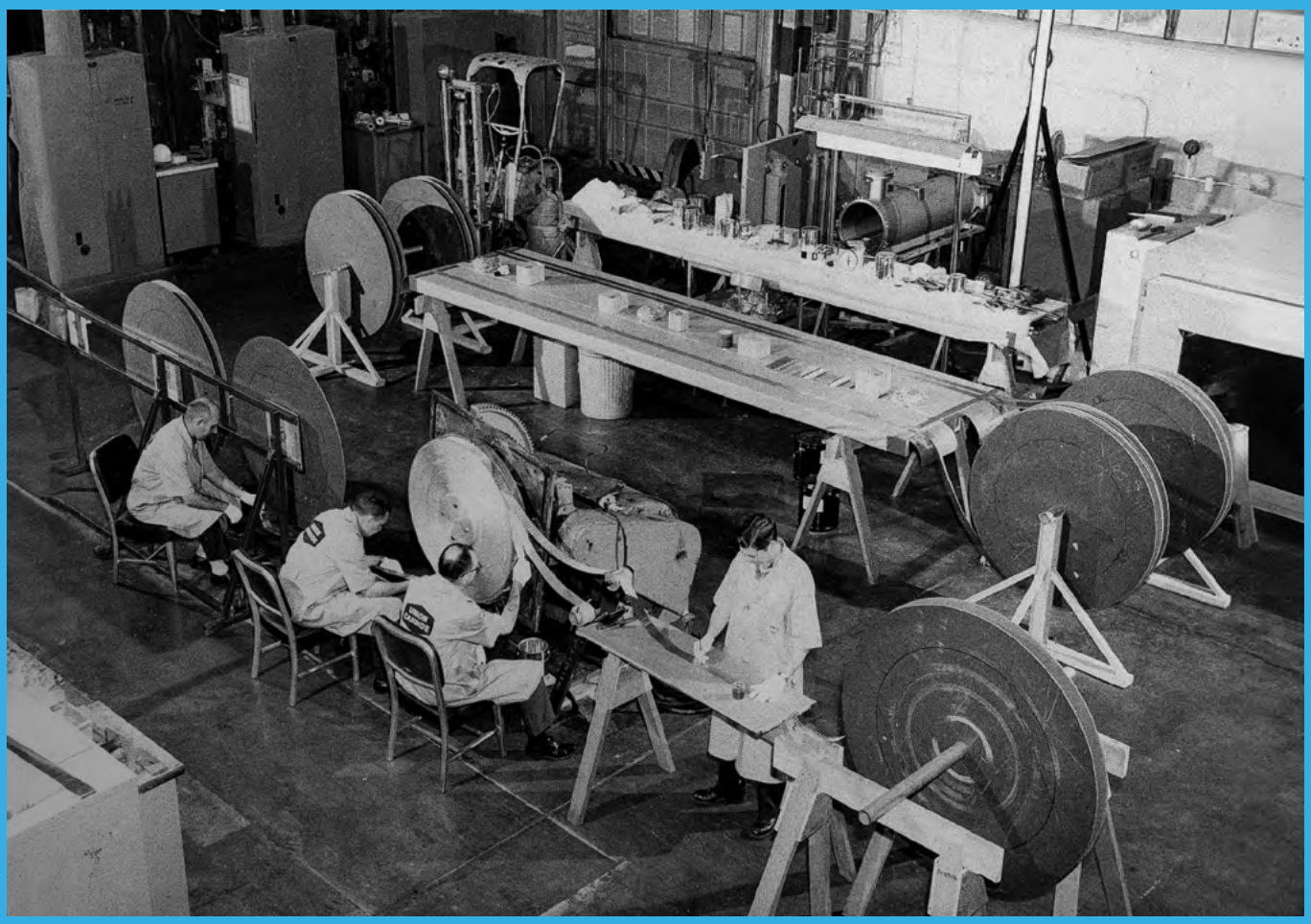
OFFICE OF THE OMBUDSMAN FOR THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM

2023 ANNUAL REPORT TO CONGRESS



OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Cover Photo: Study of magnetic fields by Paducah Gaseous Diffusion Plant workers.
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U.S. Department of Labor

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

July 30, 2024

The Honorable Kamala D. Harris
President
United States Senate
Washington, DC 20510

Dear Madam President:

I am pleased to present the 2023 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Amanda M. Fallon
Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

U.S. Department of Labor

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

July 30, 2024

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Johnson:

I am pleased to present the 2023 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Amanda M. Fallon
Ombudsman for the Energy Employees
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Enclosure

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PREFACE TO THE REPORT

In this Annual Report to Congress, the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (Ombuds) sets forth the complaints, grievances, and requests for assistance received during calendar year 2023, and provides an assessment of the most common difficulties encountered by claimants and potential claimants in that year. However, before addressing the complaints, grievances and requests for assistance received in 2023, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in 2023 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA):

- DEEOIC published two updates, Version 7.1 (March 15, 2023) and Version 8.0 (November 17, 2023) of the EEOICPA Procedure Manual (PM). The changes to the PM included:

  - Chapter 11.7(c) – Initial Development, Obtaining Former Worker Program (FWP) Records, updated to make reference to relevant websites for each FWP that can potentially assist with collection of claim evidence. (Version 7.1).

  - Chapter 15.11(e) – Establishing Toxic Substance Exposure and Causation, Exposure levels used by the Industrial Hygienist (IH), modified to incorporate language communicated in EEOICPA Bulletin No. 23-02, Industrial Hygiene Reporting of Exposure Levels. (Version 7.1). Bulletin 23-02 modified how IH staff are to characterize toxic substance exposures to eliminate reference to exposures that occur withing regulatory standards. IH characterization of exposure will describe a level of exposure given the assessment of available employee-specific evidence and application of the professional judgment of the certified IH. (Bulletin 23-02, October 24, 2022).

  - Chapter 18.12(c-d) – Silicosis Employment and Exposure Criteria, Part B, updated to incorporate EEOICPA Bulletin No. 23-04, Silicosis Employment and Exposure Criteria Under Part B for the Nevada Test Site. (Version 7.1). According to Bulletin 23-04, DEEOIC recently determined that since the unilateral moratorium on nuclear weapons testing went into effect in 1992, the mining of tunnels related to noncritical atomic weapons testing experiments has continued through the present at the Nevada Test Site. Accordingly, DEEOIC updated the Part B silicosis procedure to remove the reference that tunnel work had to occur prior to the 1992 moratorium. (Bulletin 23-04, February 27, 2023).

  - Chapter 29.5(n) – Ancillary Medical Benefits, Marijuana (cannabis) Reimbursement Policy, modified to address an exception for Food and Drug Administration (FDA) approved cannabis-derived and synthetic cannabis-related drug products. (Version 7.1).

- Chapter 33.3 – Compensation Payments, edited to include language regarding the ability to submit an EN-20 (Acceptance of Payment Form) electronically through the Energy Document Portal (EDP). (Version 7.1).
- Chapter 1 – Definitions, A Second Opinion (SECOP) Examination, edited to communicate an updated definition that aligns with guidance provided in EEOICPA Bulletin 23-06 – Directed Medical Examinations.[1] (Version 8.0). The updated definition states that a SECOP examination becomes necessary when the Claims Examiner or Medical Benefits Examiner concludes that the claimant's initial medical opinion is not well-rationalized and thus is insufficient for reaching an adjudication decision and, that an in-person examination is the appropriate mechanism for obtaining a second, independent medical opinion.
- Chapter 21.4(c) – Impairment Ratings, General Requirements for Impairment Ratings, Maximum Medical Improvement (MMI), modified to add a new section (3) that discusses that a claimant's eligibility for an impairment award is not extinguished while awaiting an organ transplant. (Version 8.0).
- Chapter 21.6(b) – Impairment Ratings, Impairment Ratings by the Employee's Choice Physician, Scheduling an Appointment with the Selected Physician, updated to include a new procedure for handling of claimant delays in scheduling or obtaining an impairment rating appointment with their chosen physician. (Version 8.0).
- Chapter 30.9 – Issuing Recommended Decision (RD) to Deny or Reduce Authorized Home and Residential Health Care (HRHC), updated to ensure impacted providers are provided a copy of all decisions related to medical benefits. (Version 8.0).

- DEEOIC hosted nine virtual webinars in 2023 and the following in-person outreach events:
  - Joint Outreach Task Group Events in Las Vegas and Pahrump, NV (February),
  - Joint Outreach Task Group Event in Oak Ridge, TN (April),
  - Joint Outreach Task Group Event in Hanford, WA (May),
  - Joint Outreach Task Group Events in Kayenta, AZ, Shiprock, NM, and Farmington, NM (June),
  - Joint Outreach Task Group Event in Hamilton, OH (August), and
  - Joint Outreach Task Group Event in Arvada, CO (September).

In addition, we wish to acknowledge the many instances throughout the year where members of DEEOIC staff assisted claimants and the Ombuds in resolving matters brought to their attention.

[1]. Bulletin 23-06 – Directed Medical Examinations, noted the use of Contract Medical Consultants in lieu of directed medical examinations during the COVID-19 public health emergency. Bulletin 23-06 communicated that with the end of the COVID-19 public health emergency, DEEOIC intends to resume the use of directed medical examinations, when necessary, to assist in the resolution of claims for compensation benefits involving Home and Residential Health Care and Durable Medical Equipment.

INTRODUCTION

Section 7385s-15 of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, requires the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program to submit an annual report to Congress. See 42 U.S.C. § 7385s-15. In this annual report, we are to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and (b) an assessment of the most common difficulties encountered by claimants and potential claimants during that year. See 42 U.S.C. § 7385s-15(e). The following is the Office of the Ombudsman's annual report for calendar year 2023.

I. An Overview of the Energy Employees Occupational Illness Compensation Program Act (the EEOICPA)

Congress enacted the EEOICPA as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, on October 30, 2000. The purpose of the EEOICPA is to provide for timely, uniform, and adequate compensation of covered employees, and where applicable, survivors of such employees, suffering from illnesses incurred by such employees in the performance of duty for the Department of Energy (DOE) and certain of its contractors and subcontractors. 42 U.S.C. § 7384d(b).

In enacting this program, Congress recognized that:

1. Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapon production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.
2. Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay.
3. Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the Department of Energy and its predecessor agencies have been, since World War II, self-regulating with respect to nuclear safety and occupational safety and health. No other hazardous Federal activity has been permitted to be carried out under such sweeping powers of self-regulation.

See 42 U.S.C. § 7384(a)(1), (2), and (3).

As originally enacted in October 2000, the EEOICPA contained two parts, Part B and Part D. Part B, which is administered by the Department of Labor (DOL), provides the following compensation and benefits:

- Lump-sum payment of $150,000 and the payment of medical expenses (for the accepted illness starting as of the date of filing) for:

  a) Employees of the DOE, as well as its contractors, subcontractors, and employees of atomic weapons employers (AWE) with radiation-induced cancer if: (a) the employee developed cancer after working at a covered facility; and (b) the cancer is "at least as likely as not" related to covered employment.[2]
  b) Employees who are members of Special Exposure Cohort (SEC) and who develop one of the specified cancers outlined in 42 U.S.C. § 7484l (17).[3]
  c) All federal employees, as well as employees of the DOE, its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and who develop Chronic Beryllium Disease (CBD).
  d) Employees of the DOE or its contractors and subcontractors who worked at least 250 days during the mining of tunnels at underground nuclear weapons test sites in Nevada or Alaska and who develop chronic silicosis.

  If the employee is no longer living, eligible survivors of the employees listed above are entitled to $150,000 in lump sum compensation under Part B.

- Uranium miners, millers, and ore transporters, or their survivors, who are awarded $100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note, are entitled under the EEOICPA to a lump-sum payment of $50,000 and to medical expenses for the accepted illness.

- All federal employees, as well as employees of the DOE, as well as its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and whose claims for beryllium sensitivity are accepted under Part B are entitled to medical monitoring to check for the development of CBD.

Part D of the EEOICPA required the DOE to establish a system by which DOE contractor employees and their eligible survivors could seek assistance in obtaining state workers' compensation benefits if a Physicians Panel determined that the employee sustained an accepted illness as a result of work-related exposure to a toxic substance at a DOE facility. On October 28, 2004, Congress abolished Part D and created Part E as Subtitle E of Title XXXI of the

[2] An atomic weapons employer is an entity, other than the United States, that: (A) processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining, and milling; and (B) is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program [EEOICPA]. See 42 U.S.C. § 7384l(4).
[3] If a claimant qualifies for inclusion in a SEC class and develops one of the specified cancers, that claimant receives compensation for that specified cancer without the completion of a radiation dose reconstruction by the National Institute for Occupational Safety and Health, and without a determination by DOL of the probability of causation that the cancer was caused by exposure to radiation at a covered facility.

Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178 (October 28, 2004). Part E is administered by DOL.

The compensation and benefits allowable under Part E are as follows:

- DOE contractor and subcontractor employees who develop an illness due to exposure to toxic substances at certain DOE facilities are entitled to medical expenses and may receive monetary compensation of up to $250,000 for impairment and/or wage-loss.
- Eligible survivors of DOE contractor and subcontractor employees receive compensation of $125,000 if the employee's death was caused, contributed to, or aggravated by the covered illness. If the employee had between 10 and 19 years of wage-loss, the survivor receives an additional $25,000. If the worker had 20 or more years of wage-loss, the survivor receives an additional $50,000.
- Uranium miners, millers, and ore transporters are eligible for medical benefits, as well as up to $250,000 in monetary compensation for impairment and/or wage-loss if they develop an illness as a result of toxic exposure at a facility covered under Section 5 of RECA. (These uranium miners, millers, or ore transporters are eligible for compensation and medical benefits under Part E even if they did not receive compensation under RECA).

DOL has primary authority for administering Part B and Part E of the EEOICPA. However, other federal agencies are also involved with the administration of this program.

- The DOE ensures that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or the National Institute for Occupational Safety and Health (NIOSH) with information related to individual claims such as employment verification and exposure records; (2) supporting DOL, NIOSH, and the Advisory Board on Radiation and Worker Health with large-scale records research and retrieval efforts at various DOE sites; (3) conducting research, in coordination with DOL and NIOSH, on issues related to covered facility designations; and (4) hosting the Secure Electronic Records Transfer (SERT) system, a DOE hosted environment where DOL, NIOSH, and DOE can securely share records and data.
- NIOSH conducts activities to assist claimants and supports the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: (1) developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; (2) developing methods to estimate worker exposure to radiation (dose reconstruction) and using those methods to prepare dose reconstructions for claimants; (3) recommending that classes of workers be considered for inclusion in a SEC class; and (4) providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and Special Exposure Cohort (SEC) petitions.

- The Ombudsman to NIOSH helps individuals with a variety of issues related to the SEC petition process and the dose reconstruction process. The Ombudsman to NIOSH also conducts outreach to promote a better understanding of the EEOICPA, as well as the claims process.

II. The Office of the Ombudsman

Public Law 108-375, which was enacted on October 28, 2004, also established within the DOL an Office of the Ombudsman. The National Defense Authorization Act for 2021, which became effective January 1, 2021, amended the EEOICPA to provide for the permanent extension of the Office of the Ombudsman within DOL. Public Law 116-283, § 3145 (Jan. 1, 2021). The EEOICPA outlines four (4) specific duties for the Office:

1. Provide information to claimants and potential claimants on the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits.
2. Provide guidance and assistance to claimants.
3. Make recommendations to the Secretary of Labor regarding the location of resource centers for the acceptance and development of EEOICPA claims.
4. Carry out such other duties as the Secretary specifies.

See 42 U.S.C. § 7385s-15(c).

The EEOICPA also requires the Office to submit an annual report to Congress which sets forth:

1. The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and
2. An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

See 42 U.S.C. § 7385s-15(e)(2).

Additionally, not later than 180 days after the submission to Congress of the annual report, the Secretary shall submit to Congress in writing, and post on the public Internet website of the Department of Labor, a response to the report that—

> (A) includes a statement of whether the Secretary agrees or disagrees with the specific issues raised by the Ombudsman in the report;
> (B) if the Secretary agrees with the Ombudsman on those issues, describes the actions to be taken to correct those issues; and
> (C) if the Secretary does not agree with the Ombudsman on those issues, describes the reasons the Secretary does not agree.

See 42 U.S.C. § 7385s-15(e)(4).

SUMMARY OF ISSUES AND RECOMMENDATIONS

1. **Effectiveness of Outreach Efforts:** The EEOICPA calls for eligible individuals, including covered employees and their families, to be informed of the compensation available under the program and provided assistance with the claims process. Over the past few years, the Ombuds has reported that direct mailings to potential claimants would be an effective and efficient method of informing potential claimants of the existence of the EEOICPA. We have observed increased participation at outreach events where the FWP Projects have utilized their former worker rosters to send invitations directly to potential claimants. Moreover, for those who do not reside near one of the eleven DEEOIC Resource Centers (RC) or near outreach event locations, direct mailings to former workers has the highest likelihood of success. Therefore, given the history of collaboration between DOE and DEEOIC in sending outreach event invitations to those on the FWP Projects rosters, the Ombuds recommends that DOE and DEEOIC expand their efforts by sending direct mailings to all former DOE workers informing them of the existence of the EEOICPA.

   Likewise, many surviving spouses and children of former workers remain unaware of the EEOICPA, particularly when the employees worked at AWE facilities or for Beryllium Vendors. Dynamic outreach strategies are needed to inform more individuals about the EEOICPA, as evidenced by informal encounters with individuals in communities near covered facilities who were still unaware of the program. Feedback from outreach events underscored the need to hold events in new locations, closer to local community hubs. Likewise, continued, and enhanced utilization of newspaper and radio advertisements is recommended, particularly where potential language barriers have been identified. Targeted outreach near AWE facilities and Beryllium Vendors is needed, as many family members of former workers are unaware of their loved one's employment history and their own potential eligibility for benefits under the EEOICPA. Such efforts help ensure broader awareness and understanding of potential benefits available under the EEOICPA.

2. **Issues Regarding the Claims Process and Decisions:**

   A. **Developing Evidence and Policy Updates:** We were contacted by claimants, ARs, and healthcare providers who had questions about development letters received from DEEOIC. Many had difficulties understanding, in a practical way, the information being sought in a development letter. Our recommendation is for DEEOIC to use plain language in development letters and personalize them for each claim. An explanation or example of the type of information or evidence being sought would help claimants understand what was being asked of them. Furthermore, DEEOIC should identify evidence already acquired, inform claimants of the relevance of the evidence, and that they may request copies.

In 2023, we continued to receive complaints that as a result of claims being distributed nationally instead of regionally, there were inconsistencies in the evaluation of evidence submitted in support of claims. In some cases, when claimants and ARs submitted employment evidence that they understood was responsive to development letters from a district office, they became concerned when the district office informed them additional evidence was needed. Our recommendation is for DEEOIC to provide additional information and training to district offices on the specific areas of inconsistency that have been identified among the district offices as it relates to covered facilities previously outside their jurisdiction.

Another area of concern involved the frequent updates to DEEOIC policies. When policy updates included substantive changes, it is important for DEEOIC stakeholders to directly inform claimants in a timely manner. For instance, it would have been beneficial for those with previously denied hearing loss claims to be directly informed of the updated hearing loss policy. Likewise, it would have been beneficial for those filing new hearing loss claims in 2023 to be informed of the updated hearing loss policy. When a previously denied claim is impacted by a policy update, individuals who believe they are impacted by the policy change can request the reopening of their claim in order to potentially have it re-adjudicated. It is our understanding that DEEOIC reviewed some previously denied hearing loss claims, but we encountered individuals in 2023 with denied hearing loss claims who were unaware of the policy update and were interested in assessing the evidence in their case under the updated hearing loss policy. Our recommendation is for DEEOIC to directly inform claimants with previously denied claims that there has been a policy update that may impact their claim. We also believe more outreach efforts should be focused on providing all claimants, including those with previously denied claim, clear and current guidance explaining exactly what type of evidence they need in order for DEEOIC to approve their claim.

B. Difficulties Proving a Claim: In 2023, we heard from claimants and ARs who described the process of getting a new claim approved under Part E of the EEOICPA as one that has seemed to grow more challenging. Concerns centered around DEEOIC's requirement of "significant exposure" under Part E, as well as the implementation of changes to the way in which contractor IHs describe the exposure levels encountered by claimants. Other concerns involved the information DEEOIC shared with, as well as the quality of the reports prepared by, contractor IHs. We also received complaints regarding the scrutiny given to reports prepared by claimants' treating physicians, as well as the quality of reports prepared by CMCs.

The EEOICPA and regulations use the term "significant" to describe whether a toxic substance exposure was a factor in aggravating, contributing to, or causing the illness, not to characterize the level of toxic substance exposure. As a result, the question has been raised and our office has been requested to point to the requirement that all claimants must prove a "significant exposure" to a toxic substance in order to potentially qualify for benefits under Part E.

ARs and claimants also took issue with the addition of the "more than incidental, less than significant" level of toxic exposure in IH assessments. The specific complaint was that the addition of a sixth level of potential toxic exposure for IHs to use when characterizing levels of exposure was unclear and somewhat confusing. Claimants and ARs complained that they did not have sufficient information to understand the various levels of exposure that IHs were required to apply to their claims. And if they did not fully understand the various levels of exposure, it was even more difficult to challenge them when claimant believed the IH assessment was not accurate. We encourage DEEOIC to continue working with the Board to enhance the IH process and bring greater transparency to the use of the term "significant" and the toxic substance exposure levels reported by IHs.

