly furnished treatment, services or supplies which are substantially in excess of the employee's needs, or of a quality which fails to meet professionally recognized standards;

(h) Collected or attempted to collect from the employee, either directly or through a collection agent, an amount in excess of the charge allowed by OWCP for the procedure performed, and has failed or refused to make appropriate refund to the employee, or to cease such collection attempts, within 60 days of the date of the decision of OWCP;

(i) Failed to inform OWCP of any change in their provider status as required in § 30.700; or

(j) Engaged in conduct related to care of an employee's occupational illness or covered illness that OWCP finds to be misleading, deceptive or unfair.

■ 57. Amend § 30.716 by adding paragraph (c) to read as follows:

§ 30.716 What will cause OWCP to automatically exclude a physician or other provider of medical services and supplies?

* * * * *

(c) A provider may be excluded on a voluntary basis at any time.

■ 58. Revise §§ 30.717 through 30.721 to read as follows:

§ 30.717 When are OWCP's exclusion procedures initiated?

(a) Upon receipt of information indicating that a physician, hospital or provider of medical services or supplies (hereinafter the provider) has or may have engaged in activities enumerated in paragraphs (c) through (j) of § 30.715, OWCP will forward that information to the Department of Labor's Office of

Inspector General (DOL OIG) for its consideration. If the information was provided directly to DOL OIG, DOL OIG will notify OWCP of its receipt and implement the appropriate action within its authority, unless such notification will or may compromise the identity of confidential sources, or compromise or prejudice an ongoing or potential criminal investigation.

(b) DOL OIG will conduct such action as it deems necessary, and, when appropriate, provide a written report as described in paragraph (c) of this section to OWCP. OWCP will then determine whether to initiate procedures to exclude the provider from participation in the EEOICPA program. If DOL OIG determines not to take any further action, it will promptly notify OWCP of such determination.

(c) If DOL OIG discovers reasonable cause to believe that violations of § 30.715 have occurred, it shall, when appropriate, prepare a written report, *i.e.*, investigative memorandum, and forward the report along with supporting evidence to OWCP. The report shall be in the form of a single memorandum in narrative form with attachments.

(1) The report should contain all of the following elements:

(i) A brief description and explanation of the subject provider or providers;

(ii) A concise statement of the DOL OIG's findings upon which exclusion may be based;

(iii) A summary of the events that make up the DOL OIG's findings;

(iv) A discussion of the documentation supporting DOL OIG's findings;

(v) A discussion of any other information that may have bearing upon the exclusion process; and

(vi) The supporting documentary evidence including any expert opinion rendered in the case.

(2) The attachments to the report should be provided in a manner that they may be easily referenced from the report.

§ 30.718 How is a provider notified of OWCP's intent to exclude him or her?

Following receipt of the investigative report, OWCP will determine if there exists a reasonable basis to exclude the provider or providers. If OWCP determines that such a basis exists, OWCP shall initiate the exclusion process by sending the provider a letter, by certified mail and with return receipt requested (or equivalent services from a commercial carrier), which shall contain the following:

(a) A concise statement of the grounds upon which exclusion shall be based;

(b) A summary of the information, with supporting documentation, upon which OWCP has relied in reaching an initial decision that exclusion proceedings should begin;

(c) An invitation to the provider to:

(1) Resign voluntarily from participation in the EEOICPA program without admitting or denying the allegations presented in the letter; or

(2) Request a decision on exclusion based upon the existing record and any additional documentary information the provider may wish to furnish;

(d) A notice of the provider's right, in the event of an adverse ruling by the deciding official, to request a formal hearing before an administrative law judge;

(e) A notice that should the provider fail to respond (as described in § 30.719) the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider without conducting any further proceedings; and

(f) The address to where the response from the provider should be sent.

§ 30.719 What requirements must the provider's response and OWCP's decision meet?

(a) The provider's response shall be in writing and shall include an answer to OWCP's invitation to resign voluntarily. If the provider does not offer to resign, he or she shall request that a determination be made upon the existing record and any additional information provided.

(b) Should the provider fail to respond to the letter of intent within 60 days of receipt, the deciding official may deem the allegations made therein to be true and may order exclusion of the provider.

(c) The provider may inspect or request copies of information in the record at any time prior to the deciding official's decision by making such request to OWCP within 20 days of receipt of the letter of intent.

(d) OWCP shall have 30 days to answer the provider's response. That answer will be forwarded to the provider, who shall then have 15 days to reply. Any response from the provider may be forwarded to DOL OIG, should OWCP deem it appropriate, to obtain additional information which may be relevant to the provider's response.

(e) The deciding official shall be the Regional Director in the region in which the provider is located unless otherwise specified by the Director for Energy Employees Occupational Illness Compensation.

