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

2024 ANNUAL REPORT TO CONGRESS

OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Front Cover Photo: The LOFT (Loss of Fluid Test) Mobile Test Assembly (MTA) enroute to the LOFT containment building on November 2, 1973, at the Idaho National Laboratory.
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U.S. Department of Labor

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

July 3, 2025

The Honorable JD Vance
President
United States Senate
Washington, D.C. 20510

Dear Mr. President:

I am pleased to present the 2024 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Tonya H. Taylor

Tonya H. Taylor
Acting 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 3, 2025

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

Dear Mr. Speaker:

I am pleased to present the 2024 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

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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 sets forth the complaints, grievances, and requests for assistance received during calendar year 2024, and provides an assessment of the most common difficulties encountered by claimants and potential claimants in that year. However, before addressing this assessment, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in 2024 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The DEEOIC published Version 9.0 (October 28, 2024), an update of the Federal (EEOICPA) Procedure Manual (PM)

The changes to the PM[1] included:

- Chapter 6.2(c) – Processing Mail, Bills. This section replaces the reference to Form OWCP-957 with Form OWCP-957 Part A and Form-957 Part B. It notes that Form 957 Part A is used for reimbursement of private auto mileage for covered medical travel expenses and Form 957 Part B is used for reimbursement of medical travel expenses, including mileage requiring pre-authorization and any additional covered expenses, such as related transportation, meals, and lodging costs.
- Chapter 7.6 – Case Creation, Claims Examiner Review. This section has been updated to instruct claims examiners (CE) to contact a claimant or their authorized representative (AR) directly by phone for clarification of unclear information on claim forms to facilitate timely adjudication. If the claim requires additional follow-up action by the resource center (RC), the CE may assign additional tasks to them as necessary.
- Chapter 7.8(e) – Case Creation, Consequential Illness Claims. This section indicates that any claimant filing a claim for a consequential condition must do so by submitting Form EE-1A, titled “Claim for Consequential Illness Benefits.” No Energy Compensation System (ECS) case record will be created for a new Form EE-1A which cannot be associated with an existing case.
- Chapter 13.2(b) – Establishing Covered Employment, Beryllium Vendors. This section has been updated to reflect a change in the Federal Register Notice that broadens the scope of coverage for some beryllium vendor sites. Specifically, it states that beryllium vendors are companies which are named in the EEOICPA, or that the Department of Energy (DOE) has determined to have processed or produced beryllium for sale to, or use by, the DOE. The EEOICPA identifies some beryllium vendors by corporate name, and these are known as statutory beryllium vendors. A complete list of statutory beryllium vendors can be found within the text of the EEOICPA under 42 U.S.C § 7384l(6).

  Additionally, the DOE, through publication in the Federal Register, has designated a list of beryllium vendor facilities. Any employee of a statutory beryllium vendor who worked for the vendor during

1. EEOICPA Transmittal No. 25-01 (October 28, 2024).

periods when the company was engaged in activities related to the production or processing of beryllium for sale to or use by DOE, has covered employment, regardless of the vendor facility location. Should the claims staff identify claimed employment at a statutory beryllium vendor, including, but not limited to Brush Wellman Inc. and its predecessors and successors, that is not listed in the DOE covered facility list and/or in the Employment Pathways Overview Document (EPOD), they should refer those cases to the DEEOIC National Office for review.[2]

- Chapter 14.7(h) – Establishing Special Exposure Cohort (SEC) Status, Identifying Specified Cancers.[3] This section has been modified to eliminate the requirement that CEs seek clarification from the DEEOIC National Office to determine whether a cancer is a "specified cancer." Where there is uncertainty as to whether a diagnosed cancer is a specified cancer, the CE must obtain a well-rationalized medical opinion from a qualified physician, including either the claimant's physician or a contract medical consultant (CMC), that interprets available pathology to opine whether a diagnosed cancer originates within the anatomic structure of one of the specified cancer locations within the body, and conforms to the pertinent latency period, if any.
- Chapter 15.12(b) – Establishing Toxic Substance Exposure and Causation, Non-Cancerous Conditions. This section has been updated to clarify the role of a DEEOIC Health Physicist (HP) with respect to characterizing occupational radiation for non-cancer claims. It notes that non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by the National Institute for Occupational Safety and Health (NIOSH) but will need a review by the DEEOIC HP to estimate the extent of occupational exposure to radiation to the effected organ or body part. It further outlines the steps that are taken in this process: The CE submits a referral to the HP to assess the extent of the employee's likely occupational exposure to radiation, and upon receipt of the HP's response, the CE uses the information contained therein to obtain a well-rationalized medical opinion from the claimant's physician as to whether the extent of occupational radiation exposure was at least as likely as not a significant factor in causing, contributing to, or aggravating the claimed non-cancerous condition. In the absence of a response, or the receipt of an opinion that the CE cannot weigh as being well-rationalized, the CE must forward the matter to a CMC for review.
- Chapter 17.6(c) – Development of Radiogenic Cancer Claims, Multiple Skin Cancers. This section has been updated to incorporate EEOICPA Bulletin No. 24-02: "Categorization of basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) as non-melanoma skin cancers." The section states that when a claimant provides evidence that the covered employee has multiple skin cancers, the CE will proceed as follows: The CE considers each malignant skin neoplasm (e.g., BCC, or SCC) as a separate primary cancer, unless the medical records state that the neoplasm is a metastatic lesion. For NIOSH dose calculations, the date of diagnosis and the location (e.g., arm, neck, back) of the skin cancer are important, and the CE must include this information in the medical section of the NIOSH Referral Summary Document (NRSD). There may be situations where a claim is filed for a non-melanoma skin cancer (BCC or SCC) and there is a previous Part E acceptance for a BCC or SCC skin cancer based on a positive causation determination for a toxic substance other than radiation. The previous positive

2. EPOD is a document that the DEEOIC National Office created to assist CEs in identifying facility-specific contact persons and resources to use in obtaining employment verification. Federal (EEOICPA) Procedure Manual, Chapter 11.3j, Version 9.0.
3. If a claimant qualifies for inclusion in a Special Exposure Cohort 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 NIOSH, and without a determination by DOL of the probability of causation that the cancer was caused by exposure to radiation at a covered facility. A list of the specified cancers can be found at 20 C.F.R. § 30.5(gg).

causation determination for a BCC or SCC skin cancer will apply to any other BCC or SCC skin cancer that the employee is diagnosed with, and the Part E claim for the additional BCC or SCC skin cancer will be in posture for acceptance by letter decision.

- Chapter 18.5 – Eligibility Criteria for Non-Cancerous Conditions, Beryllium Sensitivity. The section has been modified to incorporate EEOICPA Bulletin No. 24-01, "Updated Criteria for Establishing Beryllium Sensitivity." Beryllium sensitivity is an allergic reaction of the immune system to the presence of beryllium in the body because of contact with beryllium dust particles or fumes. The evidence required to establish beryllium sensitivity is described under 42 U.S.C. § 7384l(8)(A), as updated by Public Law No. 118-31, the National Defense Authorization Act (NDAA) for FY 2024 (enacted on December 22, 2023). In developing claims for beryllium sensitivity, the CE must verify whether the medical evidence submitted by the claimant is sufficient as noted below:

    1) Testing - A claimant establishes beryllium sensitivity under the EEOICPA by submitting the results of either one beryllium lymphocyte proliferation test (BeLPT) or one beryllium lymphocyte transformation test (BeLTT), performed on blood or lung lavage cells, which shows abnormal or positive findings; or three borderline BeLPT/BeLTT, performed on blood cells, conducted over a period of three consecutive years. A claimant can also establish beryllium sensitivity by submitting the results of one beryllium patch test, which shows a positive reaction.