Moreover, claimants and ARs have consistently complained that while there were radiation monitoring programs at DOE facilities, there were not robust chemical monitoring programs. They objected to the assumption that although they had the potential for significant exposures to a particular toxic substance, because the exposure occurred after the mid-1990s, they must now produce evidence of a "workplace exposure violation or incident" in order for exposures to be considered significant by the IH. They argued that low level exposures to some toxic substances can play a significant factor in aggravating, contributing to, or causing certain illnesses, thereby making it unreasonable to hold them to this higher standard. The concern expressed to our office was that by mandating this higher level of toxic exposure evidence for all Part E claims after the mid-1990s, claimants who worked after that time period would effectively be prevented from proving their claims unless they produce documentation of a workplace exposure violation or incident.

Claimants who worked after the mid-1990s then found it problematic when the absence of toxic exposure records in their employment file was equated by contractor IHs to a finding of no significant toxic substance exposures. The source of the language used by contractor IHs is uncertain, but it consistently appears in almost all IH reports evaluating toxic exposures after the mid-1990s. Our recommendation is for DEEOIC to advise contractor IHs that the absence of records documenting a workplace exposure violation or incident cannot be presumed to mean the absence of any toxic substance exposures after the mid-1990s. However, in the event DEEOIC has documentation to support this assumption, such information should be made publicly available on the DEEOIC website.

Most Part E claims required the employee's treating physician to submit documentation in support of the claim, which their physicians were often hesitant to do. We heard from claimants that not only was it difficult for them to get the requested medical report from their treating physician, but in many cases DEEOIC found that the physician's documentation was insufficient. When this occurred, either DEEOIC or the claimant had to go back to the treating physician and request additional information to support the claim. If a claimant's physician was unable to provide the requested evidence, DEEOIC usually referred the claim to a contract medical consultant (CMC) to provide an opinion. Claimants and ARs complained

that DEEOIC often found CMC opinions to be "well-rationalized" and routinely accepted them over the opinion of the treating physician. The Ombuds recommends specific outreach to claimants and treating physicians focused on providing clear and current guidance regarding the type of evidence needed to prove their claim. This can be accomplished through both development letters and targeted outreach.

C. Issues Involving Expedited Claims Processing for Terminal Claimants: ARs and family members also contacted our office to request assistance and share complaints regarding the inconsistent process to have claims for terminally ill claimants expedited. They reported inconsistencies in the types of medical evidence they were asked to submit in order to have the claim approved for expedited processing via a terminal designation. DEEOIC policy indicates that the medical evidence must support that the claimant is end-stage terminal or that death is imminent. Yet, there is little clarity regarding what constitutes sufficient medical evidence to meet the DEEOIC policy, and it appears the decision is left to the subjective discretion of DEEOIC staff. Moreover, DEEOIC has not defined the time frame by which DEEOIC staff are to make a determination or how the claimant's family is informed of the determination. There is a pressing need to establish clear guidelines regarding the medical evidence sufficient for a claim to be designated terminal, as well as standardized procedures to ensure timely and equitable processing of these claims. Claimants and their families should be provided clear expectations regarding when they will receive a response to their request from DEEOIC. The Ombuds recommends DEEOIC consider implementing a form of centralized oversight to assess how individual requests for expedited processing are to be handled.

3. Challenges Obtaining Medical Treatment: Difficulties in obtaining medical treatment remained on ongoing concern in 2023. Claimants and ARs expressed frustration, particularly those residing in rural areas, in finding medical and home healthcare providers in their area. Many had to travel extreme distances in order to obtain the care they need. Claimants living in suburban and urban areas had challenges identifying providers who accepted payment from DEEOIC or learned that their treating physicians no longer accepted payment from DEEOIC. Healthcare providers also reached out to our office seeking assistance when DEEOIC did not respond to authorization requests to treat claimants or remained in a pending status for extended periods of time.

A. Challenges in Finding a Healthcare Provider: In 2023, there were consistent concerns raised by claimants regarding the challenges of finding healthcare providers willing to accept payment from DEEOIC. Despite efforts by DEEOIC RCs to assist claimants, many still struggled to find healthcare providers. Several reasons contributed to these difficulties:

1. Enrolled providers stopped accepting DEEOIC claimants as patients.
2. Providers refused to enroll with DEEOIC.
3. Lack of clarity in provider search portals, where sometimes only institutional names were listed instead of individual physicians.
4. Providers opted out of appearing in the Provider Search portals.
5. Limited availability of healthcare providers in certain areas, especially rural regions.

The Ombuds recommends that DEEOIC conduct greater outreach to healthcare providers to assess the issues that prevented them from enrolling and staying enrolled with DEEOIC. With a better understanding of the specific reasons why healthcare providers were unwilling to enroll or to accept the medical benefits card, perhaps more concrete steps can be taken to keep those healthcare providers enrolled.

B. Challenges with the Medical Authorization Process: Claimants are frequently required to obtain prior authorization from DEEOIC for various medical treatment and services. However, delays and miscommunication in the authorization process were major concerns in 2023. Claimants and providers also experienced challenges in receiving a response from DEEOIC regarding authorization requests. The Ombuds specifically identified the following concerns:

1. Lack of communication and failure to provide expectations regarding the status of authorization requests.
2. Lack of acknowledgment of time-sensitive medical needs, leading to delays in treatment.
3. Instances where claimants believe DEEOIC influenced physicians to recommend lower levels of care without informing claimants.
4. Challenges faced by healthcare providers due to delays in authorization, impacting their ability to serve patients effectively.

The Ombuds recommends that DEEOIC pay more attention to efficiently and effectively communicate with stakeholders during the medical authorization process. If a request is pending for an extended period of time due to a specific reason, the claimant and provider should be informed of the reason in a timely manner. And if delays are the result of a workload issue, for those requests that have been pending beyond a reasonable period of time, the claimant should have the option to seek expedited review through a clear, dedicated process.

4. Difficulties with Payment of Medical Bills and Expenses: For claimants with a DEEOIC Medical Benefits Card, there have been an array of issues that delayed, or prevented full reimbursement of, medical bills related to their accepted illness(es). In addition to claimants, healthcare providers and other service providers reported a variety of issues involving the DEEOIC bill payment process. The scope of those impacted by medical billing issues varied from individual claimants to large healthcare organizations.

The issues ranged from delayed responses to billing inquiries, to more technical issues such as medical bill coding issues. An increasingly common issue reported in 2023 was that of healthcare providers directly submitting bills to a claimant's private health insurance company or Medicare instead of DEEOIC. This usually occurred when bills remained unpaid for an extended period of time. Additionally, for surviving family members of claimants, obtaining payment of outstanding medical bills and out-of-pocket expenses presented their own set of challenges.

Claimants consistently found themselves caught between DEEOIC claims staff, RC staff, healthcare providers, pharmacies, bill pay contractors and others as they tried to get their medical bills

paid or prescriptions filled. In these situations, claimants usually had little to no knowledge regarding how to identify the issues or get them resolved. The Ombuds recommends DEEOIC create a process that involves having a dedicated person or group to address outstanding medical bills and requests for reimbursement that have not been provided a response within 60 days from the date of submission of the bill/request.

Moreover, claimants were often anxious to have these bill-pay issues quickly resolved because they wanted to prevent these issues from impacting their credit and/or impacting the relationship with their provider. Thus, to avoid the frustrations that arise with these situations, more effort needs to be undertaken to ensure direct communication between DEEOIC, contractors, and providers to resolve these matters promptly. Additionally, many claimants and healthcare providers report being unaware of the public email address for medical bill inquiries, which is DEEOICbillinquiries@dol.gov. Our recommendation is for this email address to be posted prominently on the DEEOIC homepage, as well as with the documentation accompanying the issuance of a new DEEOIC Medical Benefits card.

In mid-2023, a new company, myMatrixx, began providing Pharmacy Benefit Management (PBM) services for DEEOIC claimants. As a result, claimants with accepted medical conditions were sent new medical benefits cards in order for their pharmacy bills to be processed by myMatrixx. We received feedback from claimants that the transition to myMatrixx was challenging because many pharmacies were unaware of the change and did not know how to bill myMatrixx. These challenges almost always resulted in claimants having their prescription medication delayed or required them to find another way to pay for their medication. Given that the demand for timely processing of pharmacy bills has increased year over year, greater communication and assistance to claimants and healthcare providers, including pharmacies, is required in order to avoid the confusion and delays.

Finally, when an employee's claim has been accepted and there are outstanding medical expenses at the time of their passing, DEEOIC issues reimbursement checks made payable to the estate of the employee. However, surviving family members have complained of a lack of flexibility to have checks issued to a trust established by the employee prior to their passing, or to surviving family members when the cost to set up an estate would exceed or significantly limit the value of the reimbursement check. Claimants have shared that setting up an estate is complex, inefficient, and expensive. Because trusts are widely used legal tools, the Ombuds recommends that, as requested and with proper documentation, DEEOIC issue reimbursement checks made payable to the trusts of the deceased employees. With respect to employee who pass away with assets that do not meet the minimum threshold for creating an estate, DEEOIC should exercise its discretion to issue the reimbursement check made payable to the employee surviving spouse and/or any other survivors as required by relevant state laws.

5. **Customer Service**: During conversations with claimants they either shared with us or it became apparent during the course of the conversation that they did not have a clear understanding of the DEEOIC claims process or the roles of the DEEOIC staff members

they communicated with during the process. Claimants also found it frustrating when they were unable to speak directly with their assigned claims examiner, hearing representative, or medical benefits examiner. Many claimants were also unaware of their ability to access some of the documents in their claim file and upload documents directly to their claim file electronically via the Employees' Compensation Operations & Management Portal (ECOMP) and Energy Document Portal (EDP), respectively.

A. Confusion Surrounding Roles of Individuals in DEEOIC: A common refrain from claimants, authorized representatives, and medical providers was their inability to discern the roles and responsibilities of different personnel within DEEOIC, as well as the various DEEOIC contractors. For instance, claimants often encountered difficulties distinguishing between Resource Center staff, CEs, HRs, and MBEs, leading to confusion regarding whom they had spoken with and which person in which role had the authority to make a decision in their claim. It is important for EEOICPA stakeholders to clearly understand who they are speaking with, what office the person is assigned to, and the person's role in the EEOICPA claims process. It would be helpful if all calls were answered in a way that identified the location and role of the person the caller had reached, as well as how to contact that same person again for follow up assistance.

B. Communication, Deadlines, and Expectations: To ensure that claims are adjudicated efficiently, DEEOIC has established deadlines for claimants to submit evidence and respond to communication from CEs, HRs, and MBEs. However, stakeholders have noted that some deadlines for them to submit evidence have been shortened over time. Claimants also complained of inadequate communication regarding their claim status, and delays in processing their claims. Lack of communication and delays resulted in claimants expressing uncertainty regarding the status of their claim. A lack of clear expectations regarding the next steps in the claims process likewise exacerbated their concerns. Going forward, development letters should inform claimants and doctors of the total number of days they will be afforded to submit evidence. Development letters seeking employment documentation should also inform claimants that DEEOIC has already requested employment records from DOE. Claimants should be informed at the outset of their claim and in development letters that they can request copies of any/all records from their claim. Utilization of DEEOIC online portals, or email, for sending and receiving electronic messages with DEEOIC staff is recommended to improve communication and accessibility for EEOICPA claimants and other stakeholders. Likewise, enhanced customer service for those who experience difficulties accessing and using the DEEOIC online portals would be beneficial.

C. Delays: Delays in claim processing emerged as a significant issue, impacting not only claimants but also their families and healthcare providers. Claimants and authorized representatives commented that they experienced delays in receiving recommended decisions, a final decisions, and/or authorizations for medical treatment. Furthermore, when stakeholders reached out to the Ombuds for guidance and assistance, the requirement that they sign a signed Privacy Act Waiver before information could be shared with the Ombuds about their claim further slowed claimants ability to obtain information and assistance.

Moreover, while DEEOIC has set specific deadlines for claimants to provide information and documentation, it did not appear that DEEOIC was required to communicate with them regarding delays in the processing of their claims. One claimant specifically asked whether DEEOIC was required to inform them that the determination on their claim for medical benefits was delayed and why. We were unable to point claimant to any guidance indicating DEEOIC was required to inform them of delays in the processing of their claim, nor were we able to direct claimants to a single point of contact to register their concern about a delay. Instead, per DEEOIC policy, we could only advise them to call a supervisor in the DEEOIC office handling their claim.

When DEEOIC is aware that a claim is taking longer than normal to process, every effort should be made to communicate with the claimant or AR to acknowledge the delay and provide an expectation regarding when action on the claim will proceed. Likewise, claimants and ARs should have a specific point of contact to communicate with when they are unable to reach their assigned examiner.

D. Behavior of DEEOIC Staff: When claimants reported negative encounters with DEEOIC staff, it usually occurred during conversations where they were already asking questions or seeking assistance with other matters from our office. Some mentioned feeling dissatisfied with the customer service they received, while others reported rude or insensitive behavior. It is also apparent that a very small number of individuals can have broad impact upon the customer service provided to DEEOIC stakeholders. Following such instances, claimants were often reluctant to complain to the staff member's supervisor for fear of retaliation or an unfavorable decision. This underscored the lack of recourse for individuals who encounter such behavior, emphasizing the need for a transparent and accountable process for lodging complaints and seeking resolution. A publicly stated process by which claimants and EEOICPA stakeholders can lodge specific complaints without fear of retaliation, and with an understanding of when and how they will receive a response from DEEOIC, is necessary to rebuild confidence in the program for those who experience such behavior. In conclusion, it should be noted that a single customer service issue can impact DEEOIC customers in multi-faceted ways. Greater transparency, better communication, and responsiveness would serve to significantly ameliorate some of these issues.

TABLES

Background

The Office of the Ombudsman is required to submit to Congress an Annual Report that sets forth: (1) the number and types of complaints, grievances, and requests for assistance that we received in the preceding year, and (2) an assessment of the most common difficulties encountered by claimants and potential claimants received in the preceding year. 42 U.S.C. § 7385s-15(e)(2).

In addition to being contacted by individuals via telephone, email, facsimile, and written correspondence, the Office attended 20 in-person outreach events in 2023. Most of these events were well-attended and therefore the ability to record each conversation held with attendees was often challenging. At each of these events we heard from a variety of people who interacted with the agencies charged with implementing the EEOICPA, including potential claimants, claimants, authorized representatives (AR), and health care providers. In-person meetings afforded us the time to not only speak with individuals and respond to their questions and concerns but review any documents they brought to the events. During these conversations, additional questions, concerns, and requests for assistance were frequently raised. An added benefit of attending in-person outreach events was learning of issues or concerns relevant to a particular area of the country.

Some of the individuals we spoke with during 2023 articulated their questions and concerns to us in their own unique way. Thus, identifying the type or nature of a complaint was sometimes challenging since individuals rarely expressed themselves using the terms and phrases commonly utilized by those who administer the program. In the table that follows, we endeavored to capture not only the concerns or requests that prompted the individual to contact us, but also the questions and issues raised during those conversations.

TABLE 1
COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE

COMPLAINTS AND REQUESTS FOR ASSISTANCE	NUMBER
Authorized Representative	**7**
Causation/Burden of Proof	**388**
Affidavits (Exposures)	5
CMC (Contract Medical Consultant)	18
DOE/DAR Records	12
IH (Industrial Hygienist)	26
NIOSH Dose Reconstruction	12
Part B Causation	37
Part E Causation	73
Presumptions (Exposures)	30
Scientific Studies	7
SEC (Special Exposure Cohort)	15
SEM (Site Exposure Matrices)	44
Specified Cancer	6
Toxic Exposure	62
Treating Physician/Claimant Medical	18
Weighing of Evidence	31
Claim Adjudication	**92**
Claim Development	28
DEEOIC Decisions & Waivers	12
FD Following Hearing & Review of Written Record	23
Letter Decisions	3
Recommended Decisions	13
Reconsideration Decisions	3
Remand Orders	6
Reopening Decisions	4
Covered Employment	**14**
AWE (Atomic Weapons Employer)	1
Beryllium Vendor	1

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TABLE 1, cont'd.

COMPLAINTS AND REQUESTS FOR ASSISTANCE	NUMBER
Covered Employment	3
DOE contractor employment	6
DOE Federal Employment	1
DOE subcontractor employment	2
Covered Illness	**184**
Beryllium Sensitivity	2
Cancer	33
CBD (Chronic Beryllium Disease)	12
Chronic Silicosis	4
Consequential Conditions	18
Non-Cancerous Conditions	61
Presumptive Illnesses	46
RECA 5 Illnesses	8
Customer Service	**231**
Behavior of DEEOIC Staff/Management	17
Delays	55
Problems with ECOMP	6
Problems with EDP (Energy Document Portal)	13
Request for status of claim	19
Telephone Communication Issues	35
Third-Party Exposure	2
Unaware Can Request Copy of File or Documents	21
Unaware of how to file a claim	3
Unsure Who to Contact for Assistance	60
Fiscal Issues	**7**
Coordination of Benefits (SWC Claim)	2
EN-20 Issues	2
Federal and State Taxes	2
Offset of Benefits (Tort Action/Lawsuit)	1
Impairment Benefits	**15**
Development of Medical Evidence	3

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TABLE 1, cont'd.

COMPLAINTS AND REQUESTS FOR ASSISTANCE	NUMBER
Multiple Illnesses	4
Subsequent Impairment Evaluations	8
Medical Benefits	**226**
Authorization/Reimbursement for Medical Travel	9
Consequential Illness Issues	31
DME (Durable Medical Equipment)	15
Finding a Health Care Provider	42
Home Health Care	48
Home Modifications	5
Pre-Authorization or Authorization for Treatment	47
Prescriptions	25
Terminal Status	4
Medical Bills	**186**
CNSI Billing Issues (Medical Bill Contractor)	23
Coding Issues	16
Health Care Provider Issues	56
Medicare/Private Health Insurance Reimbursement	33
Prescription Billing Issues	28
Out-of-Pocket Expense Reimbursement	30
Outreach	**24**
Unaware of EEOICPA	5
Unaware of how to file a claim	9
Outreach-Related	10
Survivor Claims	**7**
Biological Child	1
Election of Benefits	3
Part E Eligibility Issues	3
Wage-Loss Benefits	**1**
Wage-Loss Evidence	1
TOTAL	**1,382**

TABLE 2
CONTACTS BY FACILITY

In order to assist claimants, it is not always necessary to identify the facility where the worker was employed. Moreover, even when identifying the facility is necessary, this does not suggest any fault on the part of the facility. Rather, the intent of the Table of Facilities is to illustrate the reach of this program and the need for more outreach. Claimants who worked at facilities all across this country contact us with complaints, grievances, and requests for assistance. Some of the facilities in this Table employed large numbers of employees, while others employed smaller numbers. Some operated as covered facilities for many years, while others engaged in covered employment for a relatively brief period of time. Yet, regardless of the size of the facility or the number of years it operated as a covered facility, there are those who work, or once worked, at these facilities who have questions and concerns that need to be addressed.

FACILITY	NUMBER
Ames Laboratory	35
Area IV of the Santa Susana Field Laboratory	12
Canoga Avenue Facility	8
Coors Porcelain	1
De Soto Avenue Facility	8
Feed Materials Production Center (FMPC)	28
General Electric Company (Ohio)	2
General Steel Industries	1
Hanford	48
Iowa Ordnance Plant (Line 1 and Associated Activities)	16
Kansas City Plant	6
Kerr-McGee	1
Lawrence Livermore National Laboratory	1
Los Alamos National Laboratory	39
Mound Plant	16
Nevada Test Site	45
Oak Ridge Gaseous Diffusion Plant (K-25)	22
Oak Ridge National Laboratory (X-10)	8
Pacific Northwest National Laboratory	6
Pacific Proving Ground	1
Paducah Gaseous Diffusion Plant	12

table continued on next page

TABLE 2, cont'd.

FACILITY	NUMBER
Pantex Plant	3
Pinellas Plant	2
Portsmouth Gaseous Diffusion Plant	5
Rocky Flats Plant	59
Sandia National Laboratories	4
Savannah River Site	14
Speedring, Inc.	1
Tonopah Test Range	2
University of Denver Research Institute	1
Uranium Mill in Lowman	1
Uranium Mines	44
Waste Isolation Pilot Plant	2
Y-12 Plant	40
TOTAL	**494**

CHAPTER I.
EFFECTIVENESS OF OUTREACH EFFORTS

The DEEOIC is required to take appropriate actions to inform and assist covered employees who are potential claimants under the EEOICPA compensation program. See 42 U.S.C. § 7384v(b). Moreover, the DEEOIC has been tasked with informing individuals who are potential claimants of the existence of the EEOICPA. See 42 U.S.C. § 7384v(b). Over the years, one strategy successfully employed by DEEOIC to inform potential claimants of the existence of the EEOICPA has been by hosting in-person outreach events and participating in similar events hosted by other agencies.