(f) The deciding official shall issue his or her decision in writing, and shall send a copy of the decision to the provider by certified mail, return receipt requested (or equivalent service from a commercial carrier). The decision shall advise the provider of his or her right to request, within 30 days of the date of the adverse decision, a formal hearing before an administrative law judge under the procedures set forth in § 30.720. The filing of a request for a hearing within the time specified shall stay the effectiveness of the decision to exclude.

§ 30.720 How can an excluded provider request a hearing?

A request for a hearing shall be sent to the deciding official and shall contain:

- (a) A concise notice of the issues on which the provider desires to give evidence at the hearing;
- (b) Any request for the presentation of oral argument or evidence; and
- (c) Any request for a certification of questions concerning professional medical standards, medical ethics or medical regulation for an advisory opinion from a competent recognized professional organization or Federal, state or local regulatory body.

§ 30.721 How are hearings assigned and scheduled?

(a) If the deciding official receives a timely request for hearing, he or she shall refer the matter to the Chief Administrative Law Judge of the Department of Labor, who shall assign it for an expedited hearing. The administrative law judge assigned to the matter shall consider the request for hearing, act on all requests therein, and issue a Notice of Hearing and schedule for the conduct of the hearing. A copy of the hearing notice shall be served on the provider by certified mail, return receipt requested. The Notice of Hearing and schedule shall include:

- (1) A ruling on each item raised in the request for hearing;
- (2) A schedule for the prompt disposition of all preliminary matters, including requests for the certification of questions to advisory bodies; and
- (3) A scheduled hearing date not less than 30 days after the date the schedule is issued, and not less than 15 days after the scheduled conclusion of preliminary matters, provided that the specific time and place of the hearing may be set on 10 days' notice.

(b) The provider is entitled to be heard on any matter placed in issue by his or her response to the notice of intent to exclude, and may designate "all issues" for purposes of hearing.

However, a specific designation of issues is required if the provider wishes to interpose affirmative defenses, or request the certification of questions for an advisory opinion.

■ 59. Amend § 30.723 by revising paragraph (b) to read as follows:

§ 30.723 How will the administrative law judge conduct the hearing and issue the recommended decision?

* * * * *

(b) The administrative law judge shall receive such relevant evidence as may be adduced at the hearing. Parties to the hearing are the provider and OWCP. Evidence shall be presented under oath, orally or in the form of written statements. The administrative law judge shall consider the notice and response, including all pertinent documents accompanying them, and may also consider any evidence which refers to the provider or to any claim with respect to which the provider has provided medical services, hospital services, or medical services and supplies, and such other evidence as the administrative law judge may determine to be necessary or useful in evaluating the matter.

* * * * *

■ 60. Revise § 30.724 to read as follows:

§ 30.724 How does a recommended decision become final?

(a) Within 30 days from the date the recommended decision is issued, the provider may state, in writing, any objections to the recommended decision. This written statement should be filed with the Director for Energy Employees Occupational Illness Compensation.

(b) For the purposes of determining whether the written statement referred to in paragraph (a) of this section has been timely filed with the Director for Energy Employees Occupational Illness Compensation, the statement will be considered to be "filed" on the date that the provider mails it to the Director, as determined by postmark or other carrier's date marking, or the date that such written statement is actually received by the Director, whichever is earlier.

(c) Written statements objecting to the recommended decision may be filed upon one or more of the following grounds:

- (1) A finding or conclusion of material fact is not supported by substantial evidence;
- (2) A necessary legal conclusion is erroneous;
- (3) The decision is contrary to law or to the duly promulgated rules or decisions of the Director;

- (4) A substantial question of law, policy, or discretion is involved; or
- (5) A prejudicial error of procedure was committed.

(d) Each issue shall be separately numbered and plainly and concisely stated, and shall be supported by detailed citations to the record when assignments of error are based on the record, and by statutes, regulations or principal authorities relied upon. Except for good cause shown, no assignment of error by the provider shall rely on any question of fact or law upon which the administrative law judge had not been afforded an opportunity to pass.

(e) If a written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will review the objection. The Director will forward the written objection to DOL OIG, which will have 14 calendar days from that date to respond. Any response from DOL OIG will be forwarded to the provider, which will have 14 calendar days from that date to reply.

(f) The Director for Energy Employees Occupational Illness Compensation will consider the recommended decision, the written record and any response or reply received and will then issue a written, final decision either upholding or reversing the exclusion.

(g) If no written statement of objection is filed within the allotted period of time, the Director for Energy Employees Occupational Illness Compensation will issue a written, final decision accepting the recommendation of the administrative law judge.

(h) The decision of the Director for Energy Employees Occupational Illness Compensation shall be final with respect to the provider's participation in the program, and shall not be subject to further review.

■ 61. Amend § 30.725 by revising paragraph (a) to read as follows:

§ 30.725 What are the effects of non-automatic exclusion?