    2) Evaluation - A physician is required to validate the results of an abnormal or borderline BeLPT/BeLTT, or a beryllium patch test which shows a positive reaction, with his or her findings specifically outlined (e.g., abnormal, or borderline response to beryllium). If the test is not accompanied by a physician's interpretation, the CE obtains the interpretation from the physician who performed the test. If the testing physician is not available, the CE obtains an evaluation from another qualified physician (e.g., a CMC).

- Chapter 23.3 – Consequential Conditions, Claims for Consequential Conditions. This section has been modified to remove references to forms EE-1 or EE-2 being used to claim consequential illness. The PM now explains that the claimant must file a claim for consequential condition(s) using Form EE-1A, "Claim for Consequential Illness Benefits Under the Employees Occupational Illness Compensation Program Act." Form EE-1A is required because it communicates a claimant's intent to file a consequential illness claim, rather than an illness associated with an occupational toxic substance exposure and provides guidance to the claimant about their responsibilities in filing for a consequential illness under the EEOICPA. When a Form EE-1A is received but cannot be associated with an existing case file, the district office or RC must return the form to the submitter for correction.
- Chapter 23.11a(2) – Consequential Conditions, Impairment and Wage Loss. This section has been modified to remove all references to using forms EE-1 or EE-2 to claim a consequential illness and instead will now reference Form EE-1A: Claim for Consequential Illness Benefits.
- Chapter 24.10g – Recommended Decisions, Letter Decisions. This section has been updated to include guidance from EEOICPA Bulletin No. 24-02, "Categorization of basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) as non-melanoma skin cancers." The section states that for any

primary skin cancer that is accepted under Part E for toxic substance exposure other than radiation (e.g., chemical, or biological exposure), the DEEOIC may accept any other claim of the same type of primary skin cancer diagnosed at a different anatomical location. In administrating this standard, the CE will accept that the non-melanoma skin cancers (BCC and SCC) are considered the same type of primary skin cancer. Melanoma skin cancers are a distinct primary cancer type, which is a different primary cancer than a BCC or a SCC.

- Chapter 30.8 – Home and Residential Health Care, Authorizing Reimbursement for Medically Appropriate Care. This section has been updated to incorporate EEOICPA Bulletin No. 24-03, which increased the maximum allowable authorization for Home Health Care (HHC) from a duration of 6 months to 12 months. Ancillary medical benefits (AMB), including use of recurring durable medical equipment, rehabilitative therapies, treatments, services, and medical supplies, remain unchanged at 6 months.

EEOICPA Circular No. 25-02: DEEOIC Compound Drug Policy

On November 4, 2024, the DEEOIC issued EEOICPA Circular No. 25-02 advising of a change in the program's Compound Drug Policy. As of November 4, 2024, the DEEOIC requires medical justification to support prescriptions for extemporaneously compounded drugs. Extemporaneous compounding is a practice in which a licensed pharmacist, a licensed physician, or a person under the supervision of a licensed pharmacist combines, mixes, or alters the ingredients of a drug to create a medication tailored to the needs of an individual patient. Extemporaneously compounded drugs are not approved by the U.S. Food and Drug Administration (FDA). However, compounding may be necessary to meet the unique medical needs of a patient who cannot be treated with an FDA-approved drug. The DEEOIC will now require prior authorization before reimbursing pharmacies, medical providers, or claimants for compounded drugs, and such requests must be submitted on Form OWCP-26 and include an opinion from a qualified physician that provides a compelling, well-rationalized justification for the use of a compounded drug to treat an illness accepted under the EEOICPA.

Sunsetting of the Radiation Exposure Compensation Act (RECA) and its Relationship to EEOICPA

On October 5, 1990, Congress passed the RECA. Section 5 of the RECA provided $100,000 in compensation to uranium miners, millers, and ore transporters who contracted specified diseases linked to their covered employment. If an individual received an award under Section 5 of the RECA, they were also entitled to receive $50,000 in compensation under Part B of the EEOICPA and medical benefits under Parts B and E of the EEOICPA for treatment of the same medical condition for which they received benefits under RECA. In addition, Section 5 uranium workers were entitled to file a claim for any medical condition that they believed was related to their covered employment under Part E of the EEOICPA. The DEEOIC would develop their claim and if it was determined that the condition was causally linked to their employment, the employee would be entitled to benefits under Part E of the EEOICPA.

By statute, the period to file a claim under RECA ended on June 10, 2024. However, the sunsetting of RECA has not impacted an individual's ability to pursue a claim under the EEOICPA. If an individual has received an award under Section 5 of RECA and has not filed a claim for benefits under Parts B and E of the EEOICPA,

they may still do so. In addition, Section 5 uranium workers may continue to file claims for benefits under Part E of the EEOICPA regardless of whether they received an award under RECA.

INTRODUCTION

Section 7385s-15 of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, requires the Office of the Ombudsman (Ombuds or Office) to submit an annual report to Congress. In this Annual Report, we are to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by our 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 Ombuds' Annual Report for calendar year 2024.

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 for 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. *See* 42 U.S.C. § 7384d(b).

In enacting this program, Congress recognized that:

- 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.
- Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the DOE 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.
- Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the DOE 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[4] and the payment of medical expenses (for the accepted illness starting as of the date of filing) for:

    1. 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.[5]
    2. Employees who are members of the Special Exposure Cohort (SEC) and who develop one of the specified cancers outlined in 42 U.S.C. § 7384l (17).
    3. 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 who develop Chronic Beryllium Disease (CBD).
    4. Employees of the DOE, 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.

- Uranium miners, millers, and ore transporters, or their survivors, who are awarded $100,000 under Section 5 of the 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.[6]
- 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 Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178. Part E is administered by DOL.

4. If the employee is deceased, eligible survivors of the employees listed below are entitled to $150,000 in lump sum compensation under Part B.
5. An AWE 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 AWE for purposes of the compensation program [EEOICPA]. *See* 42 U.S.C. § 7384l(4).
6. Radiation Exposure Compensation Act (RECA) was originally scheduled to sunset on July 9, 2022. The RECA Extension Act of 2022 extended the filing deadline for all RECA claims until June 10, 2024. To be deemed timely filed, claims submitted to the Department of Justice (DOJ) must have been postmarked or stamped by another commercial carrier by June 10, 2024. This deadline applied to all claims (including refiles of a previously denied claim).

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 the 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.

The 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 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 the 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 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.

The Office of the Ombudsman

Public Law 108-375, § 3686, which was enacted on October 28, 2004, 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 (January 1, 2021). Pursuant to 42 U.S.C. § 7385s-15(c), the EEOICPA outlines four 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 of Labor specifies.

Pursuant to 42 U.S.C. § 7385s-15(e)(2), the EEOICPA also requires the Office to submit an annual report to Congress which sets forth:

(A) The number 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 the preceding year.

Additionally, pursuant to 42 U.S.C. § 7385s-15(e)(4), 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 DOL, 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.