In considering the effectiveness of these efforts to notify potential claimants of the EEOICPA, the types and locations of facilities where potential claimants work (or worked) is important. There are 383 covered facilities[4] throughout 43 states[5] with employment periods ranging from the start of the Manhattan Project in 1942 to the present. Of these, 165 are designated DOE facilities for whom the DOE potentially has employment rosters. Another 190 are designated AWE facilities and 78 are designated Beryllium Vendors.[6] While DEEOIC has hosted and participated in outreach events, there remains numerous locations near covered facilities where no in-person outreach has been conducted to date.

Likewise, our office has continued to encounter surviving spouses and children of former workers who were entirely unaware of the EEOICPA or that they could file claims for survivor benefits. Given the thousands of potential surviving spouses and children of former workers, it is not entirely clear what efforts have been made to specifically notify these individuals of the existence of the EEOICPA. It has also been raised that outreach efforts are needed for those who work (or worked) at AWE facilities, Beryllium Vendors, and facilities undergoing remediation work. In particular, individuals currently employed at such facilities should be notified of the EEOICPA.

A. Greater Collaboration Between the DEEOIC and the DOE Former Worker Projects

Over the past few years, the Ombuds has reported that direct mailings to potential claimants would be an effective and efficient method of informing potential claimants of the existence of the EEOICPA. While DEEOIC does not have lists or rosters of potential claimants, it is aware that DOE FWP Projects' conduct outreach via direct mailing to former DOE workers.[7] It is also

[4] DOE Covered Facilities database https://ehss.energy.gov/search/facility/.
[5] Ibid.
[6] Some facilities have more than one designation, such as General Atomics in La Jolla, CA, which is a designated DOE facility, AWE facility, and Beryllium Vendor.
[7] The DOE's FWPs began providing free medical screening examinations for former DOE federal, contractor, and subcontractor workers in 1997. The FWP medical screening exams check for potential adverse health effects caused by exposures to radiation, beryllium, asbestos, silica, welding fumes, lead, cadmium, chromium, solvents, noise, and other toxic substances and hazardous conditions. See https://www.energy.gov/ehss/former-worker-medical-screening-program-0.

true that DOE FWP Projects routinely use direct mailings to invite former workers to in-person outreach events hosted by DEEOIC. Therefore, given the history of collaboration between DOE and DEEOIC, the recommendation of the Ombuds continues to be that DOE and DEEOIC collaborate to send direct mailings to all former DOE workers informing them of the existence of the EEOICPA.

The DOE Office of Environment, Health, Safety & Security works closely with DOE Headquarters program offices to acquire employee rosters from site contractors and field/site offices.[8] The FWP Projects send medical screening invitations directly to former DOE workers using their last known address. Address update services are utilized to obtain current contact information in case of inaccuracies or outdated addresses.[9] As a result of the FWP Projects' outreach efforts, including direct mailings, a total of 99,316 initial screening examinations and 75,639 re-screening examinations of former DOE workers have been performed from 1997 through 2023.[10] Given that over 90,000 former DOE workers have participated medical screenings thus far, it is likely that the six FWP Projects have mailed thousands of invitations directly to former workers since 1997.[11]

A level of collaboration already exists between the DEEOIC and the DOE, as evidenced by the DOE FWP Projects' sending letters directly to former workers, inviting them of some of in-person outreach events.[12] We have observed increased participation at outreach events where the FWP Projects have utilized their rosters to send invitations directly to potential claimants. Thus, it is evident that former workers are being reached beyond those who have already filed claims for EEOICPA benefits.[13]

It is this Office's experience that when a DOE FWP Project directly mails former workers about an in-person outreach event, attendance significantly surpasses events without these mailings. Moreover, updated FWP Project rosters also facilitate reaching individuals who have relocated from areas where events have consistently been held. For instance, we encountered former workers at outreach events located a significant distance from the location of their DOE employment as a result of the DOE FWP Projects direct mailings.

As noted in the 2022 Annual Report to Congress, the EEOICPA, which has no statute of limitations, allows individuals to file claims at any time and without a deadline. Despite this

8. See https://www.energy.gov/ehss/former-worker-medical-screening-program-0.
9. The FWP Projects also periodically check the list of workers' names against the National Death Index to ensure they do not send letters invitation letters to deceased individuals. Ibid.
10. See https://data.doe.gov/MS/asp/Main.aspx?evt=3140&src=Main.aspx.3140&documentID=4F4031A44377CA2AA49385AD1C46EE0C&Server=AVAHSNAPPD01&Project=FWP&Port=0&share=1.
11. The DOE FWP includes four regional projects located near major DOE sites, and two nationwide projects. The regional projects are: Pantex Former Worker Medical Surveillance Program, Medical Exam Program for Former Workers at Los Alamos and Sandia National Laboratories, Worker Health Protection Program, and Former Burlington Atomic Energy Commission Plant and Ames Laboratory Workers Medical Screening Program. The two nationwide projects are: National Supplemental Screening Program and Building Trades National Medical Screening Program. See https://www.energy.gov/ehss/former-worker-medical-screening-program-0.
12. In FY 2023, the FWP Projects assisted the DOL with 12 of its outreach events. However, statistics were not available regarding how many DOL events the FWP Projects utilized direct mailings to notify former workers of the outreach events.
13. The DEEOIC mails invitations for outreach events only to people who have already filed a claim for benefits under the EEOICPA. Thus, direct mailings by DEEOIC only reach those who are already aware of the EEOICPA.

fact, many former workers (or their families) remain unaware of the EEOICPA. To address this concern, the Ombuds continues to recommend that letters be sent directly to potential claimants informing them of the existence of the EEOICPA. For those who do not reside near one of the eleven DEEOIC Resource Centers or near the location of an outreach event, this form of outreach has the highest likelihood of success. Moreover, the Ombuds is unaware of any other agency or entity besides the FWP Projects that maintain rosters of individuals who worked in our nation's nuclear weapons complex.

B. Need for Dynamic Outreach

In 2023, the Office attended in-person outreach events in Nevada, New Mexico, and Arizona. In each location, as a result of casual conversations in the communities we traveled through, we encountered individuals who were unaware of the EEOICPA. Some of the individuals we encountered lived in close proximity to covered facilities and had family members or friends who they believed would potentially qualify for benefits. During these informal conversations, people expressed interest in and appreciated receiving brochures and other literature regarding the EEOICPA and the claims process. Some of the reasons why these individuals had not attended the outreach events in their area were: 1) they were unaware of the event; 2) they were working during the time of the event;[14] and 3) they did not appreciate the purpose of the event until they had an opportunity to speak with someone involved with the EEOICPA.[15] The question then becomes how to effectively communicate to as many people as possible the existence of the EEOICPA and its potential benefits.

Some of the feedback shared at the outreach events in New Mexico and Arizona included a desire for outreach events to be held in new locations and in areas closer to where local community events are routinely held. Likewise, newspaper and/or radio advertisements can be an effective way of potentially reaching those who had not received an invitation to an event. However, in some areas of the country, unless the advertisements are in the language(s) spoken in that area, e.g., Navajo, the message may still be missed by many people. Translating information into any/all relevant languages would also enhance notification to potential meeting attendees. Thus, the effectiveness of indirect methods of informing potential claimants of the EEOICPA has distinct limitations, such as only reaching those living in the immediate geographic area of an outreach event. Direct mailings and in-person events in new locations are recommended to inform individuals of the existence of the EEOICPA.

C. AWE and Beryllium Vendors

As previously noted, there are 190 AWE facilities and 78 Beryllium Vendors in the United States. The last two in-person outreach events hosted near an AWE facility were in Lynchburg, Virgnia, in November 2018, and in Central Falls, Rhode Island in November 2019. Targeted outreach to

[14] In-person outreach events usually begin at 9 am and end by 4 pm.
[15] Even when presented with outreach materials, some people are unable to appreciate the purpose of the EEOICPA until given the opportunity to ask questions and learn more about the law and the various agencies tasked with implementing the law.

those who worked (or work) at these facilities is important considering the majority of AWE facilities and Beryllium Vendors were smaller facilities. Moreover, since the periods of covered employment at a number of these facilities ended decades ago, it is unclear whether the family members of those who worked at these facilities are aware of the EEOICPA or that the EEOICPA is a federal workers' compensation program for which they may qualify, unless outreach is specific and targeted to them. We have encountered family members who, for example, knew the name of their loved one's employer, but did not know the employer was a covered AWE or Beryllium Vendor. Thus, for such family members, it is important to notify them that their loved ones may have worked at a covered facility, and that as a result they may be entitled to file a claim for benefits under the EEOICPA. Some individuals who worked at these locations, as well as their family members, are unaware that the EEOICPA is a federal workers' compensation program for which they may qualify unless the outreach is specific and targeted to them.

CHAPTER II.
ISSUES REGARDING THE CLAIMS PROCESS

In 2023, some claimants were unaware of the policies and tools that could have potentially assisted them in proving their claim. Other claimants needed assistance understanding the decisions they received from DEEOIC. Some ARs and claimant complained of the content and quality of IH and CMC reports. Lastly, some reported the need to have their claims expedited due to failing health and complained of not receiving clear direction regarding the evidence required to do so.

A. Developing Evidence and Policy Updates

The period of time between the filing of a claim for benefits and the issuance of a decision by DEEOIC is considered the development phase of a case. During the development phase, DEEOIC takes a variety of actions to obtain information and evidence in order to make a decision, while simultaneously seeking information from claimants and healthcare providers in support of the claim. DEEOIC's requests for information and documentation from claimants are made in a "development letter." Many claimants had difficulties understanding, in a practical way, the information being sought in a development letter.

Depending on the type of benefits being sought, the development actions taken by DEEOIC and the type of evidence DEEOIC requested from claimants varied.[16] In 2023, we were contacted by claimants, ARs, and healthcare providers who had questions about development letters received from DEEOIC. Moreover, while speaking with these individuals, it often became apparent that they were unaware of some of the specific development actions being taken by DEEOIC, or that they could review the information and documentation obtained by DEEOIC.[17]

Some individuals expressed frustration upon learning that they were being asked to find and produce documentation that DEEOIC may have already obtained from other sources. For others, a sense of frustration stemmed from learning that DEEOIC had obtained information and documentation but did not share it with them. In other words, some claimants and ARs believed they were trying to prove a claim without full knowledge of or access to relevant information obtained by DEEOIC.[18] Our recommendation is for DEEOIC to use plain language

[16] Claimants initially file their claim for compensation and medical benefits under Part B and/or Part E EEOICPA. Should the claim be accepted, claimant may then file a claim for consequential illness, impairment compensation, and wage-loss compensation. Additionally, claimants may request authorization for home healthcare benefits, supplemental oxygen, home modification, and other ancillary benefits. Each type of benefit the claimant files for or requests usually requires some level of development by the DEEOIC before a decision is issued to claimant.

[17] For example, as previously discussed in Chapter 2, claimants are not informed when they file their claim for benefits that DEEOIC will request their employment records from DOE. Despite requesting employment records from DOE, claimants are usually sent a development letter asking for documentation to confirm their claimed employment.

[18] Claimants can access some of their claim file information online if they sign up for ECOMP. However, ECOMP does not permit claimants to view any records in their claim file from DOE or NIOSH. Instead, claimants must submit a request to DEEOIC in writing if they would like a copy of these records. Most claimants are unaware they can make such a request. The records are then mailed to claimant on a compact disc (CD), which a number of claimants have stated they are unable to access. These records from DOE and NIOSH contain relevant information that claimants could potentially use to assist in proving their claim.

in development letters and personalize them for each claim. An explanation or example of the type of information or evidence being sought would help claimants understand what was being asked of them. Furthermore, DEEOIC should identify evidence already acquired, inform claimants of the relevance of that evidence, and that they may request a copy.

Since the inception of the EEOICPA, it is our understanding that over time each district office developed knowledge and information about the specific facilities in its region. In 2023, we continued to receive complaints that as a result of claims being distributed nationally instead of regionally, there were inconsistencies in the evaluation of evidence submitted in support of claims. For example, claims for individuals who worked at the Rocky Flats Plant in Golden, CO, were previously assigned exclusively to the Denver District Office, and now any one of the four district offices may receive claims from Rocky Flats workers.

A number of ARs pointed out that it did not appear the district offices had adequate institutional knowledge to properly develop and consistently process claims involving facilities outside their region. We received complaints regarding the development and adjudication of claims for workers at the Nevada Test Site, the Rocky Flats Plant, and Area IV of the Santa Susanna Field Laboratory. In some cases, when claimants and ARs submitted employment evidence that they understood was responsive to development letters from a district office, they became concerned when the district office informed them additional evidence was needed. For example, an AR complained that documentation previously accepted to establish employment for a period of one month at the Nevada Test Site was only accepted for one day of employment when evaluated by a district office that had not previously adjudicated Nevada Test Site claims. Another AR questioned whether all of the specific facility information used to adjudicate claims by one regional district office had been made available to the other district offices. They posited that either the information had not been shared with the other district office or had not been applied consistently.

With respect to how a CE evaluates the evidence of covered employment at a facility, the DEEOIC PM includes the following language:

> The process of employment verification is a difficult and challenging hurdle in many cases. Because the atomic weapons program dates back to the early 1940s and involves a large number of public and private organizations, locating pertinent individual employment records can be difficult. Moreover, records may be missing, degraded, lost, or destroyed.
>
> As the statute allows latitude in the assessment of evidence, it is not necessary for the CE to collect evidence that establishes that the claimed employment is proven beyond a reasonable doubt, but merely that a reasonable basis exists to conclude that the employment occurred as alleged. This ensures that the claimant receives favorable treatment during the employment verification process.
> See EEOICP PM Chapter 13.5 (Version 8.0) (November 17, 2023).

However, some of the claims brought to our attention suggested that unless claimants produced documentation unequivocally proving exactly when and where they worked, their claimed employment was not always accepted. Some of the variability regarding whether claimed employment was confirmed by DEEOIC may also relate to the fact that certain district offices have not analyzed employment evidence from certain facilities until more recently. For example, some claimants who worked at DOE facilities in southern California found that the process of proving their covered employment remained challenging given the lack of familiarity that some district offices had with the employment documentation provided by these DOE facilities. Our recommendation is for DEEOIC to provide additional information and training on the specific areas of inconsistency that have been identified among the district offices as it relates to covered facilities previously outside their jurisdiction.

A second area of concern involved the ongoing policy updates that are typically published by DEEOIC twice a year. DEEOIC publishes Transmittals on its website, which provides notice of changes to one or more sections of the EEOICP Procedure Manual. However, the individuals who contacted our office were not aware that DEEOIC routinely updates its policies and published Transmittals describing some of the changes. When policy updates include substantive changes, it is important for DEEOIC stakeholders to be made aware of them in a timely manner. Instead, we encountered individuals in 2023 who were not aware of relevant policy changes that could impact their claim. In other instances, it was apparent that a decision had been made in a case without the adjudicator taking into account the most recent policy update.

For example, some claimants and healthcare providers were unaware of the 2022 policy update regarding how claims for hearing loss as a result of exposure to noise and toxic substances had changed. Prior to the update, the policy limited consideration only to claims with a period of 10 consecutive years of employment in certain, specific labor categories prior to 1990. The updated language broadened potential eligibility to claimants who worked in any labor category during 10 consecutive years of employment and had exposure to a qualifying toxic substance.[19] Thus, the 2022 policy update broadened the criteria regarding how DEEOIC evaluated claims for bilateral sensorineural hearing loss and noise exposure.

This 2022 policy update should have been shared with those filing new claims, as well as claimants whose hearing loss claims were previously denied. When a previously denied claim is potentially impacted by the policy update, those individuals can file a Reopening Request in order to potentially have their claim re-adjudicated.[20] It is our understanding that DEEOIC reviewed some previously denied hearing loss claims, but we encountered individuals in 2023 with denied hearing loss claims who were unaware of the policy update and were interested in assessing the evidence in their case under the updated policy. It is challenging for claimants

[19] The specific policy update permits further development of a claim where the employee had any 10-year period of consecutive (applies to any time period and any labor category) employment during which the employee had exposure to a qualifying toxic substance. See EEOICP PM Exhibit 15.4.10(c)(2) (Version 8.0) (November 17, 2023) (emphasis added).

[20] A claimant who identifies a change in the law, regulations, or policies governing EEOICPA subsequent to receiving a final decision denying their claim may seek to have it reopened. There is no deadline to submit a reopening request. See EEOICP Procedure Manual, Chapter 27.3 (Version 8.0) (November 17, 2023).

to gather information and evidence to prove their claim if they are not apprised of current DEEOIC policies.

Following one particular outreach event in 2023, we received multiple inquiries regarding the hearing loss policy update. One healthcare provider contacted us because they were aware of "quite a few" DEEOIC claimants with hearing loss claims in their area of the country who they believed would benefit from learning about the policy update. They requested our assistance in sharing this information and indicated that they would do their best to inform their patients of the policy change as well. Our recommendation is for DEEOIC to directly inform claimants with previously denied claims that there has been a policy update that may impact their claim. We also believe more outreach efforts should be focused on providing all claimants, including those with previously denied claim, clear and current guidance explaining exactly what type of evidence they need in order for DEEOIC to approve their claim.

B. Difficulties Proving a Claim

In 2023, we heard from claimants and ARs who described the process of getting a new claim approved under Part E of the EEOICPA as one that had seemed to grow more challenging. Concerns centered around DEEOIC's requirement of "significant exposure" under Part E, as well as the implementation of changes to the way in which contractor IHs describe the exposure levels encountered by claimants. Other concerns involved the information DEEOIC shared with, as well as the quality of the reports prepared by, contractor IHs. We also received complaints regarding the scrutiny given to reports prepared by claimants' treating physicians, as well as the quality of reports prepared by CMCs.

i. "Significant Exposure" and Changes to Exposure Levels Reported by IHs

By way of background, the EEOICPA and its implementing regulations do not mention nor define the term "significant exposure" under Part E. Moreover, prior to DEEOIC engaging the services of an IH contractor in 2016, the Procedure Manual contained no reference to "significant exposure" or specific toxic substance exposure levels.

It was not until September 2017, that DEEOIC published the specific exposure levels that contractor IHs were to use when characterizing a claimant's toxic substance exposures. According to the PM,

> DEEOIC IH staff broadly separates exposures into those which were significant and those which were incidental. Significant exposures are further characterized as low, medium, and high. See EEOICP PM Chapter 15.11(e) (Version 1.1) (September 2017).[21]

Thus, from September 2017 through October 24, 2022, contractor IHs were instructed to characterize a claimant's toxic substance exposures in their reports as follows:

[21] This version of the PM did not define "significant exposure".

- Significant, High;
- Significant, Moderate;
- Significant, Low;
- Incidental; or
- No Exposure

During this time period, claimants and ARs who wanted to better understand the meaning of "significant exposure" as used in IH reports were provided an example or two in the PM, but no definition or further explanation. It was not until DEEOIC published Bulletin 23-02 on October 24, 2022, that a definition of "significant exposure" was published,

> A significant exposure is one that occurs at some interval of routine frequency and intensity associated with the work performed by the employee. Based upon the agent under consideration, such exposures may have occurred by inhalation, ingestions, or absorption.[22]

In addition to publishing a definition of "significant exposure", Bulletin 23-02 updated the levels of exposure the IH uses when characterizing toxic exposures in their reports. The levels of exposure were updated to:

- Significant, High;
- Significant, Moderate;
- Significant, Low;
- Incidental;
- More than incidental, but less than significant; or
- No Exposure

In response to these updates, ARs and claimants first complained that DEEOIC implemented policies and procedures that required an IH assess whether a claimant had a "significant exposure" to a toxic substance despite the apparent lack of a requirement for significant exposure in the EEOICPA or implementing regulations. The EEOICPA and implementing regulations state,

> …a DOE contractor employee shall be determined for purposes of this part to have contracted a covered illness through exposure at a DOE facility if –
> (A) it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness; and
> (B) it is at least as likely as not that exposure to such toxic substance was related to employment at a DOE facility.
> See 42 U.S.C. § 7385s-4(c)(1) and 20 C.F.R. § 30.230(d)(1), (2) (2019).

[22] The definition of "significant exposure" has been incorporated into subsequent versions of PM Chapter 15.11(e) (Versions 7.1 and 8.0) (March 15, 2023 and November 17, 2023).

The EEOICPA and regulations use the term "significant" to describe whether a toxic substance exposure was a factor in aggravating, contributing to, or causing the illness, not to characterize the level of toxic substance exposure. As a result, the question has been raised and our office has been requested to point to the requirement that all claimants must prove a "significant exposure" to a toxic substance in order to potentially qualify for benefits under Part E.

Second, ARs and claimants took issue with the addition of the "more than incidental, less than significant" level of toxic exposure. The specific complaint was that the addition of a sixth level of potential toxic exposure for IHs to use when characterizing levels of exposure was unclear and somewhat confusing. In other words, claimants and ARs complained that they did not have sufficient information to understand the various levels of exposure that IHs were required to apply to their claims. And if they did not fully understand the various levels of exposure, it was even more difficult to challenge them when claimant believed the IH assessment was not accurate.