(a) OWCP shall give notice of the exclusion of a physician, hospital or provider of medical services or supplies to:

- (1) All OWCP district offices;
- (2) CMS;
- (3) All employees who are known to have had treatment, services or supplies from the excluded provider within the six-month period immediately preceding the order of exclusion; and
- (4) The state or local authority responsible for licensing or certifying the excluded provider.

* * * * *

■ 62. Amend § 30.726 by revising paragraph (c) to read as follows:

§ 30.726 How can an excluded provider be reinstated?

* * * * *

(c) A request for reinstatement may be accompanied by a request for oral presentation. Oral presentations will be allowed only in unusual circumstances where it will materially aid the decision process.

* * * * *

■ 63. Amend § 30.800 by revising paragraph (c) to read as follows:

§ 30.800 What types of wage-loss are compensable under Part E of EEOICPA?

* * * * *

(c) Whether the employee's inability to earn at least as much as his or her average annual wage was due to a covered illness as defined in § 30.5(s).

■ 64. Amend § 30.801 as follows:

- a. Revise paragraph (a);
- b. Redesignate paragraphs (c), (d), and (e) as paragraphs (d), (e), and (h), respectively;
- c. Add new paragraph (c);
- d. Revise newly redesignated paragraph (e); and
- e. Add paragraphs (f) and (g).

The revisions and additions read as follows:

§ 30.801 What special definitions does OWCP use in connection with Part E wage-loss determinations?

* * * * *

(a) *Average annual wage* means 12 times the average monthly wage of a covered Part E employee for the 36 months preceding the month during which he or she first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility (referred to as the "trigger month"), excluding any months during which the employee was unemployed. Because being "retired" is not equivalent to being "unemployed," months during which an employee had no wages because he or she was retired will not be excluded from this calculation.

* * * * *

(c) *Month during which the employee was unemployed* means any month during which the covered Part E employee had \$250 (in constant 2013 dollars) or less in wages unless the month is one during which the employee was retired.

* * * * *

(e) *Quarter during which the employee was unemployed* means any quarter during which the covered Part E employee had \$750 (in constant 2013 dollars) or less in wages unless the

quarter is one during which the employee was retired.

(f) *Trigger month* means the calendar month during which the employee first experienced a loss in wages due to exposure to a toxic substance at a DOE facility or RECA section 5 facility.

(g) *Wages* mean all monetary payments that the covered Part E employee earns from his or her regular employment or services that are taxed as income by the Internal Revenue Service. Salaries, overtime compensation, sick leave, vacation leave, tips, and bonuses received for employment services are considered wages under this subpart. However, capital gains, IRA distributions, pensions, annuities, unemployment compensation, state workers' compensation benefits, medical retirement benefits, and Social Security benefits are not considered wages.

* * * * *

■ 65. Revise § 30.805 to read as follows:

§ 30.805 What are the criteria for eligibility for wage-loss benefits under Part E?

(a) In addition to satisfying the general eligibility requirements applicable to all Part E claims, a claimant seeking benefits for calendar years of qualifying wage-loss has the burden of proof to establish each of the following criteria:

(1) He or she held a job at which he or she earned wages;

(2) He or she experienced a loss in those wages in a particular month (referred to as the "trigger month" in this section);

(3) The wage-loss in the trigger month was caused by the covered Part E employee's covered illness, *i.e.*, that he or she would have continued to earn wages in the trigger month from that employment *but for the covered illness*;

(4) His or her average annual wage;

(5) His or her normal retirement age and the calendar year in which he or she would reach that age;

(6) Beginning with the calendar year of the trigger month, the percentage of the average annual wage that was earned in each calendar year up to and including the retirement year;

(7) The number of those calendar years in which the covered illness caused the covered Part E employee to earn 50% or less of his or her average annual wage; and

(8) The number of those calendar years in which the covered illness caused him or her to earn more than 50% but not more than 75% of his or her average annual wage.

(b) OWCP will discontinue development of a request for wage-loss benefits, during which the claimant

must meet his or her burden of proof to establish each of the criteria listed in paragraph (a) of this section, at any point when the claimant is unable to meet such burden and proceed to issue a recommended decision to deny the request.

■ 66. Revise § 30.806 to read as follows:

§ 30.806 What kind of medical evidence must the claimant submit to prove that he or she lost wages due to a covered illness?

OWCP requires the submission of rationalized medical evidence of sufficient probative value to convince the fact-finder that the covered Part E employee experienced a loss in wages in his or her trigger month due to a covered illness, *i.e.*, medical evidence based on a physician's fully explained and reasoned decision (see § 30.805(a)(3)). A loss in wages in the trigger month due solely to non-covered illness matters, such as a reduction in force or voluntary retirement, is not proof of compensable wage-loss under Part E.