OVERVIEW

Congress established the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) to assist Division of Energy Employees Occupational Illness Compensation (DEEOIC) stakeholders as they navigate the claims adjudication process. Through legislation, Congress tasked the Office of the Ombudsman (Ombuds or office) with receiving complaints, grievances, and requests for assistance from certain employees of the nuclear weapons production and testing community. In honor of our 20th anniversary, we remain committed to the principles outlined in our mission statement:

> *The Office of the Ombudsman for the EEOICPA is committed to supporting civilian nuclear weapons workers, their families, and associated stakeholders as they navigate the EEOICPA workers' compensation claims process. We answer questions, provide information and guidance, and receive complaints and concerns while maintaining confidentiality, independence, and neutrality. The Office carries out its mission with an appreciation of the work performed and sacrifices made by those covered under the EEOICPA.*

In 2024, the Ombuds staff participated in 17 outreach events, including four events with the Joint Outreach Task Group (JOTG)[7] and nine virtual webinars hosted by the DEEOIC. The in-person outreach events provided an opportunity to acquaint claimants with our office and the services we provide. These events also allowed us to connect with claimants in their communities. Overall, stakeholders provided positive feedback and expressed their satisfaction with the events/webinars.

Individuals generally contact the Ombuds for assistance with their EEOICPA claims or to ask general questions related to the program. Stakeholders can contact our office via telephone, email, facsimile, written correspondence, or at in-person outreach events. During our initial contact with claimants, we gather pertinent information regarding their employment location, work processes/job title, the claimed or approved conditions, and the specific issue at hand. We gather additional information, if needed, and offer our assessment of the issue being presented.

Legislation mandates that the Ombuds submits to Congress an annual report that sets forth: (1) the number and types of complaints, grievances, and requests for assistance received by our 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).

This report to Congress includes two tables: one that provides a breakdown of the number of complaints, grievances, and requests for assistance based on EEOICPA Topics, and another that identifies the facilities where the employee worked. The "Complaints, Grievances, and Requests for Assistance" Table (CGRA Table) highlights key issues raised by claimants, though it does not include every issue mentioned. While we receive complaints, grievances, and requests for assistance from across the country, the "Contacts by Facility" Table is limited to those where the facility was specifically identified.[8]

7. The JOTG includes the DEEOIC and partner agencies that play a role in the administration of the EEOICPA. These agencies include the Department of Energy (DOE) and their former worker medical screening programs, NIOSH, and the Ombuds.
8. See Appendices 3 and 4.

The 2024 report provides a detailed analysis of complaints, grievances, and requests for assistance received by our office. As highlighted in the CGRA Table, the most common concerns raised by stakeholders involve uncertainty about who to contact for assistance, delays, customer service issues, and the behavior of DEEOIC staff and management. These issues are often interconnected. They are often raised in conjunction with various other concerns such as unanswered phone calls, negative interactions with DEEOIC personnel, and questions related to the claim adjudication process.

When speaking with claimants, it became evident that their frustrations stemmed not only from the difficulty in reaching someone when they had questions or needed assistance, but also from the challenges due to DEEOIC-imposed deadlines for submitting evidence or responding to communications. Claimants reported that delays contributed to the unnecessary lengthening in claims adjudication, processing reimbursement requests for out-of-pocket expenses, authorizations for medical treatment, approval of prescriptions, home health care determinations, home modification determinations, etc. While the DEEOIC is not required to notify claimants of such delays or the reasons for it, the lack of communication increases the volume of phone inquiries and written correspondence. Furthermore, it is essential to remember and recognize that DEEOIC claimants have performed a valuable service to the country and, as such, deserve prompt, clear, and professional responses to their inquiries.

Stakeholders also expressed frustrations due to negative interactions with DEEOIC staff, often citing a lack of clear procedures for reaching a supervisor or transferring cases to another examiner. A common refrain from those that reached out to our office was the inability to make a direct call to the claims staff. Incoming telephone calls are initially routed to the DEEOIC Resource Center (RC) staff, who have extensive training and knowledge of program policy. However, RC staff do not engage in adjudicatory functions. If the RC staff member is unable to address the inquiry, then the call is transferred to the appropriate DEEOIC staff member.

DEEOIC staff members have very specific roles in the claim process. The district office claims examiner (CE) is responsible for evidence development and issuing a recommended decision to accept or deny the claim. The case file is then assigned to a Final Adjudication Branch (FAB) hearing representative (HR) who reviews the case file to determine whether the district office's recommendation is consistent with program policy. The HR is charged with issuing a final decision or remanding the case file to the district office for additional development if required. The HR is also responsible for addressing any appeal actions that may be filed against the district office's recommendation. The medical benefits examiner (MBE) addresses issues related to medical treatment.

While there may be an efficiency component to routing initial calls to RC staff, it can serve as a point of confusion for the claimant. Some claimants are not aware of the various roles of the DEEOIC staff. Claimants report being confused as to whom they need to speak with regarding their claims, where their claims are being handled, and the role of the person the caller had reached. While the DEEOIC does provide an e-mail address for general inquiries, it does not offer an effective means for claimants to escalate their concerns or issues.

Another significant area of concern raised by our stakeholders is the adjudication process for Part E claims. In 2024, the Ombuds received numerous requests for assistance in understanding why their Part E claims were denied. Under this part, claimants are required to: 1) establish a diagnosis of the claimed condition; and 2) provide a "well-rationalized" medical opinion to establish a link between their claimed condition and their workplace toxic substance exposures.

Claimants and their ARs have expressed difficulty in understanding why submitted medical documentation did not meet the DEEOIC standard of a "well-rationalized" opinion. In speaking with our shareholders, many believed that the DEEOIC's denial of their submitted evidence was subjective and arbitrary. Many claimants believed that the submitted documentation should have been considered sufficient to meet the eligibility requirements of DEEOIC's policies and procedures, warranting a claimant favorable determination and acceptance of their claim.

While this is a brief overview of the complaints, grievances, and issues received by the Ombuds in 2024, the following chapters will provide a more in-depth discussion and analysis of our findings.

CHAPTER 1 - PART E

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA), enacted to support workers affected by toxic and radiologic exposures at covered facilities, is divided into two parts: Part B and Part E. Each part has distinct provisions and eligibility criteria.

Part B, effective on July 31, 2001, provides lump sum compensation, as well as medical benefits, to Department of Energy (DOE) employees, DOE contractor and/or subcontractor employees, certain of its vendors, as well as their survivors, for the covered conditions of cancer, certain beryllium diseases (i.e., chronic beryllium disease and beryllium sensitivity), and chronic silicosis. Conditions covered under Part B must be the result of occupational exposure to radiation, beryllium, or silica at covered facilities. Part B can also include recipients of an award under Section 5 of the Radiation Exposure Compensation Act (RECA).

Part B of the EEOICPA does not cover illnesses linked to toxic exposures other than radiation, beryllium, or silica. As such, in October 2004, Congress introduced Part E through the National Defense Authorization Act for Fiscal Year 2005. This part expanded eligibility to cover any medical condition (including those covered under Part B) causally related to an employee's exposure to toxic substances (radiological, chemical, or biological) while working for DOE contractors or subcontractors. Part E also offers medical benefits and, in some cases, impairment and wage loss benefits. Survivors of eligible employees may also be entitled to benefits.