When the ABTSWH (ABTSWH or the Board) met in May of 2023, the Board members discussed the term "significant," as well as the updated exposure levels IHs are required to use. One of the concerns raised by the Board was that even if the exposure to a toxin was high, if the route was wrong, it may not ever be associated with a disease.[23] On the other hand, an exposure could be very low, but in the correct route, and this would be deemed highly associated with that disease. Thus, the concern of applying a significance overall that doesn't fully address the intensity, route, frequency, and duration of exposure is that it could lead to inaccurate decisions by the medical professionals who are just looking at the terminology. See ABTSWH Transcript pg. 59 (May 17, 2023).

Based upon the Board's discussion, the Board issued the following recommendation,

> Improvements in Industrial Hygiene Assessment of Exposures in EEOICPA Claims
> The ABTSWH recommends that exposure assessments made by Industrial Hygienists (IH) be enhanced to specifically refer to the basic metrics of exposure science: (1) exposure intensity, (2) exposure route, (3) exposure frequency, and (4) exposure duration. These elements can have distinct value in determining causation. These metrics may further be divided by the facility and job under which they occurred for a claimant as relevant. We recommend that DOL adopt an IH exposure assessment form that puts the work of the IH in the context of these four basic metrics of exposure. The toxicants to be included on the form would be those determined relevant to the claimed medical conditions.
> - ABTSWH Recommendation to Acting Secretary Su (July 7, 2023).

Thus, the Board recommended a move away from the current exposure levels used by IHs to the use of an assessment form that asked the IH to put their assessment of each toxic substance into the context of (1) exposure intensity, (2) exposure route, (3) exposure

[23] Routes of exposure include inhalation, skin contact, skin absorption, or ingestion. See EEOICP PM Chapter 15.11(a)(2) (Version 8.0) (November 17, 2023).

frequency, and (4) exposure duration. While DEEOIC agreed with some aspects of the Board's recommendation, it declined to move away from the use of six exposure levels.

For claimants and ARs, the challenge remains in trying to discern the meaning of the various exposure levels used by contractor IHs, as well as how a treating physician or Contract Medical Consultants (CMC) are to accurately interpret this information from the IH. We encourage DEEOIC to continue working with the Board to enhance the IH process and bring greater transparency to the use of the term "significant" and the toxic substance exposure levels reported by IHs.

ii. IH Exposure Assumptions and Unavailable Exposure Records

Claimants and ARs have consistently complained that while there were radiation monitoring programs at DOE facilities, there were not robust chemical monitoring programs. In the past, DEEOIC has acknowledged a general lack of industrial hygiene and chemical monitoring records for those who worked at DOE facilities. Nonetheless, in 2023, each IH report that addresses toxic substance exposure for a claimant employed after the mid-1990s contained the following language,

It is important to note that after the mid-1990s, environmental health and safety programs at DOE facilities were well developed and fully implemented. These programs included, but are not limited to, chemical/hazardous material management programs, strong administrative and engineering controls, the extensive use of personal protective equipment (PPE) and, where appropriate, industrial hygiene monitoring. This does not mean that employees would not have had the potential for hazardous exposures. However, it does mean that the likelihood of significant exposures to toxic materials at DOE facilities was greatly reduced after the mid-1990s, and that any work processes, events, or circumstances leading to a significant exposure would likely have been identified and documented in employment records.
- June 6, 2023, IH report provided by claimant. (Emphasis added.)

The assumption that environmental health and safety programs at DOE facilities were fully implemented after the mid-1990s has seen strenuous objections from claimants. Claimants not only point to the fact that such programs were not fully implemented for chemical exposures, but that in their opinion, the risk of such exposures was not greatly reduced after the mid-1990s. Claimants and ARs shared stories of their toxic substance exposures after the mid-1990s that were not assessed by an IH at the site, nor documented in any way. One individual shared that large quantities of banned toxic substances that were at a specific DOE site after the mid-1990s not only remained there but were used until they were gone. Since the toxic substances were technically no longer approved, the site provided little to no controls over how these toxins were used.

Moreover, whenever a claimant did not have documentation of a significant toxic substance exposure after the mid-1990s, the IH also routinely included the following language in the report,

Although [claimant], in [his/her] capacity as a [laborer] at the Oak Ridge National Laboratory (X-10), would have had the potential for significant exposures to chromium, there is no evidence in the case file (i.e., personal and/or area industrial hygiene monitoring data, claimant provided information or documentation, or other relevant site industrial hygiene records) indicating that, as part of this position during the subject time frame (i.e., between [2010 and 2014]), exposures to this agent occurred that would have been considered a workplace exposure violation or incident.
- June 6, 2023, IH report provided by claimant. (Emphasis added.)

Numerous issues were raised by claimants and ARs regarding this language. First, claimants consistently reported that regardless of their employment dates, they were rarely, if ever attended to by an IH for a toxic substance exposure. Even when an IH responded to an incident, claimants stated they were rarely provided documentation nor did they expect any such documentation to be found in their official employment records.

Second, claimants objected to the assumption that although they had the potential for significant toxic substance exposures, because the exposures occurred after the mid-1990s, they were now required to produce written documentation of a "workplace exposure violation or incident" in order for their exposures to be considered "significant" by the IH. They argued that low level exposures to some toxic substances can be a significant factor in aggravating, contributing to, or causing certain illnesses, thereby making it unreasonable to require documentation of a much higher level of exposure because it occurred after the mid-1990s. The concern expressed to our office was that by mandating this more stringent level of toxic exposure evidence for all Part E claims after the mid-1990s, claimants who worked after that time period would effectively be prevented from proving their claims unless they produce documentation of a workplace exposure violation or incident.

Finally, claimants who worked after the mid-1990s found it problematic that the absence of toxic exposure records in their employment file was equated to a finding of no significant toxic substance exposures by contractor IHs. The ABTSWH also raised the concern that contractor IHs frequently determined that the absence of exposure records meant the absence of toxic substance exposure rather than simply the absence of documentation. Members of the ABTSWH noted that after the mid-1990s the state of industrial hygiene conditions in the workplace were generally not well-documented and particularly not well-documented in employment records, although they undoubtedly had improved. See ABTSWH Meeting (November 15, 2023). They stressed that lack of documentation could not be interpreted as the lack of exposure, and the general improvement of conditions over time may have limited relevance when examining an individual claim. (Ibid.). Of note, there is no explicit mention in the PM or other DEEOIC policy guidance that the absence of records demonstrating a workplace exposure violation or incident after the mid-1990s should be treated as the absence of toxic substance exposure(s). The source of the language used by contractor IHs is uncertain, but it consistently appears in almost all IH reports evaluating toxic exposures after the mid-1990s.

Our recommendation is for DEEOIC to advise contractor IHs that the absence of records documenting a workplace exposure violation or incident cannot be presumed to mean the absence of any toxic substance exposures after the mid-1990s. In the event DEEOIC has documentation to support this assumption, such information should be made publicly available on the DEEOIC website.

iii. Quality of IH Reports

Under Part E, the toxic substance exposure analysis usually begins with the CE's review of the evidence in the claim file, as well as the Site Exposure Matrices (SEM) database. Of the number of toxins identified, the CE selects no more than seven (7) toxic substances to refer to an IH. In most cases, when toxic substances have been identified that have a link to a claimed illness, the IH is asked to prepare a report addressing the nature, frequency, and duration of the claimant's toxic exposures. See EEOICP PM Chapter 15.11 (Version 8.0) (November 17, 2023). This IH report is then provided to a CMC (or claimant's physician when one has been identified). The IH report is almost always the only evidence of a claimant's toxic substance exposure provided to the CMC. In fact, in the cases shared with our office in 2023, the IH report was the only toxic exposure information DEEOIC provided to a CMC, or treating physician, when requesting a causation report under Part E.

Prior to DEEOIC entering into a contract with an outside IH contractor in 2016, only a small percentage of Part E claims were reviewed by federal DEEOIC IHs. However, by 2023, the five contractor IHs prepared 4,483 reports for DEEOIC, which were then reviewed by two federal DEEOIC IHs for quality and consistency. These reports followed a template and contained identical language regarding, for example, the way employee's exposures after the mid-1990s were assessed by the IH.

A specific critique of IH reports our office received stated,

> The IH letters are written from a form letter, these letters are not customized to the employee, some of the text is allegedly lifted from web sources without citation, and all four (4) of the cited…references are out of date. The IH findings cannot be independently verified.
> - AR email to Office of the Ombudsman (July 3, 2023).

This raised concerns for claimants because, according to DEEOIC, the CE generally may only refer seven toxic substances to the IH for consideration. See EEOICP PM Exhibit 15-5.3 (Version 8.0) (November 17, 2023).[24] However, there are certainly cases where the evidence indicates the claimant was exposed to more than seven toxic substances that could potentially be

[24] If more than seven toxic substances are established by the CE, there is a process by which the CE can consult with a DEEOIC National Office IH to identify which toxins were most likely to have been encountered and which would likely have the greatest impact on the claimant's claim. Based on this consult, the CE will include as many of the toxins as is necessary. See EEOICP PM Exhibit 15-5.3 (Version 8.0) (November 17, 2023). However, it is unclear if this process is used by CEs, and if so, how often does the consultation result in more than seven toxins being referred to the IH for review.

a significant factor in causing, contributing to, or aggravating the claimed illness. We are unaware of any explanation regarding how the number seven was chosen as the limit on the toxic substances referred to an IH. However, in response to a question raised during an ABTSWH meeting,

[DEEOIC] acknowledged that workers might be exposed to a greater number of substances, but DOL has to account for the need to process claims in an efficient and timely manner given its caseload. The CE lists the substances most likely to have a causal impact…[and] further substances can be added to the profile when requested by the claimant.
See ABTSWH Minutes (November 30 – December 1, 2022).

The PM does not direct the CE to share the list of toxic substances to be reviewed by the IH with the claimant, nor the total list of toxic substances that have been identified as having a known link to the claimed medical condition. Our recommendation is for the Statement of Accepted Facts (SOAF) and any SEM database search results to be forwarded to the claimant at the same time they are sent to the IH.[25] This will ensure that the claimant has had the opportunity to review the toxic substance exposures that have been confirmed by the CE and the opportunity to share any relevant information they believe should be considered by the IH. Currently, the SOAF is not shared with the claimant and the IH report is only provided to claimant when the Recommended Decision to accept or deny the claim is issued. Without the ability to speak directly with the IH about their employment and exposure history, claimants do not have the opportunity to engage in a dialogue with the IH regarding the work processes they engaged in and their toxic substance exposures. Therefore, claimants should be provided greater opportunity to participate in the process of providing their toxic substance exposure information to the IH.

Another concern raised in 2023 pertained to the SOAF that is sent to IHs, specifically with respect to hearing loss claims. As previously discussed, the hearing loss criteria in the PM was updated such that when the claimant had any 10-year period of consecutive employment during which there was exposure to qualifying toxic substances, the CE is to refer the claim to an IH who will decide whether the claimant concurrently had consistent daily exposure to noise of at least 85 decibels. See EEOICP PM Exhibit 15-4.10(c)(2) (Version 8.0) (November 17, 2023). However, it did not appear that IHs were consistently asked the proper questions in this regard.

For example, in a claim that met the expanded exposure and employment criteria referred to above, the CE referred the claim to the IH, but instead of asking the IH about the claimant's daily exposure to noise above 85 decibels, the CE asked the IH about the employee's toxic substance exposures. The IH provided an opinion on the toxic substance exposures, but not the noise levels as stated in the policy. The IH report was then forwarded to a CMC who relied upon it to state that the evidence was insufficient to establish causation under Part E, and the district

[25] The SOAF is the document prepared by the CE that contains exposure evidence from the claim file, including SEM database findings, and poses specific questions to the IH.

office recommended denial of the claim. The claimant contacted our office for information and assistance, and we were able to direct the claimant to the updated hearing loss provision in the PM. Based upon this new information, the claimant objected to the recommended denial and pointed out that the question posed to the IH was not consistent with the hearing loss policy in the PM. Ultimately, the FAB issued a Remand Order based on the deficiencies in the IH report, and the claim was returned to the district office for further development.[26] Based upon feedback and examination of claim file records, the proper questions were not always posed to IHs in hearing loss claims, or the IHs were possibly not apprised of the updated hearing loss policy provisions. We recommend enhanced review of SOAFs and IH reports by DEEOIC to improve the implementation of policy.

iv. Issues with Reports from Treating Physicians and CMCs

Another concern brought to our attention involved Part E cases where the claimant submitted medical evidence from their personal physician linking their toxic substance exposure(s) at a covered facility to their claimed medical illness. The concerns arose from the fact that their doctor's opinion was found to be insufficient by the claims examiner because it was not "well rationalized".

Under Part E, claimants are required to prove that it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness; and it is at least as likely as not the exposure to such toxic substances was related to employment at a DOE facility. See 42 U.S.C. § 7385s-4(c). In large part, claimants' physicians have been unwilling to write a report addressing the relationship between their patient's work-related toxic exposures and their claimed medical illness. However, for those physicians who are willing to write such a report, DEEOIC requires the doctor provide a "well-rationalized" opinion. This means that the statement of the physician must be supported by an explanation of how his or her conclusions were reached, including reference to appropriate medical health science literature.

Under Part E, a physician may opine on topics for which DEEOIC has not made a finding of a link between exposure and disease, but in so opining a physician must communicate his or her understanding of the different factors considered that justify a particular opinion regarding causation, including providing a scientific basis upon which to base such an opinion. Specifically, a well-rationalized causation opinion from a qualified physician is one that communicates an accurate understanding of an employee's toxic substance exposure; discusses an employee's medical history and pertinent diagnostic evidence; and applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused, or aggravated the employee's claimed condition." EEOICP PM Chapter 15.13(b) (Version 8.0) (November 17, 2023).

[26] The Ombuds was informed in 2024 that this claim for hearing loss had been accepted. PM Chapter 16.9 (Version 8.0) (November 17, 2023).

The trend noted by our office in 2023 is that reports from claimants' physicians were more frequently found to not be "well-rationalized" and therefore, inadequate, by DEEOIC. In these cases, DEEOIC took issue with the claimant's physician's assessment and/or the scientific literature cited in the physician's opinion. Absent expert assistance, claimants and ARs questioned whether the DEEOIC claims examiners had the medical and/or scientific background necessary to determine that the medical opinions and scientific studies from the claimant's doctor were not "well-rationalized."

Claimants and ARs also found this trend concerning because once the physician's report was deemed insufficient, the claim was eventually referred to a CMC for a causation report in many cases.[27] In the claims shared with us, the CMC frequently found the claimant's physician had not provided a well-rationalized adequate opinion addressing the relationship between claimant's workplace exposures and their illness, and determined the evidence in the claim file was insufficient to establish causation. In the majority of these cases, the opinion of the CMC was routinely given greater weight and the claim was recommended for denial.

For example, an AR shared a report from a claimant's physician describing when and where the claimant worked, as well as the toxic substances that the claimant worked with which have a link to the claimed illness. The physician also cited scientific studies in support of their opinion. The district office recommended acceptance of the claim, but the FAB remanded it to the district office for further development. The FAB found the physician's opinion was not well-rationalized, specifically questioning the relevance of the scientific studies cited in the physician's report. In turn, the AR for this claim questioned the examiner's assessment of the scientific articles, arguing that DEEOIC examiners rarely, if ever, take exception to or note the scientific articles cited by CMCs but now seem to routinely analyze those cited by claimant's physician. The claimant's AR further noted that according to the PM,

> Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the opinion on an accurate factual basis, has weight over a physician conducting a file review.
> See EEOICP PM Chapter 16.6(a)(1) (Version 8.0) (November 17, 2023).

This claim was subsequently referred to a CMC to review the claim file evidence, including the claimant's physician's opinion. The CMC reached a different conclusion than the claimant's physician and the claim was recommended for denial. We note that the PM specifically states, "The function of the CMC is not to validate probative input by the claimant's treating physician." See EEOICP PM Chapter 16.9 (Version 8.0) (November 17, 2023). In this case it was not entirely clear whether the CMC had been asked to validate the probative input of the claimant's physician, but the claimant and AR believed it had been the primary reason for the CMC referral.

In each case involving a CMC report brought to our attention in 2023, the opinion of the CMC was relied upon by the district office. In some cases, as discussed above, the CMC opinion

[27] The CMC is a physician contracted by DEEOIC to provide medical opinions in DEEOIC claims. With very limited exceptions, the CMC does not meet with or examine the claimant. Instead, instead the CMC reviews documents and responds to questions posed by the CE or MBE. EEOICP

was weighed against an opinion provided by the claimant's doctor. In other cases, the CMC opinion was the only evidence in the file addressing the link between workplace exposures and a claimed illness. Claimants and ARs found it troubling that CMC opinions were consistently provided greater weight, even in cases where the opinion from the CMC did not appear to provide a similar level of explanation and scientific support as the reports submitted by the claimant's doctor.

For example, claimant advised us that their physician wrote a report stating that their exposure to toxic substances at a DOE facility was a significant factor in contributing to their COPD. The CE found the claimant's physician's report insufficient and referred the claim to a CMC. Instead of addressing the physician's report and the relationship between the toxic exposures and the claimed illness, the CMC focused on the claimant's smoking history. Under Part E, a claimant's smoking history is not relevant to the causation analysis. Regardless of any smoking history, the CMC is to only address whether the toxic substance exposures at a DOE facility played a role in the claimant's medical illness. Despite the CMC's reliance upon the claimant's smoking history, the CE gave greater weight to the opinion of the CMC over the claimant's physician and the claim was recommended for denial.

The opinions provided by CMCs were also a topic that the ABTSWH paid attention to in 2023, particularly as it related to the accuracy of CMC reports. According to the ABTSWH,

> …in claim reviews by the Board over the last seven years, between 10 and 20 percent of CMC reports rendered inaccurate causation opinions. This led to claimants not being compensated, and the Department procedures had an inadequate way of catching these errors. See ABTSWH Summary Minutes, November 16, 2023, page 10.

Thus, when the reports prepared by claimant's physicians were determined to be insufficient by claims examiners, some claimants and ARs question the accuracy of CMC opinions that were often determinative to the outcome of the claim. The Ombuds recommends specific outreach to claimants and treating physicians focused on providing clear and current guidance regarding the type of evidence needed to prove their claim. This can be accomplished through both development letters and targeted outreach.

C. Issues Involving Expedited Claims Processing for Terminal Claimants

In 2023, we received requests for assistance and complaints from claimants' family members and ARs regarding what was characterized as an inconsistent process for claimants with failing health to have their claims expedited. For instance, an AR shared documentation indicating the claimant was admitted to hospice in July 2023, and that they sought to have DEEOIC designate the claimant terminally ill so their claim could be expedited. However, the AR did not receive a response from the CE regarding the request, and complained that without expedited processing, the claim would potentially remain pending for a significant amount of time as it

went through the appeals process. The AR expressed frustration that documentation from hospice was not sufficient to have the request for expedited claim processing approved.

In another claim, medical documentation, hospice records, and a request for expedited processing were submitted to DEEOIC in mid-August, 2023. We were contacted by an individual on behalf of the claimant at the end of September, who reported that the request to have the claim expedited was still pending. Our office communicated with DEEOIC regarding this claim and were informed a short time later that the request for expedited processing had been approved.

One AR complained that despite being informed a claim was going to be expedited, the claims process did not seem to move any faster. The AR stated, "I don't want to be a pest. I don't want to call every day, I know they are busy" but at the same time, the AR noted the need for the claims process to move on an expedited timeline. The concerns raised with respect to having a claim designated terminal for expedited processing ranged from lack of clear guidance regarding the medical evidence needed to qualify for expedited processing, to difficulties determining which DEEOIC personnel were making the determination in an individual case.

DEEOIC has established policies to adjudicate claims it has identified as being in a "terminal" status. CEs and HRs are directed to remain vigilant for signs of terminally ill claimants whenever they review case files or prepare decisions. However, it was more often that ARs and family members of claimants requested a claim be given a terminal designation.

DEEOIC defines indicators of end-stage illness as including requests for hospice care, medical evidence confirming the claimant's terminal condition, or communications from stakeholders concerning the claimant's health. Upon receiving information suggesting a claimant may be in a terminal stage, CEs or HRs are instructed to promptly notify the District Director (DD) or FAB Manager. If medical documents or other information indicate that the claimant is in the end-stage of their illness or that death is imminent, the DD or FAB Manager directs expedited adjudication of the claim and the DEEOIC Energy Compensation System (ECS) is updated to include the terminal indicator. If the claimant's terminal medical status is unclear, the DD or FAB manager must initiate development to obtain medical evidence to establish the status of the claimant is at the end-stage of a disease or illness. See Federal (EEOICPA) Procedure Manual, Chapter 11.8 (Version 8.0) (November 17, 2023).

While this policy aims to expedite the processing of claims for claimants who are at the end-stage of their illness, our office continued to receive questions and concerns regarding this policy. Two of the most frequent questions were (1) what medical evidence is needed to satisfy the policy? and, (2) how much time does DEEOIC have to make the determination and how will we be notified?

With respect to the first question, there are a lack of clear guidelines regarding what constitutes sufficient medical evidence to satisfy the requirement that an employee is at the end-stage of their illness or death is imminent. As a result, DEEOIC staff have complete discretion to apply

their own, subjective assessment to the medical evidence submitted in support of a request for expedited claims processing. For example, a medical report from hospice was deemed sufficient to satisfy the policy in one case, while in another case a medical report from hospice was not.