■ 67. Add § 30.807 immediately preceding the undesignated center heading "Determinations of Average Annual Wage and Percentages of Loss" to read as follows:

§ 30.807 What factual evidence does OWCP use to determine a covered Part E employee's average annual wage?

(a) OWCP may rely on annual or quarterly wage information reported to the Social Security Administration to establish a covered Part E employee's presumed average annual wage (see § 30.810) and the duration and extent of any years of wage-loss that are compensable under Part E of the Act (see § 30.811). OWCP may also rely on other probative evidence of a covered Part E employee's wages, and may ask the claimant for additional evidence needed to make this determination, if necessary. For the purposes of making these two types of determinations, OWCP will consider all monetary payments that the covered Part E employee received as wages (see § 30.801(g)).

(b) A claimant who disagrees with the evidence OWCP has obtained under paragraph (a) of this section and alleges a different average annual wage for the covered Part E employee, or that there was a greater duration or extent of wage-loss, may submit records that were produced in the ordinary course of business due to the employee's employment to rebut that evidence, to the extent that such records are determined to be authentic by OWCP. The average annual wage and/or wage-loss of the covered Part E employee will

then be determined by OWCP in the exercise of its discretion.

■ 68. Amend § 30.810 by revising paragraphs (a) through (d) to read as follows:

§ 30.810 How will OWCP calculate the average annual wage of a covered Part E employee?

* * * * *

(a) Aggregate the wages for the 36 months that preceded the trigger month, excluding any month during which the employee was unemployed;

(b) Add any additional wages earned by the employee during those same months as evidenced by records described in § 30.807;

(c) Divide the sum of paragraphs (a) and (b) of this section by 36, less the number of months during which the employee was unemployed; and

(d) Multiply this figure by 12 to calculate the covered Part E employee's average annual wage.

■ 69. Amend § 30.811 as follows:

■ a. Revise paragraph (a);

■ b. Remove paragraph (b); and

■ c. Redesignate paragraphs (c) and (d) as paragraphs (b) and (c), respectively.

The revision reads as follows:

§ 30.811 How will OWCP calculate the duration and extent of a covered Part E employee's initial period of compensable wage-loss?

(a) To determine the initial calendar years of wage-loss, OWCP will use the evidence it receives under §§ 30.805 through 30.807 to compare the calendar-year wages for the covered Part E employee, as adjusted, with the average annual wage determined under § 30.810 for each calendar year beginning with the calendar year that includes the trigger month, and concluding with the last calendar year of wage-loss prior to the submission of the claim or the

calendar year in which the employee reached normal retirement age (as defined in § 30.801(b)), whichever occurred first.

* * * * *

■ 70. Amend § 30.901 by revising paragraphs (a) and (b) to read as follows:

§ 30.901 How does OWCP determine the extent of an employee's impairment that is due to a covered illness contracted through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate?

(a) OWCP will determine the amount of impairment benefits to which an employee is entitled based on one or more impairment evaluations submitted by physicians. An impairment evaluation shall contain the physician's opinion on the extent of whole person impairment of all organs and body functions of the employee that are compromised or otherwise affected by the employee's covered illness or illnesses, which shall be referred to as an "impairment rating."

(b) In making impairment benefit determinations, OWCP will only consider medical reports from physicians who are certified by the relevant medical board and who satisfy any additional criteria determined by OWCP to be necessary to qualify to perform impairment evaluations under Part E, including any specific training and experience related to particular conditions and other objective factors.

* * * * *

■ 71. Revise § 30.902 to read as follows:

§ 30.902 How will OWCP calculate the amount of the award of impairment benefits that is payable under Part E?

(a) OWCP will multiply the percentage points of the impairment rating by \$2,500 to calculate the amount of the award.

(b) An employee's impairment rating may be comprised of multiple impairments of organs and body functions due to multiple covered illnesses. If an impairment award is payable based on a whole person impairment rating in which at least one of the impairments is subject to a reduction under §§ 30.505(b) and/or 30.626, OWCP will reduce the impairment award proportionately.

■ 72. Amend § 30.908 by revising paragraphs (b) and (c) to read as follows:

§ 30.908 How will the FAB evaluate new medical evidence submitted to challenge the impairment determination in the recommended decision?

* * * * *

(b) The employee shall bear the burden of proving that the additional impairment evaluation submitted is more probative than the evaluation relied upon by the district office to determine the employee's recommended impairment rating.

(c) If an employee submits an additional impairment evaluation that differs from the impairment evaluation relied upon by the district office, the FAB will review all relevant evidence of impairment in the record, and will base its determinations regarding impairment upon the evidence it considers to be most probative. The FAB will determine the impairment rating after it has evaluated all relevant evidence and argument in the record.

Signed at Washington, DC, this 28th day of January, 2019.

Julia K. Hearthway,

Director, Office of Workers' Compensation Programs.

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