To qualify under Part E, the claimant must show by a preponderance of the evidence, that their work-related exposure to a toxic substance "at least as likely as not" caused, contributed to, or aggravated their claimed condition. Establishing a claim under Part E involves proving DOE contractor/subcontractor employment at a covered DOE facility; or employment as a uranium miner, miller, or ore transporter as defined by RECA Section 5; the diagnosis of the claimed condition; and a causal link between the occupational exposure and the illness. This process can be complex, and challenges may arise in meeting the evidentiary requirements.

During the claim development process, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) staff requests employment records from the facility where the employee worked. Additional steps taken by DEEOIC to establish covered employment include submitting a Document Acquisition Request (DAR)[9] to the DOE and seeking earnings data from the Social Security Administration (SSA). The claims staff may also request affidavits from individuals who can confirm employment. The claims examiner (CE) must then assess whether the evidence is sufficient to confirm claimed employment and determine the period of employment.

Claimants may also face difficulties in establishing medical diagnoses, particularly if a significant period has passed between the initial diagnosis and the claim filing. In these cases, further follow-up with the employee's physician may be required. Similarly, establishing a causal link between the claimed illness and

9. For cases involving DOE contractor employees, the CE makes a request to DOE for records useful for developing information regarding toxic exposures, employment, and other purposes. DAR records can include site medical records, job descriptions, radiological records, incident or accident reports, and other employment records.

toxic exposure can be challenging. The CE may consult with a DEEOIC Industrial Hygienist (IH) to assess the potential extent of exposure. The medical evidence must support the assertion that a causal link exists between occupational exposure to a toxic substance and the claimed illness.

The Part E adjudication process is inherently complex, requiring careful evaluation of employment, medical, and exposure records. The DEEOIC has taken steps to improve the claims process, including increasing transparency, providing additional resources for claimants, and enhancing access to exposure records. These efforts include outreach to the Navajo Nation and the creation of the Employees' Compensation Operations & Management Portal (ECOMP), a secure online platform that allows claimants to access case information and download documents. Despite these efforts, the DEEOIC continues to face challenges in addressing complaints and assisting claimants with navigating the Part E claims process.

Difficulties Understanding EEOICPA Policies & Procedures/Unawareness of Policy

The Federal (EEOICPA) Procedure Manual (PM) outlines the guidelines for processing claims. The DEEOIC publishes the PM on its website so that stakeholders are knowledgeable about its processes. However, many claimants have approached this office struggling to understand the policies and procedures used in the adjudication of their claims. The PM outlines the guidelines for processing claims; however, claimants have found it difficult to navigate and overly complex. As a result, they often feel overwhelmed and confused when trying to apply the policies to their own claims. This lack of clarity delays the process and contributes to the frustration among claimants.

Frustrations have risen over frequent changes to the PM, specifically when these changes occur without prior communication from the DEEOIC. Our office has interacted with claimants at various outreach events who first learned about policy changes (e.g., changes that could have impacted previously denied claims) at these events. Typically, the DEEOIC updates the PM twice a year.[10] While these updates are announced via Transmittals on the DEEOIC website, claimants have reported being unaware of how the changes are communicated. It is important to note that many EEOICPA claimants are older and are facing health challenges. Many are not computer savvy and do not have access to email or the internet. For those claimants who have been made aware of changes through other avenues, such as organizations like the DOE Former Worker Program (FWP), or simply word of mouth from other EEOICPA claimants, they report that DEEOIC claims staff were sometimes unaware of updates. While Transmittals provide information on updates, it is crucial to ensure that claimants and stakeholders alike are promptly informed when substantive changes are made.

For instance, on October 20, 2022, the PM was updated regarding the adjudication of bilateral sensorineural hearing loss claims. Prior to this update, DEEOIC policy required employees to have at least 10 consecutive years of employment in **specific** labor categories before 1990 for their hearing loss claims to be approved under Part E. The updated policy expanded eligibility to include claimants with 10 consecutive years of employment in **any** labor category, provided they had exposure to a qualifying toxic substance.[11] Despite this policy change, two years later, employees continue to contact this office seeking assistance with previously denied claims upon learning of the update.

10. The DEEOIC also routinely updates policy via Bulletins and Circulars. There is no set schedule for these types of updates.
11. Federal (EEOICPA) Procedure Manual, Exhibit 15-4.10, Version 9.0.

As an example, an employee contacted the Ombuds regarding their denied hearing loss claim. In its September 2023 final decision, the Final Adjudication Branch (FAB) concluded that the employee did not establish 10 consecutive years of employment before 1990. In 2024, the employee filed a request to reopen his claim, as the FAB had applied the outdated policy. The employee did not receive a response to his request, which prompted them to contact the Ombuds for assistance. Our office reached out to the DEEOIC for a response. Recognizing that the employee clearly met the modified standard, a DEEOIC Director's Order was issued vacating the September 2023 final decision and returning it to the FAB for issuance of a new final decision to accept the claim.

The Ombuds recommends that the DEEOIC continue outreach efforts to inform claimants of policy changes. These efforts could include a webinar discussing updates to the PM and highlighting any major changes. For those non-computer savvy stakeholders, there should be a push for stakeholders to have a greater reliance on the DEEOIC's resource centers (RCs).[12] Additionally, for significant policy changes, when acknowledging the receipt of a new claim, district offices should include an excerpt from the PM, Bulletin, or Circular that outlines the change, as well as the adjudication process for such change.

Issues Proving Claims Under Part E

In 2024, this office received numerous requests for assistance in understanding why their Part E claims were denied. Stakeholders complained that the DEEOIC routinely disregarded medical documentation from their treating physician discussing causation, by deeming it to be not "well-rationalized." As such, their claims were sent to a Department of Labor (DOL) contract medical consultant (CMC) for review and opinion regarding causation.

Other concerns brought to the attention of our office included the DEEOIC's utilization of the Site Exposure Matrices (SEM) and the "arbitrary" nature of removing toxins from the SEM.[13] Claimants and authorized representatives (ARs) also questioned the DEEOIC's definition of significant exposure and how it was applied in the evaluation of their claim.

The PM provides guidance on determining the association between an employee's claimed medical condition and their occupational exposure to a toxic substance. The DEEOIC recognizes that medical evidence is specific to the individual, meaning that an employee may have a unique response to different toxic substance exposures. Therefore, a claim may still be compensable based on an employee's unique biology and the treating physician's opinion regarding the causal relationship between the claimed medical condition and their occupation exposure to a toxic substance, even if the SEM does not include the association in its database.

12. The DEEOIC has 11 resource centers nationwide to assist workers and their families in applying for benefits under the EEOICPA. These centers are situated in key geographic locations throughout the U.S. to provide assistance and information to the claimant community. Resource Centers can also be used to assist claimants throughout the entire claims process, such as: explain what compensation and benefits are available; assist with the completion of forms; provide ongoing claim status; submit documents to the DEEOIC; assist with finding medical providers; guide medical providers on program enrollment; and assist with authorization for medical procedures, home health care, durable medical equipment, etc.