Most ARs and family members faced challenges at this stage of the process. They complained that a lack of clear, specific guidance regarding the medical evidence needed to satisfy the policy resulted in them spending valuable time going back and forth to the employee's doctor(s) for more documentation.

Second, DEEOIC provides no expectation to ARs or employee's families regarding when they can expect a response to their request for expedited claims processing. Moreover, CEs and HRs do not appear to have timelines for processing these requests. There is a pressing need to establish clear guidelines regarding what constitutes sufficient medical evidence for a claim to be designated terminal, as well as standardized procedures to ensure timely and equitable processing of these claims. Claimants and their families should be provided clear expectations regarding when they will receive a response to their request from DEEOIC.

This topic was also addressed by the ABTSWH in November 2023. The Board recommended,

> that the EEOICP designate a single program staff person at each district office within 30 days of the date of this recommendation to serve as an initial point of contact for claims that involve people who report that they are terminally ill.
> See ABTSWH, Recommendation No. 2 (January 14, 2024).

The Board pointed out the benefits of streamlining the claims process by assigning a single person within each district office to identify, monitor, and facilitate the claims of terminally ill people, which would be a useful and compassionate addition to the efforts that the program already makes to accommodate such claimants. It would give the families and advocates a point of contact, which, in and of itself, would help forestall frustration and anxiety that may accompany the claims evaluation process. This person would have the experience and authority to monitor these claims and facilitate their resolution and overcome any "sticking points" that claims sometimes encounter in their flow. See ABTSWH, Recommendation No. 2, Rationale (January 14, 2024).

We concur with the Board that implementation of some form of centralized oversight to assess how individual requests for expedited processing are being handled is appropriate.

CHAPTER III.

CHALLENGES OBTAINING MEDICAL TREATMENT

In 2023, claimants raised concerns regarding obstacles in locating a healthcare provider willing to accept payment from DEEOIC, as well as challenges encountered during the medical care authorization process. Additionally, issues arose concerning authorization for home healthcare, durable medical equipment, and other services. DEEOIC has acknowledged these issues and responded by hiring more medical benefits examiners (MBE) to adjudicate authorization requests and facilitate the processing of medical bills. While this chapter primarily focuses on reported difficulties and complaints, we acknowledge DEEOIC's efforts to increase staffing for the adjudication of these claims.

A. Challenges in Finding a Healthcare Provider

Increasingly, our office has heard from claimants struggling to find healthcare providers willing to accept payment from DEEOIC. In 2023, we also heard from healthcare providers seeking assistance when DEEOIC did not respond to authorization requests to provide treatment to DEEOIC claimants, or when medical bills submitted to DEEOIC were unpaid for an unacceptable length of time. Based upon some of the concerns raised by healthcare providers, the reasons why some claimants had difficulties finding a healthcare provider willing to accept payment from DEEOIC became more apparent.

When individuals first approached our office seeking assistance in finding a healthcare provider willing accept payment from DEEOIC, we directed them to one of the eleven DEEOIC RCs. However, in most situations, those who contacted us had already sought assistance from a RC without success. Although RCs offered support, claimants still encountered difficulties finding healthcare providers. A discussion of the specific obstacles and reasons why claimants stated they could not find a healthcare provider are discussed below.

A claimant must receive treatment from an enrolled healthcare provider if they want to use their DEEOIC Medical Benefits Card to pay for the services.[28] More often than not, the RC had provided the claimant with contact information for enrolled healthcare providers, but the claimant was still unable to locate one.[29] Some reported that despite being enrolled to receive payment from DEEOIC, the healthcare providers were no longer accepting DEEOIC claimants as patients.

Additionally, contact information provided by RCs sometimes lacked physician names,

[28] In order to receive payment for medical bills for treatment rendered to DEEOIC claimants, healthcare providers must enroll with OWCP by registering with OWCP Connect and submitting OWCP-1168 Provider Enrollment Application.
[29] OWCP maintains a healthcare provider search tool that is available to the public and can be accessed through the "Find a Provider" link in the Medical Bill Processing Portal at https://owcpmed.dol.gov/portal/.

particularly if the physician was part of a larger facility where only the facility name was listed in the online provider portal. Thus, when the RC or claimant searched the online provider portal for a specific type of physician, they may only see the name of an institution, which would not assist in their efforts to find physicians who practice that specialty. Enrolled healthcare providers can also opt-out of appearing in the provider search portal, thereby preventing claimants from finding them online. And finally, claimants who lived in areas with a limited number of healthcare providers faced significant challenges in finding a provider willing to accept payment from DEEOIC.

For example, an individual described their difficulties of finding healthcare providers who accepted payment from DEEOIC as a "recurring issue of concern." They shared that the online physician portal was not very helpful in practice and indicated that more needed to be done to assist claimants in need of care.

It was not only finding physicians that some claimants found challenging to find in 2023. We were contacted by a claimant who lived in a relatively rural area of the country after their home healthcare provider informed them that they could no longer provide the level of service authorized by DEEOIC. The claimant and their AR then attempted to find another home healthcare provider on their own but were unsuccessful. The claimant's AR reported that when they contacted the RC for assistance, they were given the link to the online provider search tool. After having no success navigating the online provider search tool, the claimant contacted us for assistance. We reached out to DEEOIC and unfortunately no other enrolled home healthcare providers were identified in proximity to the claimant. This outcome left the claimant without the prescribed and authorized services and at increased the risk of their accepted medical condition(s) worsening.

Similarly, a claimant in a large metropolitan area struggled to find a home healthcare provider willing to accept DEEOIC payment, despite having authorization for services. The claimant's treating physician required written confirmation that home healthcare services were secured prior to proceeding with a complex, lifesaving medical procedure. Despite, being authorized for 24/7 care, the claimant was unable to secure a home healthcare provider willing to accept payment from DEEOIC due to the reimbursement fee schedule. The claimant was advised by their MBE that if they wanted to pay for home healthcare services out-of-pocket, they would be reimbursed $15 less per hour than the hourly rate charged by the least expensive home health provider in the area. The claimant reported that they were unable to afford the $15 per hour balance out-of-pocket. For this claimant, the difficulty finding a provider willing to accept payment from DEEOIC not only impacted their ability to receive home healthcare benefits but served as a barrier to the recommended medical treatment.

Moreover, claimants living in some areas of country that previously had an adequate number of medical providers enrolled with DEEOIC reported that it had since become more challenging to find enrolled providers. In other areas, some larger medical practices had stopped accepting the DEEOIC medical benefits card. For example, claimants residing in the Oak Ridge, TN area

reported that one of the largest practices of a particular medical specialty was no longer accepting payment from DEEOIC. Claimants who received treatment from this practice were faced with the dilemma of either traveling long distances to find a provider enrolled with DEEOIC, or having their medical treatment billed to an alternative insurance.

In summary, claimants reported that finding a healthcare provider who accepted the DEEOIC medical benefits card had become more challenging. The DEEOIC Medical Benefits Card is an invaluable benefit to claimants, particularly because there are no co-payments, co-insurance payments, or other out-of-pockets expenses associated with it. However, the value of the card is negated when healthcare providers are unwilling to accept it. We recommend DEEOIC conduct greater outreach to healthcare providers to assess the issues that prevented them either from enrolling with DEEOIC, and/or caused them to stop accepting payment from DEEOIC, thereby narrowing the pool of providers willing to treatment DEEOIC claimants. With a better understanding of the specific reasons why healthcare providers have been unwilling to enroll or to accept the medical benefits card, perhaps more concrete steps can be taken to keep those healthcare providers who are enrolled, as well as re-enroll those who decided to no longer accept payment from DEEOIC.

B. Challenges with the Medical Authorization Process

Claimants who seek a broad range of medical treatment, services, and/or equipment often find that they must request prior authorization from DEEOIC. For example, eleven types of home and residential healthcare services require prior authorization from DEEOIC. See EEOICP PM Exhibit 30-4 (Version 8.0) (November 7, 2023). Likewise, a chapter of the PM is dedicated to the authorization process for a variety of ancillary medical benefits.[30]

For each particular treatment, service, etc., the claimant is required to submit their request for prior authorization to DEEOIC. An MBE will then be assigned to collect the relevant medical evidence and make a decision. The MBE notifies the claimant of their decision by letter, which includes language informing claimant that if they disagree with the decision, they can submit a written request to have a Recommended Decision issued to them. A copy of the letter decision is to also be provided to the impacted healthcare or service provider. Should the claimant disagree with the Recommended Decision, they may file a letter of objection and seek to have a hearing or review of the written record by the FAB.

The PM does not include timelines for letter decisions or Recommended Decisions to be issued to claimants. Even without published timelines, the primary complaint from claimants, healthcare providers, and other service providers requesting prior authorizations was that it took far too long for DEEOIC to respond to and/or issue a decision.

[30] Ancillary medical benefits include, but are not limited to, walkers, wheelchairs, supplemental oxygen delivery systems, hearing aids, rehabilitative services (physical, speech, occupational, massage, acupuncture, and pulmonary therapy), chiropractic services, enteral formula, organ transplants, experimental treatments, home modifications, vehicle modifications and purchases, extended travel expenses, medical alert systems, sun protective clothing, gym memberships, and medical records procurement. See EEOICP PM Chapter 29, Ancillary Medical Benefits (Version 8.0) (November 17, 2023).

For instance, a claimant contacted us and complained of being unable to communicate with their MBE regarding an authorization request for time-sensitive medical treatment. The claimant explained that after receiving a bone marrow transplant, a second procedure was required to insure the efficacy of the transplant. The process to obtain the necessary materials for the second procedure contained multiple steps that required prior authorization so they could be completed within the prescribed timeline. The claimant and their healthcare provider spoke to various individuals within the DEEOIC in an effort to reach the assigned MBE, and left messages directly for the MBE as well. By the time the claimant contacted us, they were not only frustrated at not receiving a return call but expressed a lack of confidence in the authorization process. The claimant questioned why DEEOIC did not acknowledge or respond to the time-sensitive nature of the authorization request. Immediately after our office contacted DEEOIC on behalf of claimant, both the claimant and healthcare provider were contacted by DEEOIC and the authorization request was approved.

An added benefit of the attention paid to this claimant's case after contacting our office was that DEEOIC identified a billing issue that had impacted payment for the bone marrow transplant. That issue was then routed to the appropriate group in DEEOIC for resolution. This example not only highlights the communication issues and delays some claimant's encounter while seeking to have authorizations approved, but also the concern that claimants in need of time-sensitive medical treatment do not have a process by which they can request expedited review of their prior authorization request.

Another claimant contacted us to complain that their authorization for home health benefits was reduced to a lower level of care without their knowledge. The claimant had been authorized to receive skilled home nursing care but when they requested reauthorization of their home health benefits, DEEOIC only approved unskilled home health services. When the claimant spoke with their physician about the decreased level of home healthcare authorized by DEEOIC, the claimant reported that their physician said a nurse from DEEOIC had contacted his office and suggested that a lower level of care would be more appropriate. The claimant was very frustrated and believed that DEEOIC had influenced their physician's opinion regarding the level of care they needed. Because claimant's physician provided a report to DEEOIC confirming the need for a lower level of care, claimant was unable to challenge the lower level of care. Claimant also expressed frustration that the conversation between DEEOIC and their physician happened without their knowledge, thus leaving them unaware that the level of home health services was going to be reduced. Claimant shared with our office that if they had known of the conversation between DEEOIC and their physician, they would have communicated with their physician prior to his report being submitted to DEEOIC.

In another case, the child of a claimant reached out to our office for assistance after the claimant's request for home healthcare benefits had been pending for eight (8) months. The claimant's treating doctor submitted a letter of medical necessity (LMN) and the relevant forms to DEEOIC in early December of 2022. The request was for skilled nursing care for 6 hours per day through June 2023. DEEOIC then requested the claimant complete a separate form in January. Despite having the necessary documents from the claimant's treating physician,

it did not appear that DEEOIC followed up with claimant to obtain the form requiring their signature. The claimant's child reported that they did not receive any communication from DEEOIC regarding the form until May 2023. After the form was signed and submitted, DEEOIC denied the authorization request on June 20, 2023, and sought additional justification from the claimant's treating physician, which was provided on June 28, 2023. Still finding the treating physician's report insufficient, on July 20, 2023, the MBE referred the claim to a CMC, who immediately agreed with the treating physician's recommendations. Eventually, in August 2023, the claimant's request for home healthcare from December 2022 through June 2023 was approved. This scenario is not uncommon based upon the contacts we spoke with in 2023. Claimants do not understand why it sometimes takes months for DEEOIC to process an authorization request, or why it seems some treating physician's LMN are given more scrutiny than others. They report that the uncertainty caused unnecessary stress and financial insecurity.

The challenge of getting a response to a home healthcare authorization request also impacted a claimant who was trying to have their home healthcare benefits reauthorized while simultaneously requesting authorization for an increase in home healthcare benefits. This particular claimant had been receiving home healthcare benefits for a number of years and their accepted medical condition had progressively worsened over time. In addition, the claimant had been diagnosed with other medical conditions as a result of the accepted illness, also known as consequential conditions, which had also worsened. A family member, who also served as claimant's AR, shared that the claimant's treating physician submitted a report indicating the need for a higher level of care and that DEEOIC had found the report inadequate. While the AR was obtaining the claimant's updated medical records and coordinating with the treating physician for additional information to provide to DEEOIC, the claimant's home healthcare provider terminated their services. The AR stated that the home healthcare provider had grown frustrated over the delays and lack of communication from DEEOIC during the reauthorization process. The AR wrote,

> I am at my wits end. [HHC provider] just discontinued services as of 3/24/23 because they did not get another extension or authorization of the 20 hours per week [claimant] has had since [he/she] was first approved for care while they are still pending on [his/her] 24-7 care. This is really stressing me and [claimant] out and I could lose the aide we now have who is very good and whom I and [claimant] both like better than anyone we have ever had because she can't be in limbo for however many days she is without work while this is being straightened out.
> - Email from AR to Office of the Ombudsman, March 23, 2023.

In another example, a relatively new home healthcare provider reached out in March 2023 seeking guidance regarding the expected timeframes for DEEOIC to approve authorization requests and inquired about any available channels to address delays. The provider had two claimants in need of home health services. The first experienced a sudden, significant worsening of their accepted covered illness and so a LMN was submitted in October 2022 for an emergency increase in the level of home care services. As of March 2023, the authorization

request was still pending. In the meantime, the previously approved level of home health services was about to expire and a reauthorization request had been pending since December 2022.

The provider was frustrated because they could not provide an increased level of home healthcare without authorization from DEEOIC, even though the claimant's condition necessitated a higher level of services. The provider indicated they were able to communicate with the MBE on multiple occasions and were informed by the MBE that they were behind and would get to the request soon. The provider stated they checked the online portal daily for updates, but the claims were still listed as "in process". The provider also had a second patient with an authorization request pending since mid-December 2022, and according to the provider, the MBE also advised that they had simply not gotten to it yet. The home health provider specifically stated, "This is not a complaint about any MBEs or office. We want to serve the patients under our care as effectively as possible but have been unable to due to these delays." (Email to Office of the Ombudsman, March 10, 2023).

Finally, a home modification company brought their complaints regarding the prior authorization process to our office in September 2023. They wrote to us that since April 2023 they had submitted 36 quotes to DEEOIC on behalf of claimants in need of home modifications and all of them were still pending. According to the provider, in each case, the claimant had submitted the necessary medical documentation supporting the need for home modifications and now the claimant's task was to, "…provide two or more bids for the proposed changes from licensed and/or certified contractors. The bids submitted must be for exactly the same modifications so that comparison of the competitive bids can be made." See EEOICP Chapter 29.5(g)(5)(c) (Version 8.0) (November 17, 2023). The company's representative wrote,

> We understand that some of these quotes might be held up due to case workers and/or patients continuing to look for 2nd and 3rd quotes to meet the guidelines. However, we would like to find a more significant way to know if we have been accepted and/or declined on these past quotes.
>
> In figuring out the best practices of handling DOL cases we have heard all kinds of suggestions. They seem across the board all over the place and not a fluid way of handling them. We tried to reach out to the patient and they seem lost in where the case stands, even though there are a great deal of really good case workers there are as many out there that throw their hands up and say it's been turned in and that's where they leave it.
>
> We would love to continue being a provider for DOL, but we definitely can't continue running our operation this way…The only projects we can't really give clarity on is DOL bids…I would like to know who or where I can reach out after a certain given period of time and check on status of future quotes also.
> - Email to Office of the Ombudsman (September 27, 2023).

Based upon the issues and concerns raised in 2023, more attention needs to be paid to efficiently and effectively communicate with claimants, ARs, healthcare providers, and ancillary

benefits providers regarding medical authorization requests. Extended delays in receiving responses to medical benefits authorization requests have left claimants' needs unmet for prolonged periods of time. These delays also impacted providers, who experienced multiple instances of prolonged delays spanning several months in some cases.

More can be done to provide timely, meaningful communication regarding the status of pending requests. If a request is pending for a specific reason for an extended period of time, the claimant and provider should be informed of the reason in a timely manner. And if delays are the result of a workload issue, for those requests that have been pending beyond a reasonable period of time, the claimant should have the option to seek expedited review through a clear, dedicated process. The lack of timely responses to authorization requests, according to providers, is one of the main reasons they no longer accept patients with the DEEOIC medical benefits card.

CHAPTER IV.
DIFFICULTIES WITH PAYMENT OF MEDICAL BILLS AND EXPENSES

For claimants with a DEEOIC Medical Benefits Card, there have been an array of issues that delayed, or prevented reimbursement of medical bills related to their accepted illness(es). In addition to claimants, healthcare providers and other service providers reported a variety of issues involving the DEEOIC bill payment process. The scope of those impacted by medical billing issues varied from individual claimants to large healthcare organizations.

The issues ranged from delayed responses to billing inquiries, to more technical issues such as issues with medical bill coding. An increasingly common issue reported in 2023 was that of healthcare providers directly submitting bills to a claimant's private health insurance company or Medicare instead of DEEOIC. This usually occurred when bills remained unpaid for an extended period of time. Additionally, for surviving family members of claimants, obtaining payment of outstanding medical bills and out-of-pocket expenses presented their own set of challenges.

A. Medical Bill Payment Issues

Some of the individuals who contacted our office for assistance with medical bill payment and reimbursement issues in 2023 were based upon the continuation of issues initially brought to our attention in 2022. In our 2022 annual report, we shared a claimant's difficulties getting payment for medical bills related to their organ transplant procedure, as well as a multitude of post-transplant procedures, prescriptions, and out-of-pocket medical expenses. At that time, most of the outstanding bills were from 2014 through 2020. The claimant passed away in August of 2022, and we reported that their surviving spouse continued to request assistance from our office with obtaining payment of the outstanding bills and out-of-pocket reimbursement requests. At the end of 2022, it appeared that DEEOIC had begun the process of reviewing the medical bills and was instructing the bill-pay processing agent to issue payment for some of the expenses. Unfortunately, it took all of 2023 in order to resolve the surviving spouse's outstanding medical bills and reimbursement issues.

During the course of 2023, our office submitted numerous inquiries on behalf of this individual regarding a number of outstanding bills and expenses. For instance, in May 2023, the surviving spouse shared a batch of outstanding medical bills in the amount of $4,023.67 and requested assistance resolving the payment issues with DEEOIC. This batch represented one set of outstanding bills and expenses that both the claimant and their spouse had previously submitted to DEEOIC.

A second issue was that DEEOIC informed the claimant's spouse that the outstanding bills had been paid, only for them to later learn that many bills, in fact, had remained unpaid. Upon

learning that DEEOIC did not believe there were any remaining outstanding bills, the surviving spouse responded,

> That is exactly what they told me prior to contacting your office for the first time. Since your office's involvement, I have received in excess of $2000 in payments. I will continue my efforts to recoup the remaining funds through the [Resource] Center and with any other sources available to me.
> - Email from surviving spouse to Office of the Ombudsman (September 20, 2023.)

Third, the claimant's spouse had frequently spoken with the DEEOIC bill-pay agent by telephone and had frequently used the online Medical Bill Processing portal to submit and follow-up on the status of outstanding bills. However, in September 2023, they reported being locked out of the medical bill processing portal and no longer able to speak with the DEEOIC bill-pay agent. Having grown increasingly frustrated, the surviving spouse wrote,

> Unfortunately, nothing has been resolved. I am unable to converse with CNSI because all paperwork allowing me to act as Authorized Representative for my [spouse] has been deleted/archived. CNSI refers me to the [Resource] Center in North Augusta who just make excuses about how busy they are and that they will forward my information to their director who is also very busy. So just the run around, no resolution.
>
> I continue to make monthly calls requesting status but I hold out little hope of any resolution through the [Resource] Center. The dysfunction of the DOL and the lack of response to bills that total less than $500 and are more than 5 years old, now, 18 months after my [spouse's] death is galling.
> - Email from surviving spouse to Office of the Ombudsman (November 16, 2023.)

As of December 26, 2023, the issues involving outstanding medical bills and expenses had been elevated.[31] While the surviving spouse supported the claimant through their medical treatment and passing, they were also required to dedicate much time and effort towards getting numerous outstanding medical bills paid and out-of-pocket expenses reimbursed. We have encountered few people willing to stay engaged in this process as long as the surviving spouse in this case.