13. The SEM is a relational database containing data on toxic substances known to have been present at DOE facilities and covered uranium sites. The SEM additionally associates these toxins to the work processes, labor categories, buildings, and incidents which relate to the toxin in some documented way. The SEM also provides information about toxic substances and the scientifically known health effects associated with those toxic substances. The DEEOIC claims staff are responsible for constructing a proper SEM search to produce a filtered output of the toxins an employee potentially encountered during employment that are related to the diagnosed condition. Federal (EEOICPA) Procedure Manual, Chapter 15.7-8, Version 9.0.

Since the SEM only provides information on the correlation between certain toxic substances and some medical conditions, it should be used only when a claim asserts that toxic substance exposure directly caused the claimed condition. It should not be used when adjudicating a claim in which exposure to a toxic substance is alleged to have aggravated or contributed to the claimed medical condition. Additionally, it is important to note that the SEM does not establish a causal connection for every condition linked to toxic substance exposure. The claims staff should keep this in mind as they evaluate claims.

The PM provides guidance on evaluating the sufficiency of medical evidence. When a treating physician submits an opinion that toxic substance exposure was a contributing or aggravating factor in the development of a claimed illness, the opinion must be well-rationalized before a Part E claim can be accepted. The physician must provide an interpretation of epidemiological or medical health science data to support their opinion. Pursuant to Chapter 16.6 of the PM, when evaluating submitted medical reports, the CE is instructed to evaluate the probative value of the report and assign greater value to:

1. An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information - Generally, a physician who has physically examined a patient, is knowledgeable of the patient's medical history, and should base the opinion on an accurate factual basis, has weight over a physician conducting a file review.
2. An opinion based on a definitive test and includes the physician's findings - It is incumbent for the claims staff to undertake appropriate steps to work with a treating physician in the collection of evidence, before referring the case to a Contract Medical Consultant (CMC).
3. A well-rationalized opinion over one that is unsupported by affirmative evidence - The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached, including appropriate citations or studies. An opinion that is well-rationalized provides a convincing argument for a stated conclusion that is supported by the physician's reasonably justified analysis of relevant evidence.
4. The opinion of an expert over the opinion of a general practitioner or an expert in an unrelated field.
5. An unequivocal opinion over one that is vague or speculative - A physician offering a clear, unequivocal opinion on a medical matter is to be viewed as more probative compared to an opinion that waivers or hesitates in its presentation or contains vague and speculative language.

Notwithstanding these clear directives, we have received complaints from stakeholders stating that, despite submitting a clear and unequivocal opinion from their treating physician supporting an association between their occupational exposure to a toxic substance and their claimed condition, the claims staff has routinely referred the file to a CMC for an opinion. This practice has invariably resulted in claim delays and denials.

For example, an authorized representative (AR) contacted our office expressing concerns that the CE had not followed procedural guidelines in the development of their client's claim. They noted that they submitted a causation opinion in support of the claim but had received no communication from the district office claims staff for nearly three months. When they followed up with the district office, they were advised that the file (including an IH report) had been forwarded to a CMC for review and opinion regarding causation.

The AR noted that this referral was inconsistent with policy guidelines as the IH report had not been forwarded to the employee's physician for review prior to the CMC referral. According to the AR, they were told by the DEEOIC claims staff to refer the IH report to a CMC if they identified any flaw in the causation opinion submitted by the employee's physician.[14]

In response to the AR's inquiry, our office reached out to the DEEOIC to request copies of all development letters sent to the employee's physician. After receiving the request, the CE sent a causation development letter to the employee's physician, pursuant to programmatic guidance.

In another example, an employee sought assistance from our office trying to ascertain why their claim for consequential conditions had been denied.[15] The employee had originally been awarded benefits under Part E for pneumoconiosis and end stage renal disease. They subsequently filed a claim for diabetes, hypertension, and kidney transplant as consequential illnesses due to the accepted conditions. Included with their filing were medical records and a causation report from their treating physician. The district office forwarded the case file to a CMC for review less than a week after receiving the initial claim filing. The CMC determined that there was no association between the employee's accepted condition of pneumoconiosis and the claimed conditions of diabetes and hypertension. It is unknown whether the CMC provided an opinion regarding the claimed consequential conditions and the accepted condition of end stage renal disease.

Approximately four weeks after filing for the consequential conditions, the employee received a recommended decision denying the claim for hypertension and diabetes under Part E. In its recommendation, the district office stated that the medical evidence and literature cited by the claimant's physician "were not clear enough to establish consequential causation." Moreover, the recommended decision did not address the claim for the consequential condition of kidney transplant.

Chapter 23.4 of the PM states:

> When assessing a claim for a consequential condition, medical evidence is required to clearly document the relationship that creates the nexus between a consequential condition and an accepted work-related illness. The medical documentation is to contain information identifying the diagnosis of the consequential condition. In addition, the medical evidence is to include a physician's opinion that presents a convincing and well-rationalized conclusion linking the consequential condition to a previously accepted illness. The opinion of the physician regarding a consequential condition is to be sufficiently probative and compelling to allow the CE to assign the weight of medical evidence to the conclusion offered. Physicians offering vague, equivocal, speculative positions on the relationship between a consequential condition and a work-related

14. The decision to refer a case to a CMC for review is at the discretion of the assigned CE. An obvious defect in case evidence must exist, including the absence of affirmative medical evidence or other diagnostic evidence, for which a medical opinion is necessary. A CMC review is not necessary in cases where the CE determines that other actions, such as requesting additional records from the claimant or treating physician, may be more appropriate. Moreover, the CE should view the existence of a treating physician as the primary source of medical evidence before consideration of a CMC referral. Federal (EEOICPA) Procedure Manual, Chapter 16.10, Version 9.0.

15. Pursuant to Federal (EEOICPA) Procedure Manual, Chapter 23, Version 9.0, the effect of an accepted occupational illness under Part B and/or covered illness under Part E in causing, contributing to, or aggravating an injury, illness, impairment, or disease is considered a consequential condition. A CE is to accept as compensable any claimed consequential condition(s) that is documented properly by substantive, well-rationalized medical evidence.

illness require additional investigation by the CE. Additional development is also required when a physician offers opinions that the CE considers to be unsupported by any reasonable medical justification.

The employee was confused as to why the file was sent to the CMC, given that their treating physician had submitted medical documentation in support of the claim. They stated that the CMC relied on general information unrelated to their medical history to justify its conclusion that there was no relationship between the accepted conditions and the claimed consequential conditions.

The employee alleged that the district office did not follow procedural guidelines and failed to contact their treating physician for clarification, as outlined in the PM. As a result, the employee exercised their appeal rights. In their appeal, the employee included a six-page letter from their treating physician who addressed the issues raised by the CMC and provided a detailed response challenging the CMCs rationale and conclusion. Following an inquiry from our office to the DEEOIC, the district office issued a letter decision accepting the claim for consequential kidney transplantation.

In the following example, an AR reached out to our office after their client received a recommended decision denying their claim for chronic silicosis under Parts B and E of the EEOICPA. In support of the claim, the AR submitted a B-read x-ray documenting an impression of pneumoconiosis with small opacities; and a medical report from the treating physician stating that the claimant's radiograph showed abnormalities consistent with chronic silicosis. The medical report further noted that the Nevada Test Site (NTS) was known for silica to be present and that the employee's exposure to silica was "at least as likely as not" a significant factor in contributing to the claimed condition of chronic silicosis; and that the exposure was at least as likely as not a result of their employment at the NTS.

Under Part B of the EEOICPA, a "covered employee with chronic silicosis" means a DOE employee, or a DOE contractor employee, with chronic silicosis who was exposed to silica in the performance of duty as determined under 42 U.S.C. § 7384r(c). "Chronic silicosis" means a non-malignant lung disease if:

(1) the initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years; and

(2) a written diagnosis of silicosis is made by a medical doctor and is accompanied by:

(A) a chest radiograph, interpreted by an individual certified by National Institute for Occupational Safety and Health (NIOSH) as a B reader, classifying the existence of pneumoconiosis of category 1/0 or higher;

(B) results from a computer assisted tomograph or other imaging technique that are consistent with silicosis; or

(C) lung biopsy findings consistent with silicosis.

See 42 U.S.C. § 7384r(e)

Moreover, in the absence of substantial evidence to the contrary, a covered employee shall be determined to have been exposed to silica in the performance of duty for the purposes of the compensation program if, and

only if, the employee was present for a number of work days aggregating at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon. *See* 42 U.S.C. § 7384r(c).

It is important to note that the statute governing the EEOICPA has provided for the acceptance of Part B conditions (cancer, CBD, beryllium sensitivity, and silicosis) to automatically be accepted under Part E. Therefore, if an employee meets the statutory requirements to allow acceptance of chronic silicosis under Part B, the employee will automatically be accepted for chronic silicosis under Part E.

Contrary to DEEOIC policy,[16] the claim was referred to a CMC for review and opinion, specifically to opine on whether the submitted medical documentation was sufficient to establish a "definitive" diagnosis of chronic silicosis. In response, the CMC disagreed with the treating physician and stated, "One simply cannot accurately assume that because an employee states that they were exposed to silica, that the potential exposures were significant." The CMC further opined that based on the employment timeframe, the employee's exposure would have been incidental in nature and not significant.

The CMC asserted in the report that a definitive diagnosis of chronic silicosis could not be made without an IH report. Consequently, they concluded that the diagnosis could not be established. Based on this report, the district office issued a recommended decision to deny the employee's claim for chronic silicosis under Parts B and E of the EEOICPA.

In each of these instances, consistent with several other cases we have reviewed, the claims staff did not adhere to DEEOIC policies and procedures. The PM provides explicit instructions regarding the development of medical evidence. While programmatic guidance allows the claims staff some discretion in evidentiary development, too often they prematurely refer a case file to a CMC and rely solely (and incorrectly) on a CMC's opinion rather than that of the treating physician.

We recommend stricter adherence to the PM when developing medical evidence, especially when a treating physician has provided a causation report. If a CE determines that the treating physician's report is not well-rationalized or does not meet then DEEOIC's guidelines, the CE should, in accordance with procedural guidelines, contact the treating physician to notify them of any deficiencies in the report and provide them the opportunity to address those deficiencies.

The DEEOIC should periodically take measures to remind claims staff of the appropriate procedural steps when evaluating medical evidence, ensuring staff awareness of when it is appropriate to refer a case file to a CMC. This could be in the form of an "all hands" training session conducted by appropriate DEEOIC personnel. This training would ensure that the claims staff is aware of the correct adjudication procedures.

Furthermore, when a CE refers a case file to the CMC, they must include a Statement of Accepted Facts (SOAF), relevant medical records, and any additional claim-related documentation deemed necessary. The

16. Although it is ultimately the responsibility of the claimant to submit medical evidence in support of their claim, the CE is to assist the claimant in collecting evidence necessary to establish a compensable medical illness. This includes communicating with the claimant to explain deficiencies in case evidence, requesting supportive documentation, and allowing reasonable time for the claimant to provide a response. The CE also assists by taking affirmative action to obtain medical evidence through communications with treating physicians and/or other medical providers. Federal (EEOICPA) Procedure Manual, Chapter 16.5, Version 9.0.

CE should ensure that the same claim file materials provided to the CMC are also shared when seeking a medical opinion from the employee's physician.

In 2024, our office received numerous requests for assistance from claimants struggling to provide acceptable causation evidence. A causation opinion must be well-rationalized in order to be used as the basis for accepting a claim. Some claimants and ARs specifically contacted our office because they needed assistance in understanding what constitutes a well-rationalized causation opinion report, as defined by the DEEOIC.

For example, during a 2024 outreach event, an employee requested that the Ombuds review their treating physician's report, as well as the DEEOIC's development letter. The letter indicated that the submitted medical evidence was insufficient because it was not considered well-rationalized. The employee expressed frustration and uncertainty about what to request from their physician.

After a brief review of the medical documentation and development letter, a representative from our office clarified the additional evidence being requested. Specifically, the district office sought medical documentation from the physician that included a causation opinion. This opinion required discussion of the employee's potential occupational exposure to a specific toxic substance, as outlined in the SEM report, and the link between that exposure and the known causal connection to the claimed condition.

The Ombuds finds that while the DEEOIC provides detailed development letters to claimants, these letters often rely heavily on legalistic verbiage from the PM, which many claimants find confusing and overwhelming. Furthermore, due to the lack of clear guidance, claimants are often hesitant to approach their physicians to request an amended statement. This uncertainty places additional pressure on treating physicians, making them reluctant to treat EEOICPA patients because of the extensive paperwork required by this program. In Chapter 4 of this report, "Medical Billing," our office will discuss how many employees are already having difficulty locating physicians who will accept the DEEOIC Medical Benefits Identification Card.

As mentioned previously, it would greatly benefit claimants if the claims staff prepared SOAFs, which included relevant medical and exposure records, SEM and/or IH reports. At a minimum, development letters could include SEM/IH findings and provide clear instructions on what claimants should request from their treating physicians.

Issues with SEM

In 2024, the Ombuds received feedback from claimants struggling to understand the SEM database and questioning its significant role in the denial of their Part E claims. The DEEOIC has taken great strides to familiarize EEOICPA stakeholders with the SEM database through various outreach initiatives, including AR training sessions and webinar series featuring SEM training. However, given the complexity and the ever-changing SEM, ongoing education and transparency efforts remain needed.

A persistent concern for claimants has been the absence of data and/or the removal of data from the SEM. For example, during the public comment period for the May 2024 meeting of the Advisory Board on Toxic Substances and Worker Health (Advisory Board),[17] a claimant advocate highlighted ongoing SEM issues, such as changes to site information and job categories without prior notification.

During the meeting, the Advisory Board's SEM working group noted that there were changes to the labor category of Groundskeeper at the K-25 Plant in Oak Ridge, as well as the deletion of tradename substances and mixtures, which were based on a recommendation from the Institute of Medicine (IOM). While in both instances, the DEEOIC had valid reasons for the changes, the Advisory Board's SEM working group found that the changes were not noted in the SEM database that is available to the public.

The Advisory Board recommended that the DEEOIC instruct its contractor (Paragon) to prospectively and retrospectively document any changes to toxic substances, labor categories, work processes, and facilities in the SEM, along with a clear rationale for each modification. Additionally, the Advisory Board suggested that the DEEOIC investigate the feasibility of reviewing closed cases that may have been affected by SEM changes.[18]

The Ombuds concurs with each of these recommendations. At the very least, providing timely notifications of SEM modifications will enhance transparency for stakeholders, who may already have a negative opinion about the adjudication of their claims.