In another case first brought to our attention in 2022, the surviving child of a claimant continued to seek assistance from our office into 2023. After the claimant passed away in early 2022, the surviving child directed the healthcare providers who treated the claimant for their accepted covered illnesses to submit any outstanding medical bills to DEEOIC for payment. One of the healthcare providers filed legal action against the surviving child for over $20,000 in unpaid medical bills as a result of not receiving payment from DEEOIC. As of December 2022, some of the outstanding medical bills had been paid, but it was not until April 2023 that our office received confirmation of payment for the final outstanding medical bills.

[31] We received confirmation from the surviving spouse on January 23, 2024, that the remaining outstanding payments had been received the previous day.

The surviving child in this claim spent one year attempting to obtain payment of the outstanding medical bills. During this process, they paid a number of bills out-of-pocket in order to avoid legal action, but because they were unable to pay the $20,000+ hospital bill, the hospital filed a legal action against them. In addition to the medical bills, the surviving child then hired a lawyer to defend themselves, incurring significant additional cost in doing so. By the end of this process, the surviving child expressed deep frustration with what they described as insufficient communication and assistance from DEEOIC, which in large part was due to a lack of coordination between the healthcare providers, the DEEOIC bill pay agent, and the DEEOIC bill pay staff. They also noted that they were unable to seek reimbursement for the expenses to defend themselves against the legal action taken by the hospital.

We were also contacted by claimants who repeatedly found themselves unable to obtain reimbursement for covered medical expenses. One claimant contacted our office in April and October of 2023 after being unable to resolve the issues on their own. In the first instance, the claimant requested reimbursement for over $1,300 in out-of-pocket expenses for travel to obtain medical treatment in November 2022. The claimant explained the issues as follows:

> The claim was partly paid and I was requested to fax copies of the doctors findings as evidently part of my claim was [sic] lost or misplaced by the department of labor [sic]. I repeatedly faxed the copies requested and nothing happened for several months, so I refilled [sic] the November 16, 2022 claim with notation of parts that were paid. Now after several months, I see the whole claim has been denied…When you examine the parts of the claim that were paid it doesn't make any sense. Tolls in Kansas City were paid but not the 800+ miles of travel or the per diem. I don't know who to contact to get any sort of explanation of the denial, or any way to appeal.
> - Letter from clamant to Office of the Ombudsman (April 14, 2023).

On May 16, 2023, DEEOIC confirmed that the necessary actions had been taken to have the claim paid. However, in mid-June and early July, the claimant informed us that they had still not received reimbursement from DEEOIC. The claimant finally received reimbursement on July 20, 2023.

In the second instance involving the same claimant, they submitted a medical expense claim for services provided in May 2023. The claimant submitted the expenses on June 21, 2023, and confirmed receipt by DEEOIC through correspondence tracking services. However, the claimant reported no response from DEEOIC and resubmitted the medical expenses by facsimile on July 13, 2023. In October 2023, DEEOIC advised our office that this individual's claim for medical expenses had not been received and could not be found in its system. The claimant provided documentation indicating the correspondence had been sent by priority mail with signature required, and had a copy of the signed, returned receipt. Then, in mid-November, claimant wrote that they received an unsigned letter from "Fiscal Agent Services" stating they had an invalid claimant ID number. At this point, the claimant shared with our office that they believed their claims were not going to be resolved by DEEOIC. On November 29, 2023, our

office provided the same package of correspondence to DEEOIC that claimant had previously submitted, and it is our understanding that claimant was eventually reimbursed in January 2024.

This case highlights the challenges faced by claimants in obtaining reimbursement from DEEOIC, even in relatively straightforward reimbursement transactions that only require the submission of a form and receipts from the claimant. Unlike medical bill payments involving healthcare providers or other entities, this reimbursement process only requires interaction between the claimant and DEEOIC. Nonetheless, a number of claimants encountered similar obstacles, including insufficient communication from DEEOIC and delays in addressing issues brought to their attention.

Lastly, a common issue encountered by claimants was healthcare providers who billed private health insurance or Medicare instead of DEEOIC for medical expenses related to accepted covered illnesses.[32] A claimant with multiple covered medical conditions reached out to our office because they realized that their private health insurance had been billed for medical treatment that should have been billed to DEEOIC. Consequently, since there was a cap on the total expenses their private health insurance would pay, they risked depleting their private health insurance coverage for medical treatment not related to their covered EEOICPA medical conditions. We provided the claimant with the DEEOIC policy guidance indicating that DEEOIC is responsible for coordinating benefits with private insurers or government entities like Medicare. According to DEEOIC policy, a Coordination of Benefits letter is sent from the DEEOIC Payment Systems Manager to the health insurance company or government entity instructing them to submit all reimbursable charges to the DEEOIC bill-processing contractor for payment.

In other instances, claimants first learned that their private health insurance company or Medicare had been billed when they received a co-payment or co-insurance bill. Claimants with accepted medical conditions under the EEOICPA are not responsible for any out-of-pocket expenses related to covered medical treatment and should not receive such bills. However, as mentioned earlier, this occurrence is widespread and warrants greater effort to inform claimants that DEEOIC can directly notify health insurance companies or Medicare of its status as primary payor.[33]

Claimants consistently found themselves caught between DEEOIC claims staff, RC staff, healthcare providers, pharmacies, bill pay contractors and others as they tried to get their medical bills paid or prescriptions filled. In these situations, claimants usually had little to no knowledge regarding how to identify the issues or get them resolved. On the other hand, DEEOIC has established a dedicated, internal email inbox to serve as a conduit for DEEOIC staff when seeking assistance with the "…disparate medical bill processing issues confronted by DEEOIC staff, especially MBE staff…" See EEOICP PM Chapter 28.3 (Version 8.0) (November 17,

[32.] DEEOIC is primary payor for any medical illnesses or conditions accepted under the EEOICPA.
[33.] DEEOIC Circular 21-02 describes the process by which DEEOIC is to notify private health insurance companies and government entities that bills for DEEOIC covered medical expenses must be submitted to DEEOIC for payment. Sample letters sent to private health insurance and government agencies are also included in the PM. See EEOICP Circular 21-01, Reimbursement Letter to Government Entities and Insurance Carriers (August 4, 2021).

2023). The purpose of the DEEOIC Bill Pay Mailbox is to,

> provide a method for obtaining a timely resolution of medical billing processing issues, as they arise, and provide a uniform process for responding to questions and issues, program wide. (Ibid.).[34]

The internal DEEOIC Bill Pay Mailbox appears to be set up to assist MBEs with the timely resolution of medical bill processing issues. We strongly encourage DEEOIC to identify a dedicated person or group to address outstanding medical bills and requests for reimbursement that have not been provided a response within 60 days from the date the bill was submitted for payment. The DEEOIC Bill Pay Mailbox could be used by MBEs to route those claims to the dedicated person or group of DEEOIC claims staff to assist in resolving any issues.

Additionally, many claimants and healthcare providers report being unaware of the public email address for medical bill inquiries, which is DEEOICbillinquiries@dol.gov. Our recommendation is for this email address to be posted prominently on the DEEOIC homepage, as well as with the documentation accompanying the issuance of a new DEEOIC Medical Benefits card. It would also be helpful to post this email address in the DEEOIC online How to Guides and the DEEOIC medical benefits brochure. The goal should be to provide claimants and healthcare providers access to DEEOIC staff who understand that their medical bill payments or prescriptions have been delayed and will focus on resolving those issues in a timely manner.

B. Pharmacy Billing Issues

In mid-2023, a new company, myMatrixx, began providing Pharmacy Benefit Management (PBM) services for DEEOIC claimants. As a result, claimants with accepted medical conditions were sent new medical benefits cards for their pharmacy bills to be processed by myMatrixx. As of June 5, 2023, pharmacies were required to submit their pharmacy transactions to myMatrixx.

During our outreach efforts in 2023, we encountered groups of claimants who had not yet received their new medical benefits cards and others who had received the cards but did not fully understand the reason they had been sent a new card. We also heard from claimants who experienced difficulties using their new medical benefits cards to obtain their prescription medications. For instance, we heard from a claimant in New Mexico who had been ordering their prescription medications from a specialty pharmacy in Nevada which shipped directly to their home. After the switch to myMatrixx, the claimant's pharmacy advised them that out of state shipping was no longer authorized.

Upon contacting DEEOIC on behalf of this claimant, we were informed that myMatrixx had a network of pharmacies. Thus, any issues a network pharmacy had with billing or procedures was a contractual issue between the pharmacy and myMatrixx. We were advised that if a claimant was not able to get services from their current pharmacy, they could contact

[34] The discussion of the DEEOIC Bill Pay Mailbox does not include timelines for the timely processing of medical bills.

myMatrixx to find a new, in-network pharmacy. We were also advised that myMatrixx had a mail order prescription service claimants could switch to. This claimant was pleased to learn they needed to change specialty pharmacies due to the transition to myMatrixx.

Our office received feedback from claimants that the transition to myMatrixx was also challenging because many pharmacies were unaware of the change and did not know how to bill myMatrixx. These challenges almost always resulted in claimants having their prescription medication delayed or required them to find another way to pay for their medication. Some claimants had to change their pharmacy as a result.

Another claimant who used a specialty pharmacy to fill their prescription medication immediately ran into difficulties filling their prescription, writing,

> The confusion between what was printed on my benefits card, and the required information for the contractors is a nightmare. The Case Number does not equate to a required field in the contractors database and [provider] won't use the SSN. Evidently there needs to be 5 leading zeros for my case ID of [x] which is not printed on the card. The Member ID is not listed at all on the card. To put it mildly, WHAT A CIRCUS! There is nothing timely about this process.
> - Email from claimant to Office of the Ombudsman (July 20, 2023).

This claimant required prescription medication to be administered on a set schedule, and despite their efforts contacting DEEOIC and the new PBM, their receipt of the medication was delayed.

Ensuring timely access to prescription medication is crucial for claimants. However, with each change in the system that processes claims for medical or pharmacy benefits, claimants experienced delays in obtaining their benefits for a variety of reasons. With the change to myMatrixx, it appeared that pharmacies already enrolled with myMatrixx may have had a smoother process obtaining reimbursement, however, claimants were entirely unaware of this fact or its relevance to getting their prescription filled. However, some pharmacies were also unaware of the change to myMatrixx and reportedly experienced difficulties figuring out how to access and submit bills to myMatrixx.

Each year, the number of claimants with accepted claims under the EEOICPA increases, as do the medical conditions requiring prescription medications. Given that the demand for timely processing of pharmacy bills has increased year over year, greater communication and assistance to claimants and healthcare providers, including pharmacies, is required to avoid the confusion and delays.

C. Payment of Outstanding Medical Bills for Deceased Claimants

When an employee's claim has been accepted and there are outstanding medical expenses at the time of their passing, DEEOIC routinely issues reimbursement checks payable to the estate of the employee. However, this process is almost always cumbersome and costly, as setting up an estate is often complex, expensive and time consuming. Some employees established a trust to avoid the probate process upon their death. In 2023, we heard from surviving family members of deceased employees who encountered difficulties when DEEOIC refused to issue reimbursement payable to a trust established by the employee prior to their passing. As a result, the families were unable to cash the checks that DEEOIC made payable to the estate of the employee without incurring additional time and expense of setting up an estate and going through the probate process.

For example, a surviving spouse received a $7,000 reimbursement check from DEEOIC made payable to the estate of the employee shortly after the employee's death. Despite being told by DEEOIC staff that outstanding out-of-pocket medical expenses could be submitted for reimbursement after the employee's passing, the surviving spouse was unaware that they would be required to set up an estate to cash the check. The surviving spouse expressed frustration because the employee created the trust to specifically avoid the probate process for all of their assets. The surviving spouse questioned why the check could not be made payable to the trust. When the surviving spouse consulted a lawyer regarding the creation of an estate, they were advised that it would cost a minimum of $2,000 to set up and likely even more to administer. Noting that the reimbursement check was $7,000, the surviving spouse commented,

> It's penalizing us when you say we're here to help you. It only helps the lawyers and courts. [DEEOIC] is taking money out of our pocket for no reason.
> - Statement from surviving spouse (October 20, 2023).

The surviving spouse in this case was left with no choice but to engage the services of a lawyer to set up the estate and begin the probate process.

Similarly, in another case, approximately $15,000 in outstanding medical expenses incurred prior to the employee's death in 2017 remained unpaid. Upon contacting our office in 2023, the surviving spouse advised that DEEOIC had issued a check made payable to the estate of the employee. The surviving spouse objected to the time and expense of setting up an estate in the employee's name for the sole purpose of cashing this one check. The employee's assets at the time of their passing fell below the level that prompted the creation of an estate and there was no inheritance tax in the state where the employee resided. As noted in the determination requiring the surviving spouse to set up a small estate proceeding in order to cash the check, "…it has been the practice of DEEOIC where claims for reimbursement of medical expenses are submitted after the death of the employee, to make those payments to the estates of such

covered employees." See SOL Memorandum to DEEOIC (March 27, 2023). DEEOIC also noted an exception for community property states, but determined the employee and surviving spouse did not reside in a community property state and therefore did not qualify for the exception.

According to the DEEOIC policy, if payment for medical reimbursement is being requested to a payee other than the employee's estate, the district office reviews the request to determine the appropriate action. See EEOICP PM Chapter 28.13(b) (Version 8.0) (November 17, 2023). Furthermore, if the request is for any reason other than a "community property" issue, the district office obtains documents the requesting party wishes to produce in support of his or her claim, and forwards them to the Medical Benefits Processing Unit (MBPU), who then forward the request and supporting documents to the Solicitor's Office (SOL) for review and guidance. See EEOICP PM Chapter 28.13(b)(2) (Version 8.0) (November 17, 2023).

Upon receipt of guidance from SOL supporting the request to change a payee name, the MBPU will reissue the check payable to the payee name. See EEOICP PM Chapter 28.13(b)(3)(c) (Version 8.0) (November 17, 2023). Thus, based upon DEEOIC policy, it appear to be within the discretion of SOL and DEEOIC to issue a check payable to the payee name, including to a trust created by the employee.

At first blush this may not appear to be as significant an issue as some others brought to our attention in 2023, but the impact of this policy on the surviving family members of deceased employees is broad in scope and has a significant impact. Unlike a trust that individuals create before their death, an estate can only be created after a person has passed away. Therefore, the creation of an estate most often falls to surviving family members and is a time-consuming, inefficient process that can be quite costly.

In the interest of fundamental fairness, if requested and with proper documentation, DEEOIC should approve the issuance of reimbursement checks made payable, at a minimum, to the trust of deceased employees. Trusts are widely used legal mechanisms that individuals frequently have life insurance, retirement accounts, and other proceeds deposited into after their passing. A reimbursement check from DEEOIC can undoubtably be made out to and deposited into an employee's trust. With respect to employees who pass away with assets that do not meet the minimum threshold for creating an estate, DEEOIC should exercise its discretion to issue the reimbursement check made payable to the employee's surviving spouse or any other survivors as required by relevant state laws.

CHAPTER V.
CUSTOMER SERVICE

During 2023, claimants, ARs, healthcare providers, and others reached out to us seeking clarity on claim-related matters. Many were unsure of the status of their claims or whom to contact for assistance. Other examples included children of DOE workers seeking guidance on filing for survivor benefits under EEOICPA; claimants who required assistance understanding what type of evidence they needed to provide to DEEOIC; and individuals who called the toll-free number for DEEOIC and were unable to speak with the same person twice. Moreover, almost all claimants were unaware that in limited circumstances, they could send an email to DEEOIC for assistance. DEEOIC has a public email address for medical bill inquiries (DEEOICbillinquiries@dol.gov), but the majority of the individuals who contacted us were unaware of it and/or did not know where to find it. The majority of the issues we encountered can be summarized as: A) confusion surrounding the roles of individuals in DEEOIC; B) communication, deadlines, and expectations; C) delays; and D) behavior of DEEOIC staff.

A. Confusion Surrounding Roles of Individuals in DEEOIC

When a person contacts our office before filing a claim for benefits or shortly afterwards, we appreciate the opportunity to not only answer their questions, but to give them an overview of the road that lies ahead. We informed them of the initial steps in the process and explained the various documents they would need to produce, as well as the various types of people employed by DEEOIC they could expect to communicate with during the process. For example, at the outset, we shared the ways they could file a claim for benefits and the documents that made up what it meant to "file a claim." We informed workers or their surviving family members that they would likely need to participate in an interview with RC staff that usually takes 2-3 hours and would require them to share specific details of their employment, any/all workplace exposures, and any safety equipment they used. The information sought from claimants during the interview is then incorporated into an Occupational History Questionnaire (OHQ). For those who worked for a significant amount of time at a covered facility, remembering dates, job titles, buildings, incidents and accidents, any/all exposures was often a daunting task. We suggested they write down as much as possible prior to their interview in order to increase the likelihood of providing as much detail as possible.

After this step, an individual's claim is then assigned to a CE, whose task is to gather and review evidence, and ultimately issue a decision to accept or deny the claim. The CE routinely sends correspondence to the claimant requesting information and evidence. In an effort to communicate with their CE by telephone, we heard from claimants that when they called DEEOIC, they assumed the person who answered their telephone call was their CE. However, all calls to the main telephone numbers for DEEOIC are routed to one of the eleven (11) RCs across the country.[35] RC staff not only answer all incoming calls but provide a number of services.[36]

[35] In October 2019, all telephone calls to the main DEEOIC telephone numbers were routed to the RC offices.
[36] RC staff do not issue EEOICPA decisions.

For example, RCs accept documents from claimants which are then uploaded into the claim file where their CEs can access them. Confusion arose when individuals thought they were speaking with or providing their documents to the person who would be making a decision on their claim but were actually speaking to a RC staff member. They wanted to talk to the decision-maker in their claim in order to feel confident their questions were being answered by the person who was tasked with determining their eligibility for benefits. This lack of clarity extended to understanding the various roles within the DEEOIC and the inability to communicate directly with the appropriate person to assist them.

For other claimants, their confusion was compounded by the fact that in addition to being unaware of the various roles of the DEEOIC staff they spoke to, they received letters and telephone calls from other agencies such as the National Institute for Occupational Safety and Health (NIOSH).[37] At this stage in a new claim, the claimant has already spoken to RC staff and potentially spoken to their CE. If the claimant filed a claim for cancer, they were now required to participate in an interview with a NIOSH representative.[38] We received communication from claimants in 2023 that made it clear they did not understand the difference between the OHQ interview with the RC staff and the NIOSH interview, or how the interviews were going to be used to make a determination in their claim.

The process described above addresses the relatively early stages of the claims adjudication process. As a claimant continues through the process, they may also be introduced to a host of acronyms describing other agencies and/or experts employed by DEEOIC to provide reports on their claim. Claimants are not provided advance notice that DEEOIC expert opinion reports are being requested, nor are they provided a copy of the opinion reports until they receive their Recommended Decision.

Claimants are sent a Recommended Decision and accompanying documents that inform them how to file objections, i.e., appeal, or how to waive their right to file objections, i.e., agree with the decision. Accompanying the decision should be any expert opinion reports requested by the CE. We frequently heard from individuals during this phase of the claim process because they did not understand why their claim was recommended for denial, and/or they did not understand their appeal rights or what the "waiver" meant. Also, in cases where DEEOIC asked for an expert opinion report(s), claimants had just seen these report(s) for the first time and did not understand why they were only now being provided a copy.[39] We routinely informed claimants of the role of DEEOIC contracted experts in the claims process; their options for proceeding should they disagree with the expert's findings; and that they could request a copy of the questions and documents the CE sent to the expert. Given the 60-day window that claimants have to file objections to the Recommended Decision, many claimants expressed feeling overwhelmed by the discovery that they were now required to come up with evidence to refute DEEOIC experts under a deadline. Some claimants wished to speak to their CE about

[37] NIOSH is the federal agency responsible for conducting the dose reconstruction for cancer claims under Part B of the EEOICPA.
[38] Only claims for cancer under Part B of the EEOICPA can be referred to NIOSH for dose reconstruction.
[39] A CE can refer a claim to a Toxicologist, Health Physicist, Industrial Hygienist (IH), Contract Medical Consultant (CMC), and/or Referee Specialist for an expert opinion report.

the Recommended Decision, but by the time they received their Recommended Decision, their claim has already been assigned to a hearing representative (HR) in the FAB.

At this stage, claimants were informed that an HR would address their objections, conduct a hearing when requested, and issue a final decision on their claim for benefits. Just as the claimant was unable to call their CE directly, they were also unable to call their HR directly. On the other hand, when a claimant's claim was accepted, most can expect to be assigned an MBE at some point in the claims process. The MBE decides whether to authorize certain medical benefits, and again, claimants will be unable to communicate with this person directly.

In many instances, claimants were unaware that their claim for certain medical benefits was being decided by an MBE and not their CE. When they contacted us, they were insistent that their medical authorization request had been sent to their CE and were unaware that both a CE and an MBE may be simultaneously working on different aspects of their case. For example, the CE may be addressing their claim for impairment benefits while at the same time the MBE is addressing their authorization request for home healthcare or durable medical equipment.

The claims process described above does not address the full scope and complexity of the EEOICPA claims process and the various times a claimant may need to speak to one or all of the people fulfilling the various roles in that process. We have unfortunately been made aware of circumstances where the information provided to a claimant or their family member was not accurate, and they were unable to identify the source of the information given their inability to contact the same person twice or to contact their CE, HR, or MBE directly.

It is important for EEOICPA stakeholders to clearly understand who they are speaking with, what office the person is assigned to, and the person's role in the EEOICPA claims process.[40] It would be helpful if all calls were answered in a way that identified the location and role of the person the caller had reached, as well as how to contact that same person again for follow up assistance. Likewise, as the role of the RC staff has significantly expanded over the past few years, it would be helpful for callers to still have the option to contact their CE, HR, and/or MBE directly regarding certain questions and issues.[41] It is equally important that they be able to communicate in writing via direct messages in a secure DEEOIC portal or by email in order to ensure accountability and clarity of communication.

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[40] In addition to RC staff, CEs, MBEs, and HRs, some claimants will be required to communicate with representatives from DEEOIC billing and pharmacy benefits contractors.

[41] The RC staff answer all incoming calls directed to the RC numbers and to the DEEOIC toll free lines, which results in answering approximately 2,500 calls per week. The RC staff assist claimants with filing claims, explaining benefits, checking claims status, understanding the development process, conducting Occupational History Questionnaires, uploading forms and documents directly to the case file (EDP), providing an explanation of medical benefits, providing DEEOIC medical benefits brochures, assisting with the completing of medical and travel reimbursement forms, transmitting claimant reimbursement forms to the bill pay agent, assisting in locating enrolled medical providers, troubleshooting medical billing issues for claimants and providers, notifying the Medical Bill Processing Unit and Medical Benefits Adjudication Unit about claimant reimbursement or provider bill issues, assisting providers by explaining DEEOIC provider enrollment, and updating provider enrollment and information on the OWCP Medical Bill Processing Portal and DEEOIC websites. The RC staff also identify outreach needs, identify outreach locations, venues, and oversee logistics for each event. They conduct monthly local outreach to include literature distribution, residential mailings, local advertisements, and attending meetings of local community organizations. The RC staff also plays a role in organizing the Authorized Representative workshops and JOTG outreach events. See DEEOIC Webinar Presentation – Role of the Resource Centers (May 25, 2022) - https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Outreach/Outreach_Presentation/role_of_the_rc052522.pdf.

Our recommendation is for DEEOIC to allow claimants and ARs access to communicate with the RCs, and all DEEOIC claims staff through one of DEEOIC's secure online portals (Employees' Compensation Operations & Management Portal (ECOMP) and Energy Document Portal (EDP)) or by email. The portals already allow claimants to view some of their claim file records and to upload documents directly to their claim file. The next step, which private healthcare providers and some other agencies have implemented, is to provide for written messages or email communication between claimants, AR, RC, and DEEOIC staff.

These recommendations would go a long way towards resolving the problem of claimants not knowing the name or role of the person they spoke with on a given day, as well as providing accountability around documenting exactly what each party to the conversation said. As it currently stands, claimants and ARs are often proceeding through the claims process without a complete understanding of who they are communicating with and what their role is in the process. This lack of clarity also sometimes results in a reduced time period for claimants to provide DEEOIC with the necessary information needed to prove their claim or receive medical benefits.

B. Communication, Deadlines, and Expectations

As soon as a new claim is filed, the claimant is under time constraints to provide information and documentation to DEEOIC. DEEOIC has logically noted that deadlines are required so that cases move efficiently through the adjudication process. However, some of the deadlines for claimants and their doctors to provide documents to DEEOIC have been shortened over time. For example, claimants and their doctors were previously given 30 days to submit a medical report supporting their request for home healthcare. If there was no response after 30 days, the claimant and their doctor were given another 30 days to submit the evidence. In each instance, a development letter was sent to the claimant and their doctor informing them of the 30-day deadline to submit the requested documents. (See EEOICP Procedure Manual, Chapter 30.2(h) (Version 3.0) (April 5, 2019).

Claimants and their doctors are currently only given 15 days from the date of the development letter to provide the requested medical evidence, and an additional 15 days if the evidence is not received within the first 15-day time period. (See EEOICP Procedure Manual, Chapter 30.7(b) (Version 8.0) (November 17, 2023). Claimants and healthcare providers have both complained that by the time the development letter arrives at claimant's home and doctor's office, there is inadequate time to respond to the request. Moreover, the initial development letter does not inform the claimant or doctor that failure to respond within the 15-day deadline will result in second development letter that will give them another 15 days to respond. As a result, claimants contacted our office to question how they were supposed to get their doctor to respond to DEEOIC's letter when they received it only a few days before the 15-day deadline. Claimants have shared they were unable to schedule an appointment with their doctor within the timeframe provided, and they did not anticipate being afforded another 15 days. This scenario highlights what some claimants have described as a lack of meaningful

communication, to include failure to set clear expectations for how long claimants have, in total, to respond to DEEOIC.

Another frequent example occurs at the beginning of the claims process. A claimant is asked to fill out a form listing the dates and facilities where they worked.[42] The CE then takes specific steps to verify the employment dates and facilities listed by the claimant on the form. If the claimant wrote that they worked at a DOE facility, the CE will send a request to DOE seeking verification of the claimed employment using a secure, online portal. The claimant, however, is not routinely informed that the CE requested employment verification from DOE, and often receives a letter from the CE asking them to submit evidence to prove their DOE employment.

Upon receipt of this development letter, claimants frequently request their employment records from their DOE employer, which oftentimes involves submitting a Freedom of Information Act (FOIA) request. At this stage, both the CE and claimant are simultaneously submitting requests for employment evidence from DOE, thereby creating an added burden on the claimant and DOE by duplicating the efforts of DOE to produce the employment documents. However, it's worth noting that it is beneficial for some claimants to obtain a copy of their employment records from DOE because once DEEOIC gets their employment records, DEEOIC does not inform claimants of the types of records received, nor that claimants can request a copy of their employment records from DEEOIC. In fact, we often are the first to inform claimants that they can request a copy of any and all documents from their claim file as long as the request is made to DEEOIC in writing.

Because DEEOIC has not consistently informed claimants that it has requested their employment records, many claimants believed they were solely responsible for providing this documentation to DEEOIC. Instead of automatically asking claimants for employment verification evidence, DEEOIC should first assess the response received from DOE. Then, if additional evidence is needed from a claimant, a development letter specifically identifying the deficiencies in the evidence can be sent to the claimant. Likewise, when the CE receives employment verification evidence and employment records from DOE, the claimant should be notified and provided information regarding how to obtain copies of the records. Given how frequently our office is the first to inform a claimant that they can request copies of records from their file, it is our recommendation that this information be included in all initial letters sent to claimants and ARs.[43] This basic level of communication and setting of expectations will go a long way in providing claimants a better understanding of where they are in the claims process and the evidence being used to make a decision in their case.

With respect to telephone communication, claimants, ARs, and healthcare providers contacted us this year after being unable to speak to their assigned CE, HR, or MBE. We saw an uptick in requests for assistance where the individual who contacted us was unable to speak with their MBE over the telephone. Claimants with an accepted illness(es) who were unable to

[42] This is the EE-3 Employment History form.
[43] Claimants who sign up to access ECOMP can see some of their claim file documents online. However, employment records from DOE are not available in ECOMP.

communicate with their CE or MBE by telephone frequently reported feelings of anxiety and frustration to our office. For claimants with accepted claims, the MBE is the person who decides, for example, whether their request for medical treatment is authorized. In many instances, requests for authorization of medical treatment is time-sensitive and claimants do not understand or appreciate what feels like a multi-step process of trying to speak to their MBE.

Claimants described a cycle of calling and speaking to someone in a RC, who then transferred them to the MBE who was frequently unavailable, at which point they could either leave a message with the RC staff or on the MBE's voicemail. In the event a claimant was unable to answer the MBE's return call, claimants reported they assumed it would take another 24 - 48 hours of phone tag before connecting with their MBE. Others complained that they did not receive a return call from their MBE and did not know who to contact if they could not speak with them.

Claimants and ARs made clear that the ability to correspond with their CE or MBE through one of DEEOIC's secure online portals, or by email, would be far more efficient and lead to greater accountability. The need for documentation of the communication between claimants, RC, and DEEOIC staff was top of mind as the most logical way to mitigate these issues. When we informed claimants and ARs that their only option was to call or send a letter to the MBE, one claimant who was seeking authorization for physical therapy informed us that they were simply going to stop pursuing their claim because it was not worth the effort. They shared that the physical therapy was helping them recover, but the frustration of trying to communicate with their MBE now meant they needed to consider their options to either pay out-of-pocket or allow their private insurance to cover the cost.

Other individuals filed complaints with our office when they were unable to access one of DEEOIC's online portals and the customer service number associated with the portal was not helpful. For example, in one instance, the individual was unable to access the EDP in order to upload documents to a claim file. When they called the customer service number for the portal, they were unable to connect to a person to speak with during their first three attempts. When they finally were able to speak with someone, the person was unable to help them and abruptly ended the call.

Another individual was unable to update the spelling of their name in the ECOMP portal and as a result they were not receiving documents related to their claims. Again, unable to speak to someone in customer service, they contacted our office for assistance. Poor communication in this instance resulted in the ARs inability to access thirty-one of their clients' online case files for over two months. And finally, we were informed of an individual who received copies of another claimant's personal information and records on more than one occasion. While we are unable to say how many instances of this type of breach of personal information occurred in 2023, this is more than has been brought to our attention in the past few years.

These scenarios and examples illustrate systemic issues with communication, deadlines, and expectations that can be addressed by DEEOIC in meaningful ways. Development letters can inform claimants and doctors they will be given a total of 30 days to submit medical evidence. Development letters seeking employment documentation can notify claimants that DEEOIC has

requested employment records from DOE. Claimants can be informed that they can request copies of any/all records from their claim file by including this information in the new claimant packet and development letters. Utilization of DEEOIC online portals, or email, for sending and receiving electronic messages is needed to improve communication and accessibility to DEEOIC claim staff. Likewise, enhanced customer service for those who experienced difficulties accessing and using the DEEOIC online portals would be beneficial.

C. Delays

Some individuals who contacted us in 2023 were uncertain who to call after being unable to determine the status of their claim. Others reported that the processing of their claim had slowed down considerably or had seemed to stop. Moreover, frustrations were voiced over unanswered calls and difficulty in finding reliable points of contact within DEEOIC. Often, individuals approached our office only after exhausting efforts to resolve issues directly with DEEOIC and sought immediate resolution upon reaching us.

In these situations, our office was unable to immediately provide information to the person who contacted us because in order to speak with DEEOIC regarding their claim, DEEOIC requires a Privacy Act Waiver signed by the claimant or AR. Without a signed Privacy Act Waiver, our office was unable to obtain information or documents from DEEOIC pertaining to a claim. We email the Privacy Act Waiver to some claimants, but others must be sent through the mail due to claimant's limited access to a computer or printer. Claimants who received the Privacy Act Waiver by email were required to print it out, sign it, scan it, and attach it to an email to return to our office. Those who did not have a printer had to travel to another location to have the Privacy Act Waiver printed and scanned, while others sent it back to us by facsimile or mail. Regardless, this process delayed our ability to review claim specific information or documents. As a result, we often heard claimants express exasperation at being asked to fill out another form before they could receive assistance. It's also worth noting that when an individual has already explored other avenues to obtain information or assistance, this requirement sometimes served as a roadblock, or at a minimum, an impediment to getting help.

Additionally, a wide variety of individuals involved with the EEOICPA program contacted our office during 2023 to complain about delays at various stages of the claims process. For example, one claimant sought assistance from our office after they had not received information from DEEOIC regarding their cancer claim. We confirmed with DEEOIC that the claim had no activity for over one and one-half years, and that the claimant had received no communication from DEEOIC during that time period. No reason for the delay was provided to the claimant or our office but work did immediately resume on the claim.

Another claimant contacted us after they were unable to learn the status of their authorization for home healthcare benefits for over four months. The claimant stated they had left multiple telephone messages for their MBE and had not received a return call. When our office reached out to DEEOIC, we were advised that the claim for home healthcare benefits was being denied. This came as a surprise to the claimant as they were unaware of any specific issues with the home healthcare request.

Finally, an AR sought assistance from our office when a claimant with pulmonary fibrosis was unable to get their request for supplemental oxygen processed. The AR shared that the medical records and orders had been faxed to DEEOIC several times and that,

> [Claimant] states that [he/she] has not been able to receive any clear information about the status of the request for oxygen and equipment, as [claimant] indicates that there appears to be a snag between the medical benefits unit and CNSI.
> - October 2023 email from AR to Office of the Ombudsman.

After our office provided the claimant's medical records to DEEOIC, the claimant's authorization for supplemental oxygen was granted. However, during the time period when the claimant and AR did not know the status of the authorization, the claimant reported growing increasingly stressed by the uncertainty surrounding this essential medical treatment.

The impact of the delays discussed above not only impact the claimant, but sometimes their family members and the medical professionals who treat them. We heard individuals state that it was one thing for the processing of their claim to take longer than expected, but it was an entirely different thing not to receive communication regarding the reason for delays. We worked with claimants in 2023 who, because of an immediate need for medical attention, had to pay out-of-pocket, paid with alternate insurance, or went without the fully prescribed level of care.

Moreover, it was not lost on some claimants and ARs that while DEEOIC set specific deadlines for them to provide information and documents, it did not appear that DEEOIC was required to communicate with them regarding delays in the processing of their claims. One claimant specifically asked whether DEEOIC was required to inform them that the determination on their claim for medical benefits was delayed and why. We were unable to point them to any guidance indicating DEEOIC was required to do so. Nor were we able to direct the claimant to a single point of contact to register their concern about the delay. Instead, per DEEOIC policy, we could only advise them to call a supervisor in the DEEOIC office handling their claim or send an email to the public DEEOIC email address.

When DEEOIC is aware that a claim is taking longer than normal to process, every effort should be made to communicate with the claimant or AR to acknowledge the delay and provide an expectation regarding when action on the claim will proceed. Likewise, claimants and ARs should have a specific point of contact to communicate with when they are unable to reach their assigned examiner.

D. Behavior of DEEOIC staff

During 2023, individuals contacted our office after experiencing what they described as rude or inappropriate behavior by a DEEOIC staff member. Others contacted us for a different reason, but during the course of conversation shared that a DEEOIC staff member had been rude to them or treated them inappropriately. The most common question we received following the report of rude or inappropriate behavior by a DEEOIC staff member was whether a request could be made to change the DEEOIC staff member assigned to their claim. However, there is

no DEEOIC process or form to request such a change. Instead, we shared that DEEOIC policy is to inform those with such complaints to contact a supervisor in the office where the person they are complaining about works or submit a complaint to the DEEOIC public email address. This information is almost always met with skepticism and reservation from claimants and ARs.

We have found that individuals who experienced rude or inappropriate behavior from someone who is entrusted with making a determination on their eligibility for benefits are often very reluctant to complain to that person's supervisor. In 2023, as in past years, claimants and ARs expressed fear of retaliation as a result of filing a complaint with DEEOIC. They feared that if a supervisor spoke to the staff member they complained about, that staff member would be less inclined to make a favorable decision in their case. They were equally reluctant to send a complaint to a general DEEOIC email address because they did not know who was going to read the email and there was no expectation they would receive a response. Even one staff member who behaves inappropriately can impact a significant number of claimants and ARs. Without a clear mechanism, outside the claims adjudication process, by which complaints can be brought to DEEOIC's attention, claimants and ARs complained that DEEOIC did not seem to be taking their concerns seriously.

For example, a claimant and AR in one case both reported that a DEEOIC staff person assigned to their claim mocked and questioned the claimant's medical condition during telephone conversations. The AR characterized the behavior by the DEEOIC staff member in this instance as openly hostile. Another claimant praised the original DEEOIC staff member they worked with and shared their disappointment at being assigned a new staff member who they said was rude and insensitive. The claimant explained that they had previously received impairment compensation and were now filing for additional impairment benefits due to their worsening condition. The DEEOIC staff person allegedly told the claimant that the only way they would qualify for increased impairment benefits was if they required hospice care. The claimant was astonished by this comment and said they did not feel comfortable with this DEEOIC staff person handling their claim. An AR also reported being hung up on by a customer service representative during a conversation about accessing one of DEEOIC's online portals. The AR questioned why a customer service representative's poor behavior was able to seemingly go unchecked.

It goes without saying that any large organization may have individuals whose behavior is less than professional at times. The question is whether those who are subjected to this behavior (DEEOIC claimants, ARs, and others) can file a complaint outside the chain of command of the DEEOIC staff person and with the expectation of a response, and whether they can engage in a process to change the DEEOIC staff person assigned to their case. Neither of these options is currently available to DEEOIC stakeholders. A publicly stated process by which claimants and EEOICPA stakeholders can lodge specific complaints without fear of retaliation, and with an understanding of when and how they will receive a response from DEEOIC, is necessary to rebuild confidence in the program for those who experience such behavior.

In conclusion, it should be noted that a single customer service issue can impact DEEOIC customers in many ways. Greater transparency, better communication, and responsiveness would serve to significantly ameliorate some of the issues discussed in the preceding chapter.

APPENDIX 1

ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

ABTSWH	Advisory Board on Toxic Substances and Worker Health
AEC	Atomic Energy Commission
AR	Authorized Representative
AWE	Atomic Weapons Employer
BPA	Bill Processing Agent
BeLPT	Beryllium Lymphocyte Proliferation Test
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CMC	Contract Medical Consultant (formerly known as District Medical Consultant)
CPWR	Center for Construction Research and Training
CX Team	Customer Experience Team
DCMWC	Division of Coal Mine Workers' Compensation
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DLHWC	Division of Longshore and Harbor Workers' Compensation
DME	Durable Medical Equipment
DOD	Department of Defense
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
ECS	Energy Compensation System
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FAB	Final Adjudication Branch
FECA	Federal Employees Compensation Act
FOIA	Freedom of Information Act
FWP	Former Worker Medical Screening Program
HHS	Department of Health and Human Services
HR	Hearing Representative
ICD-10	International Classification of Diseases, 10th Edition
IH	Industrial Hygienist
JOTG	Joint Outreach Task Group

MBE	Medical Benefits Examiner
MED	U.S. Army Corps of Engineers Manhattan Engineer District
NDAA	National Defense Authorization Act
NIOSH	National Institute for Occupational Safety and Health
NO	National Office
OMBUDS	Office of the Ombudsman for the EEOICPA
OWCP	Office of Workers' Compensation Programs
PM	Procedure Manual
PoC	Probability of Causation
RECA	Radiation Exposure Compensation Act
RESEP	Radiation Employees Screening and Education Program
RC	Resource Center
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SSA	Social Security Administration
The Act	Energy Employees Occupational Illness Compensation Program Act

APPENDIX 2

2023 RECOMMENDATIONS OF THE ABTSWH

Advisory Board on Toxic Substances and Worker Health

July 3, 2023

Ms. Julie A. Su
Acting Secretary of Labor
Department of Labor
200 Constitution Ave.
Washington, DC NW 20210

Honorable Secretary Su:

On behalf of the Department of Labor Advisory Board on Toxic Substances and Worker Health, I submit the attached Advisory Board Recommendation that was adopted unanimously at the Board's meeting on May 17-18, 2023.

We sincerely hope that our advice is useful to the Department. We thank you for the opportunity to serve as Board members and wish the Program continued success in meeting the needs of the United States energy employees. Please let us know if there are questions.

Sincerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Assessment of Validity of Contract Medical Consultant Reports in the Evaluation for Claims in EEOICP

Advisory Board on Toxic Substances and Worker Health Recommendation

(Adopted by the Advisory Board on Toxic Substances and Worker Health, May 17-18, 2022)

Recommendation

The ABTSWH recommends that the EEOICP implement a mechanism to evaluate the validity and accuracy of the opinions and rationales that are expressed in the reports of the Contract Medical Consultants (CMC) in the claims evaluation process, with particular attention paid to the issue of causation of disease. This process may most usefully be applied to denied claims but may also be applied prospectively to a number of claims under evaluation. This mechanism should have sufficient independence of the current method of developing and obtaining CMC opinions in order to avoid actual or perception of conflict of interest.

Rationale

The Board recognizes that the EEOICP has in the past assessed aspects of the quality of the Contract Medical Consultant (CMC) reports that are obtained in the evaluation of claims in EEOICP. These aspects include timeliness of report, selection of appropriate medical specialties, responsiveness to questions posed by claims examiners, inclusion of well-developed rationales in the reports, and others. These are important attributes of the contract medical consulting process and can be assessed by non-medical personnel.

However, the Board notes that the current evaluation process of the CMC reports does not directly assess whether the opinions expressed by physicians in these reports and the medical knowledge upon which they rely conform with generally accepted medical opinion. That is, the validity or accuracy of these reports is not assessed, either in the routine claims evaluation process or by way of a special audit of a sample of CMC reports on a periodic basis. As a general matter, physicians may face the same set of medical facts and may vary in their interpretation of those facts in making decisions, especially about disease causation. Such variation within a reasonable range of opinion is normal, expected, and tolerable. However, in its review of claims, the Board has noted that a minority of CMC reports are in gross error, even as they appear to meet quality criteria of timeliness, selection of appropriate medical specialty, responsiveness to questions posed by claims examiners, and inclusion of well-developed rationales in the

reports. This is not surprising given the volume of claims and the challenges inherent in decision-making about complex diseases and their causes. In addition, occupational medicine is a very broad medical discipline with many niches. Not all such physicians have the combined clinical and epidemiological skill sets required to weigh in accurately about disease causation.