17. The Advisory Board was created, in part, to advise the Secretary of Labor with respect to technical aspects of the DEEOIC, including the SEM, and the work of IHs and CMCs to ensure quality, objectivity, and consistency.
18. Advisory Board Summary Minutes, May 8-9, 2024. https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/advboard/minutes_05082024.pdf

CHAPTER 2 - CLAIM ADJUDICATION CONCERNS

To provide the claimant with a final decision, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) must first develop the evidence of record. Under Parts B and E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), there were multiple complaints that the DEEOIC did not fully develop employment and that the evidence of record was not always reviewed and considered prior to the issuance of a decision.

For claims adjudicated under Part E of the EEOICPA, there were multiple complaints about the DEEOIC Industrial Hygienist (IH) reports. In some cases, the claimants indicated that the DEEOIC IH was not given all the available information to determine the extent of an employee's exposure to toxic substances. Further, toxic exposures, especially those that occurred post-1995, were often minimized despite evidence to the contrary.

Verification of Covered Employment

As part of the process for adjudicating EEOICPA claims, the claimant must prove, by a preponderance of the evidence, that the employee worked for a covered employer during a covered period. A covered employee includes an employee of the Department of Energy (DOE), an employee of a DOE contractor/subcontractor, an employee of an Atomic Weapons Employer (AWE), and/or an employee of a Beryllium Vendor. It can also include employment at a covered facility under Section 5 of the Radiation Exposure Compensation Act (RECA).

With their initial filing, the claimant, who can be either an employee or a survivor, completes and submits Form EE-3, "Employment History for a Claim Under the Energy Employees Occupational Illness Compensation Program Act." On this form, the claimant provides the employee's work history, including the name of the employer, the facility name, the specific location within the facility where the employee worked, the position title and duties, the badge identification numbers, and the dates worked. The claimant is also asked if the employee participated in any employer health programs or unions at the claimed facility.

To help establish covered employment, Chapters 11 and 13 of the Federal (EEOICPA) Procedure Manual (PM) explain the procedures and resources available to the claims staff that may be used to determine whether an employee worked at a covered facility. The claims staff may ask DOE to provide worker records, facility records, and other relevant data. In an effort to establish covered employment, the claims staff may also review the Oak Ridge Institute for Science and Education (ORISE) database,[19] the Center for Construction Research and Training (CPWR),[20] and the DOE Former Worker Program (FWP).[21] Other sources of employment verification include the Social Security Administration (SSA) earnings information, Document Acquisition

19. The ORISE database contains information for over 400,000 DOE contractor and subcontractor employees from the 1940s until the early 1990s. Federal (EEOICPA) Procedure Manual, Chapter 11.3(d), Version 9.0.
20. The Center for Construction Research and Training was formerly known as the Center to Protect Workers' Rights (CPWR). DEEOIC has contracted with CPWR to maintain a database of contractor/subcontractor employers at certain DOE facilities. See https://www.btcomp.org
21. Pursuant to the Federal (EEOICPA) Procedure Manual, Chapter 11.7, Version 9.0, the FWP began in 1996, and DOE designed it to evaluate the effects of DOE's past operations on the health of workers employed at DOE facilities. In those instances where there is an indication of FWP screening of the named employee, the CE must contact the appropriate FWP for any medical or employment documentation in its possession.

Request (DAR) records, National Institute for Occupational Safety and Health (NIOSH) radiation dosimetry records,[22] and employment documentation provided by the employee, including affidavits.

Chapter 13.5 of the PM states, "The process of employment verification is a difficult and challenging hurdle in many cases… locating pertinent individual employment records can be difficult. Moreover, records may be missing, degraded, lost, or destroyed." Further, "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 reasoned basis exists to conclude that the employment occurred as alleged. This ensures that the claimant receives favorable treatment during the employment verification process."

Our office recognizes that there are instances where the verification of all claimed employment cannot be completed. However, the Ombuds has received multiple complaints about the lack of development by the DEEOIC to support the claimed employment.

Originally, the assignment of a claim to a particular district office was based on the most recent location of covered employment. As a result, the claims staff became subject matter experts with respect to the facilities within their region. In Version 4.3 of the PM, the assignment of a claim to a particular district office was changed. To maintain an equal distribution of work, claims were distributed on a rotational basis, regardless of the location of the employee's last location of employment.[23] Consequently, some of the institutional knowledge and expertise, with respect to certain facilities, was lost since the assigned district office may not have previously handled claims within that region; thereby, impacting employment development.

In one case, an employee was stated to have worked for the DOE at the Los Alamos National Laboratory (LANL) from 1948 to January 1961. This was supported by three contemporaneous obituaries from 1961 and the employee's death certificate, which indicated that the employee worked as a private secretary for the administrator of the Los Alamos Area Office of the Atomic Energy Commission (AEC)[24] Community Affairs Branch. The claimant supplied a census record showing that the employee was a federal employee living in a dormitory at Los Alamos in 1950. Apart from a Women's Army Corp dormitory, these dormitories were built solely for the purpose of housing DOE and DOE contractor employees.[25] DOE provided DAR records which identified a "Z number associated with the employee,"[26] but did not confirm their employment. Z numbers were used as identification numbers for LANL employees and were issued in chronological order.[27]

Normally, SSA records provide the name of the employer. Though requested, the district office could not obtain the SSA records for the employee and issued a recommended decision to deny the claim. The decision concluded that there was insufficient evidence to establish covered employment.

22. According to the Federal (EEOICPA) Procedure Manual, Chapter 13.8(j), Version 9.0, NIOSH, which is part of the Center for Disease Control (CDC), obtains dosimetry records from DOE as part of the radiation dose reconstruction. The district office can also request these records as they can be helpful in placing an employee on site at a DOE facility.
23. Federal (EEOICPA) Procedure Manual, Chapter 7.4, Version 4.3 (September 14, 2020).
24. The Atomic Energy Act of 1946 created the AEC, a predecessor to the DOE. https://www.energy.gov/lm/brief-history-department-energy
25. https://www.osti.gov/opennet/manhattan-project-history/Places/LosAlamos/la-town.html and https://www.nps.gov/places/000/civilian-women-s-dormitory.htm?utm_source=place&utm_medium=website&utm_campaign=experience_more&utm_content=small
26. The DOE provided a note by the reviewer with the "Z" number. There was no explanation as to origin of the information about the "Z" number.
27. https://ehss.energy.gov/ohre/new/findingaids/epidemiologic/lanl/study/50.html#:~:text=The%20Z%20numbers%20serve%20as%20identification%20numbers%20for,are%20listed%20in%20numerical%20order%20by%20Z%20number

The Ombuds recommended that the claimant contact their congressman to obtain the SSA records. The congressman was able to facilitate receipt of the SSA records. The resultant SSA records showed no employment, which was not unusual for federal civil employees during that time.[28]

Through an internet search, the Ombuds found the existence of the "Z Books" located at Los Alamos, which contain lists of persons issued Z numbers by LANL.[29] It is unclear if DOE had access to or searched these books when providing its response to the DAR request from the DEEOIC. The claimant submitted a request to the General Counsel of DOE's National Nuclear Security Administration (NNSA) to obtain the information in the Z books. Even without this information, it would have been reasonable for the district office to ask the DOE for the source of the Z number and based on the time when it was issued, determine an approximate date of hire.