The EEOICP program needs to develop an enhanced capability, strategy and protocol to ensure that CMC reports are valid and accurate and that the current CMC contractor receives needed feedback and takes corrective actions to obtain a very high level of quality of CMC reports. The Board stands ready to provide additional advice to the program in this process.

Advisory Board on Toxic Substances and Worker Health

July 7, 2023

Ms. Julie A. Su
Acting Secretary, U.S. Department of Labor
Frances Perkins Building
200 Constitution Ave.
Washington, DC

Dear Ms. Su:

I am pleased to transmit a recommendation of the Department of Labor Advisory Board on Toxic Substances and Worker Health in relation to the Board's advisory capacity to the Energy Employees' Occupational Illness Compensation Program (EEOICP). It was adopted unanimously at our meeting on May 17-18, 2023 meeting. It is:

Improvements in Industrial Hygiene Assessment of Exposures in EEOICPA Claims

The Board hopes that our input is useful to EEOICP. It remains an honor for the Board to be consulted on important issues that face the Program. I would be pleased to answer any questions.

Sincerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Improvements in Industrial Hygiene Assessment of Exposures in EEOICPA Claims

Advisory Board on Toxic Substances and Worker Health Recommendation
(Adopted by the Advisory Board on Toxic Substances and Worker Health,
May 17-18, 2022)

Recommendation

The ABTSWH recommends that exposure assessments made by Industrial Hygienists (IH) be enhanced to specifically refer to the basic metrics of exposure science: (1) exposure intensity, (2) exposure route, (3) exposure frequency, and (4) exposure duration. These elements can have distinct value in determining causation. These metrics may further be divided by the facility and job under which they occurred for a claimant as relevant. We recommend that DOL adopt an IH exposure assessment form that puts the work of the IH in the context of these four basic metrics of exposure. The toxicants to be included on the form would be those determined relevant to the claimed medical conditions. An example form is provided with this recommendation.

Rationale

Referral of a case for industrial hygiene review and evaluation of potential exposure is a critically important part of the claim adjudication process, with numerous stakeholders relying on this evaluation for their next decisions. These include the claims examiner, the treating physician, the contract medical consultant and the claimant. The importance of this report in subsequent decision-making, especially causation analysis, is fundamental.

The basic metrics of an exposure assessment influence in distinct ways the different health effects associated with that exposure. These basic metrics are:

1. Type of exposure (direct, bystander, or area)
2. Route of exposure (inhalation, ingestion, skin absorption)
3. Intensity of exposure (concentration)
4. Frequency of exposure
5. Duration of exposure
6. Calendar timing of exposure (appropriate latency)
7. Use of personal protective equipment (PPE), engineering controls or other mitigating factors

Information about each of these elements of an exposure can contribute to the determination of causation for one condition differently from how that same exposure may contribute to another condition. Their value to this process may range from very relevant, to vague, to unknown. The accuracy of causation determinations by medical professionals can be harmed when all the aspects are fused together as a single metric as an exposure that may be of low relevance for one condition, could be of high relevance for another. For this reason, a singular assessment of relevance can obscure rather than aid the causation decision-making process.

Therefore, the Board recommends that the IH report explicitly state the sources of information used to make the determinations. In many cases, there is no documentation available, and this would be important information for the end user of the industrial hygiene report to have. Our recommendation is to implement a substantive change in the reporting of exposure assessments to better inform the determination of causation. Specifically, the exposure assessment and referenced summary report should include the key metrics describing the exposure as distinct categories for each relevant exposure. The Board proposes a new IH exposure assessment form (attached) including these metrics to help inform and guide this recommended change in process.

Proposed IH Exposure Assessment Form

Claimed condition:	Facility	Dates	Expos #1	Expos #2	Expos #3	Expos #4	Expos #5	Expos #6	Expos #7
Job #1:									
Type of exposure*									
Route of exposure**									
Intensity***									
Frequency^									
Duration (# years)									
Calendar years									
Use of PPE^^									
Source(s) of data			☐ SEM ☐ OHQ ☐ Interview ☐ IH data	☐ SEM ☐ OHQ ☐ Interview ☐ IH	☐ SEM ☐ OHQ ☐ Interview ☐ IH data	☐ SEM ☐ OHQ ☐ Interview ☐ IH data	☐ SEM ☐ OHQ ☐ Interview ☐ IH data	☐ SEM ☐ OHQ ☐ Interview ☐ IH data	☐ SEM ☐ OHQ ☐ Interview ☐ IH data
File page number(s) for IH monitoring data (or N/A)									
Comments re data sources									

Medical condition(s) for which compensation is being considered should be identified by the diagnostic term used in the claim. Exposures #1, #2, etc. should be identified by name as listed in the SEM (if applicable).
*Direct, bystander, or area
** Inhalation, ingestion, skin absorption
*** High, medium, low
^ Daily, 2 or 3 X/week, a few times a month, 1/month or less
^^ Often, occasionally, never
^^^ Examples may include the SEM, on-site monitoring data (quality may be noted), OHQ, interviews, etc. Interview as source of data refers to interview conducted by the consulting industrial hygienist.

Proposed IH Exposure Assessment Form - Example

Claimed condition = COPD	Facility	Dates	Expos #1	Expos #2	Expos #3	Expos #4	Expos #5	Expos #6	Expos #7
Job #1: Pipefitter	Hanford	1/1987-9/1997	Asbestos	Cement	Silicon dioxide, crystalline	Welding fumes			
Type of exposure*			Direct	Direct	Direct	Direct and bystander			
Route of exposure**			Inhalation	Inhalation	Inhalation	Inhalation			
Intensity***			Low	Medium	Low	Medium			
Frequency^			A few times/ mo	Daily	≤ Monthly	2-3 X/week			
Duration (# years)			10	10	10	10			
Calendar years			1987-1997	1987-1997	1987-1997	1987-1997			
Use of PPE^^			Often	Never	Occasionally	Occasionally			
Source(s) of data			☑ SEM ☐ OHQ ☐ Interview ☑ IH data	☐ SEM ☑ OHQ ☐ Interview ☐ IH data	☑ SEM ☐ OHQ ☐ Interview ☐ IH data	☑ SEM ☑ OHQ ☐ Interview ☐ IH data			
File page number(s) for monitoring data (or N/A)			180, 203, 216	N/A	N/A	N/A			
Comments re data sources			IH monitoring 1995-1997						

Advisory Board on Toxic Substances and Worker Health

January 16, 2024

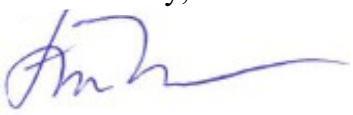
Ms. Julie A. Su
Acting Secretary of Labor
Department of Labor
200 Constitution Ave.
Washington, DC NW 20210

Honorable Secretary Su:

On behalf of the Department of Labor Advisory Board on Toxic Substances and Worker Health, I submit the two attached Advisory Board Recommendations that was adopted unanimously at the Board's meeting on November 15-16, 2023.

We sincerely hope that our advice is useful to the Department. We thank you for the opportunity to serve as Board members and wish the Program continued success in meeting the needs of the United States energy employees. Please let us know if there are questions.

Sincerely,



Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Assessing the Quality and Consistency of Consulting Physicians in Claims Evaluation in the EEOICP

Advisory Board on Toxic Substances and Worker Health Recommendation

(Adopted by the Advisory Board on Toxic Substances and Worker Health, November 15-16, 2023)

Recommendation

The ABTSWH recommends that the Department of Labor expand its quality assessment of CMC performance by implementing independent peer review of the validity of the content and analysis reflected in a quarterly sample of an appreciable number of CMC reports. Such peer review would be conducted by a small panel (2 to 3 physicians) of medical experts in causation analysis of occupational diseases. The goals are multiple: 1) to estimate the frequency of impactful correctable errors in causation determination contained in CMC reports; 2) to identify if there are systemic problems in CMC causation analyses; and 3) if so, to recommend effective and feasible solutions to reduce the frequency and impact of systemic errors in causation determination. The Board offers our assistance in planning for the implementation of this recommendation if accepted.

Rationale

The ABTSWH recognizes that the EEOICP conducts a robust quality assurance program of multiple aspects of its claim evaluation process and that this process underwent a major enhancement in 2022.

The quality of the CMC reports is currently evaluated according to a number of factors, including timeliness, appropriateness of medical specialty, presence of "well-rationalized" discussion, responsiveness to questions posed by the claims examiners (CEs), and others.

In a letter to the Board (August 31, 2023), the Department of Labor stated that current EEOICP procedures and guidance safeguard against erroneous opinions expressed in CMC reports. This is achieved by giving claims examiners proper guidance. CEs determine whether well-rationalized opinions are offered by CMCs. To do so, per the EEOICP Procedure Manual (Version 8.0), CEs must determine that CMC opinions have a "proper foundation;" represent a "reasonable justification;" not contain "contradictory information;" and have "a compelling discussion supporting a particular conclusion." The Procedure Manual further defines for the CE that a well-rationalized opinion from a physician "applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused, or aggravated the employee's claimed condition." (all quoted text is from the EEOICP Procedure Manual, Version 8.0).

The Department of Labor letter to the Board further states that quality assurance reviews are performed by dedicated staff and that CEs may demand further opinion evidence from physicians. These are positive features, but it is the opinion of the ABTSWH that there remain insufficient processes in place to identify erroneous CMC opinions.

Despite the aforementioned safeguards, we are left with the following questions. Was the CMC opinion, even when sufficiently well-rationalized, right or wrong? How are CEs, who are not required to have broad training in occupational medicine, medical diagnosis, clinical exposure assessment, epidemiology, toxicology, biostatistics or causation analysis equivalent to that required in training of occupational medicine and other physicians, supposed to recognize when a well-rationalized opinion by a physician is incorrect? Are the current procedures or quality review process sufficient to detect incorrect CMC opinions? The Procedure Manual points out that this is not a question that the CE is charged to address: "It is not the role of the assessor to agree or disagree with the conclusion; just to determine that the physician has offered a reasonable justification for how he or she responds to the referral question." But the Procedure Manual does not give guidance on how a CE should go about determining whether an apparently "reasonable" opinion is informed by relevant, creditable medical health science information, i.e. whether the opinion aligns with accepted medical knowledge. We reviewed the claims evaluation process to identify where this gap in quality assurance is addressed and could find no one who is assigned to identify CMC opinions and conclusions that do not reflect a generally held consensus within occupation medicine.

The essential problem is that neither the CEs nor the quality assessment personnel have the fund of knowledge of "relevant, creditable medical health science information" and an appropriate skill set to determine whether a CMC causation opinion is likely to reflect current consensus of medical opinion. This is not the fault of the CEs or quality assessors: their strengths lie elsewhere - in administration, communication, coordination, analysis, etc. And, in response to the Department's request of the Board, this essential problem cannot be addressed by pointing to "specific guidance or references to medical health science data." Such guidance or knowledge regarding occupational disease causation determination in individual patients is spread across textbooks, journal articles, and other forms of scientific communication, and is integral to the clinical experience of occupational medicine physicians and some other occupational health professionals (for example, individual exposure determinations by industrial hygienists).

A full and proper assessment of the validity of CMC opinions and the arguments they depend upon ultimately requires a review of these opinions by peers - occupational medicine and other physicians who focus on causation, medical diagnosis, etc. It is only through such a knowledge-based review that it can be determined whether the evidence cited and used by CMCs is correct and relevant and whether the synthesis of that evidence by the CMC and the conclusions they draw reflect generally accepted medical analysis and opinions.

It is hardly surprising that peers are required to weigh in on key aspects of performance of a peer reference group. Specialized areas of knowledge and their

application – whether it be law, architecture, engineering, or medicine – require substantial periods of training, study and practice. The result is knowledge-based value added that improves decision-making. The Board's recommendation is intended to ensure that the claims evaluation process properly reflects high quality CE and CMC decision-making and will improve an already carefully considered quality assessment process that covers much, but still leaves an important gap.

Facilitating EEOICP Claims of Terminally Ill Claimants

Advisory Board on Toxic Substances and Worker Health Recommendation

(Adopted by the Advisory Board on Toxic Substances and Worker Health, November 15-16, 2023)

Recommendation

The ABTSWH recommends that the Energy Employees Occupational Illness and Compensation Program (EEOICP) designate a single program staff person at each district office within 30 days of the date of this recommendation to serve as an initial point of contact for claims that involve people who report that they are terminally ill.

Rationale

The issue of timely and appropriate claims evaluations and decision-making with regard to claimants who are very ill has arisen several times before the ABTSWH and pertains to the Board's 5th assigned task: "the claims adjudication process generally, including review of procedure manual changes prior to incorporation into the manual and claims for medical benefits."

The Board notes that the EEOICP Procedure Manual (Version 8.0) has specific provisions in Chapter 11 and Chapter 30 to address claimants who may be terminally ill, including identification of such claimants, priority handling of claims from such claimants, describing a method to resolve uncertainties regarding status as terminally ill, and addressing the need for hospice care. It is clear that this issue has received considerable attention from the EEOICP.

Addressing the many needs of a very ill person facing death in a matter of months is a difficult challenge for all concerned – the ill person, family, other caregivers, advocates such as lawyers or authorized representatives, and physicians. Under such circumstances, enlisting help for needed medical care or compensation from a government agency, especially undertaking an effort that involves navigating a multi-step, complex administrative process, can feel daunting, at best, or insuperable, at worst.

Streamlining the entry, re-entry, or monitoring of the claims process by assigning a single person within each EEOICP District Office to identify, monitor, and facilitate the claims of terminally ill people would be a very useful and compassionate addition to the efforts that the program already makes to accommodate such claimants. It would give the families and advocates a point of contact, which, in and of itself, would help forestall frustration and anxiety that may accompany the claims evaluation process. This person would have the experience and authority to monitor these claims to facilitate their resolution and overcome any "sticking points" that claims sometimes encounter in their

flow. In addition, this person would assess whether the current provisions of Chapters 11 and 30 in the EEOICP Procedure Manual are being followed or require modification.

If this recommendation is accepted, the Board would appreciate a report on how it is implemented and whether it has resulted in improvements in facilitating claims of terminally ill claimants.

Advisory Board on Toxic Substances and Worker Health

February 1, 2024

Ms. Julie A. Su
Acting Secretary of Labor
Department of Labor
200 Constitution Ave.
Washington, DC NW 20210

Honorable Secretary Su:

On behalf of the Department of Labor Advisory Board on Toxic Substances and Worker Health, I submit the attached Advisory Board Recommendation that was adopted unanimously at the Board's meeting on November 15-16, 2023.

We sincerely hope that our advice is useful to the Department. We thank you for the opportunity to serve as Board members and wish the Program continued success in meeting the needs of the United States energy employees. Please let us know if there are questions.

Sincerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Exposure Assessment and Industrial Hygiene in Claims Evaluation in EEOICP

Advisory Board on Toxic Substances and Worker Health Recommendation

(Adopted by the Advisory Board on Toxic Substances and Worker Health, November 15-16, 2023)

Recommendation

The ABTSWH recommends that the Department of Labor modify its exposure assessment and communication procedures as follows:

I. Require that the IH consultant:

   a. Explicitly address in the IH report all reported exposures in the OHQ.
   b. Describe what exposure-relevant information was found in each of the data sources reviewed (including DAR). If none, this should be explicitly stated.

2. Share the OHQ with any physician asked to use the IH report for causation analysis.

Rationale

Referral of a case for industrial hygiene (IH) review and evaluation of potential exposure is a critically important part of the claim adjudication process, with many stakeholders relying on this evaluation for their next decisions. These include the claims examiner, the treating physician, the contract medical consultant and the claimant. The importance of this report in subsequent decision-making, especially causation analysis, is fundamental.

The usual EEOICP IH report template describes the sources of information reviewed to reach their conclusions. For example, the following statement was made in the model IH report shared by OWCP Director Godfrey in the Department's response to the Board's previous recommendation to implement a new report form:

> "The following information, which was included with the IH referral, was reviewed: e.g., OHQ, EE-3, SEM reports, physician's letter."

Statements such as this, which is, in the Board's experience, representative of what is found in a typical IH report, frequently proceed to provide details only about what is contained in the SEM. Little or no information, either in the affirmative or the negative, from the non-SEM exposure information sources is provided in the IH report. The SEM effectively becomes the dominant or sometimes the only source of information on which the conclusions reached in the IH report and ultimately in the CMC report as well.

The Board believes, as a matter of fairness and transparency, that IH consultants should be instructed to affirmatively include in their reports a description of all information concerning (regarding facility, work area, job tasks or personal monitoring records) that was available for the IH review. The claimant's specific information from the OHQ, and interview if performed, should be included in the report, as should any exposure-related information shared by the physician. This is especially true if the claimant cited any potential exposure that is linked to the claimed condition. If no specific information is available from non-SEM sources, or no monitoring data are available, the IH report should so state. The IH report can then explicitly address the significance of the non-SEM exposure information.

This envisioned more inclusive IH report would be beneficial in multiple respects. Claimants and their representatives would better understand that the claimant-supplied infom1ation was specifically considered as part of the claims evaluation process. Secondly, the CMC or other physicians involved in claims development and evaluation would gain a more well-rounded and informative understanding of the claimant's exposures, which would result in improved CMC reports. This would also be aided by the routine provision of the OHQ to the CMC when they are asked to evaluate claims.

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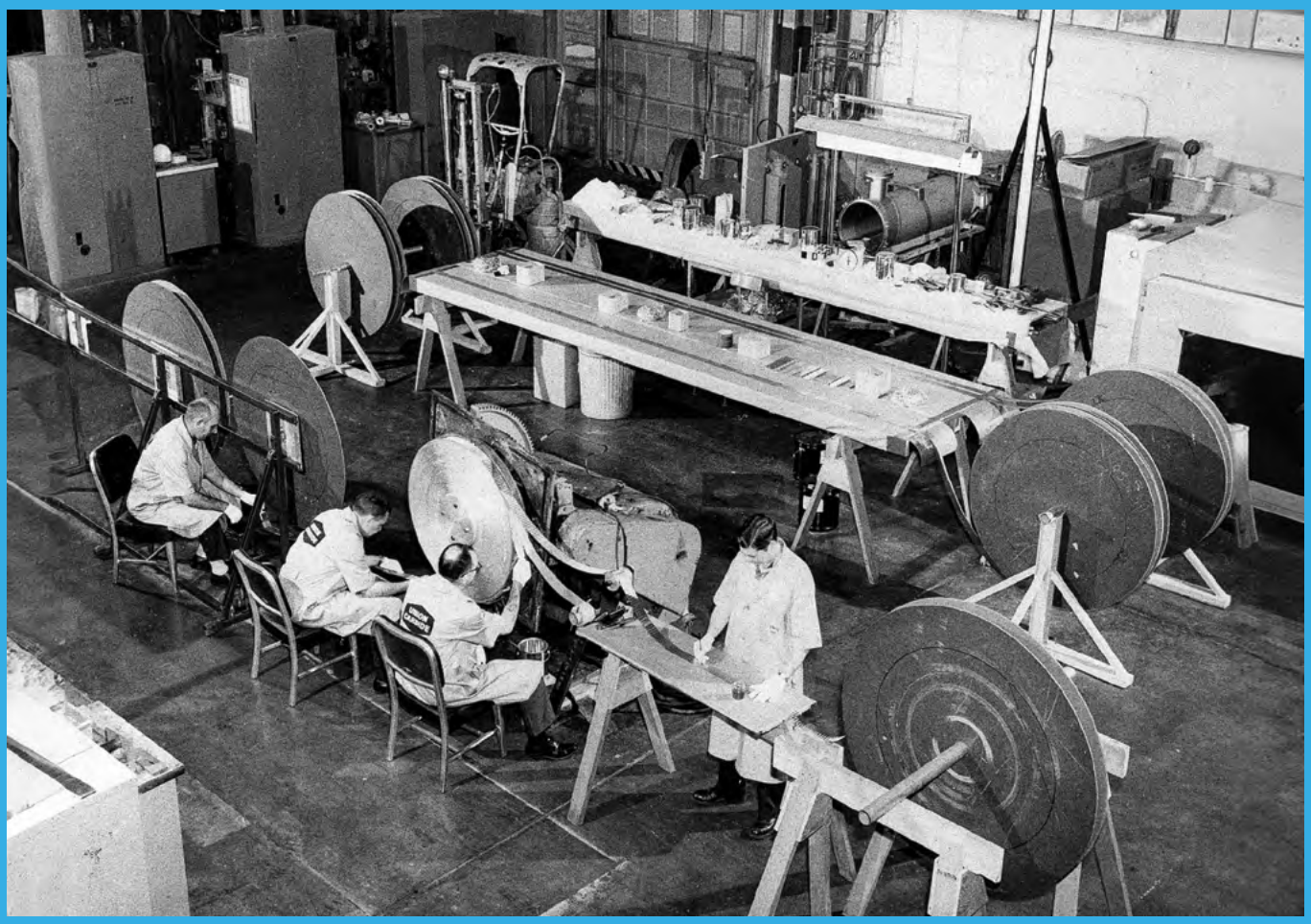

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