Following an appeal of the recommended decision where the claimant discussed all of the employment evidence, the Final Adjudication Branch (FAB) found that there was sufficient information to establish a positive finding of employment and remanded the claim to the district office for further development and issuance of a new recommended decision.

There are additional tools which can be used to further verification. When a claim is sent to NIOSH for a radiation dose reconstruction based on a diagnosed cancer, new evidence is sometimes uncovered by NIOSH which may support additional covered employment.[30] Though this additional employment is listed on the front page of the dose reconstruction report, it does not appear that the DEEOIC routinely reviews this information to see if it qualifies as verified employment. Further, a radiation dose reconstruction is not required for non-cancerous conditions. Consequently, claimants who file for non-cancerous conditions under Part E are not provided the same opportunity for additional verified employment through the dose reconstruction process. Without full verification of claimed employment, the extent of the non-radiological toxic exposures experienced by an employee may not be properly evaluated.

The Ombuds acknowledges that there are strict timelines imposed on the DEEOIC claims staff regarding the adjudication of claims, and that not every claimant has verifiable covered employment. Though the burden of proof ultimately lies with the claimant for establishing covered employment, DEEOIC claims staff should do as much as reasonably possible to ensure that a thorough search for employment evidence is conducted to support that criterion.[31] The statute establishes that if a reasoned basis exists to conclude that the claimed employment occurred as alleged, the employment should be accepted.

The Ombuds acknowledges that after the release of the PM, Version 4.3, the DEEOIC conducted training to ensure all staff members acquired a level of institutional knowledge about the DOE facilities outside of their previously assigned region. The Ombuds recommends that the DEEOIC continue to provide refresher

28. Prior to the signing of the Federal Employees' Retirement System Act of 1986, federal employees under the Civil Service Retirement System did not participate in social security coverage. congress.gov/crs_external_products/IF/HTML/IF12354.web.html.
29. https://ehss.energy.gov/ohre/new/findingaids/epidemiologic/lanl/study/50.html#:~:text=The%20Z%20numbers%20serve%20as%20identification%20numbers%20for,are%20listed%20in%20numerical%20order%20by%20Z%20number
30. Pursuant to the Federal (EEOICPA) Procedure Manual, Chapter 17, Version 9.0, in cases where a diagnosed cancer claim cannot be accepted as part of the SEC under Part B of the EEOICPA, NIOSH will perform a radiation dose reconstruction to determine if a cancer(s) is "at least as likely as not" related to occupational exposure to radiation during covered employment.
31. *See* 20 C.F.R. § 30.111(a).

training on this issue to ensure that staff are aware of information and resources that may relate to specific facilities which would be useful in determining whether a claimant has covered employment. The Ombuds also recommends that claims staff should be reminded that the bar for establishing employment, is a reasoned basis, not absolute when verifying employment, especially while trying to verify employment from the early years.

Issues with Adjudication

Claimants have brought to our office's attention that they noticed typographical errors in letters, recommended decisions, and final decisions. When the errors are minor and do not impact the outcome of the claim, although unfortunate, are ultimately inconsequential. However, when the mistakes are beyond typographical and not minor, claimants often wonder if their claim was appropriately adjudicated. They question whether these errors are indicative of the attention that was given to their claim and whether the errors negatively impacted the outcome of the claim.

In several cases, we saw errors in letters and decisions which had a greater impact. There were instances in which employment periods, facilities, and medical conditions were incorrectly identified; verified employment was not listed; and/or the employee was incorrectly noted as a DOE contractor employee instead of a DOE employee.

In one case, a recommended decision was issued to deny a claim for hearing loss because the evidence of record was insufficient to show that the claimant met the employment criteria required to establish a claim for hearing loss.[32] However, the evidence of record included verified employment which was not reflected in the recommended decision. The employee appealed the recommended decision and the FAB remanded the claim for further development. Following the remand, a final decision was issued which included all the verified employment and the claim was accepted for hearing loss.

In another case, the employee's authorized representative (AR) contacted us about errors the employee identified in the adjudication of their claim for two melanomas. The employee claimed that they worked as a DOE contractor employee at the Paducah Gaseous Diffusion Plant (PGDP) for approximately 40 years. The PGDP is a covered DOE facility from 1951 to present, apart from the period from July 29, 1998 to September 30, 2014, when an employee is only covered while working in remediation efforts.[33] While the claimant did not perform remediation work, the employee did have almost 23 years of covered DOE contractor employment. However, the DEEOIC sent multiple letters to the claimant with incorrect dates of verified covered employment and incorrect claimed illnesses. The claimant returned many of these letters to the district office claims staff with their corrections.

The claims staff then submitted a request to the IH to review the employment and exposure evidence in the claim. In its referral, the claims staff provided incorrect dates of employment, giving the employee credit for less than four years of employment at PGDP. The claims staff also incorrectly identified the

32. The presumption for an acceptance of hearing loss requires, in part, 10 years of uninterrupted employment with exposure to ototoxins. Even if an employee claims 10 years of uninterrupted employment, if the claims staff cannot verify 10 years of employment, the claim will likely be denied. Federal (EEOICPA) Procedure Manual, Exhibit 15-4, Version 9.0.
33. https://ehss.energy.gov/Search/Facility/findfacility.aspx

diagnosed cancers. When the IH report was returned to the district office, the claims staff noted the errors and submitted a new request to the IH with the correct employment and medical information. These errors caused a two month delay in the claims process.

Claimants have also received recommended decisions to accept an illness only to have it remanded by the FAB. The claimants who contacted us did not understand the reason for the remand.

Claimants have voiced concerns that the claims staff did not review or consider the documentation they submitted to support their claim because it was not addressed in a recommended or final decision. In one instance, an AR submitted medical evidence at a hearing which directly addressed a deficit in the claim. However, the final decision did not acknowledge or address the new medical evidence, and it appeared that the evidence was not reviewed prior to the issuance of the final decision. In this case, the FAB denied the claim as opposed to remanding it, to allow for development of the medical evidence. After the denial of the claim, the AR's request for re-opening was granted and the claim was returned for further development.

The Ombuds is aware that decisions are periodically reviewed by the DEEOIC Quality Assurance Unit.[34] However, those reviews are conducted after a decision has been issued. The Ombuds recommends that DEEOIC consider implementing a policy that would encourage claims staff to have their letters and decisions peer reviewed before issuance to ensure that such errors are kept to a minimum. Claimants who are denied benefits should be assured that all documentation they submit to the DEEOIC in support of their claim has been considered in the decision-making process, and when applicable, provide a clear explanation as to why the submitted documentation was deemed insufficient.

Issues with Post-1995 Exposures in DEEOIC Industrial Hygienist Reports

Under Part E of the EEOICPA, a covered illness means "an illness or death resulting from exposure to a toxic substance from employment at a DOE facility or a RECA Section 5 facility."[35] The DEEOIC defines a toxic substance as any material that has the potential to aggravate, contribute to, or cause an illness or death because of its radiological, chemical, or biological nature.[36] Claimants continue to describe difficulties proving their claims under Part E of the EEOICPA. This is an overarching issue that has been discussed in prior annual reports.

One of the resource tools used by the DEEOIC to assess an employee's history of occupational exposure during covered employment is the Site Exposure Matrices (SEM). The SEM is a web-based relational database "which acts as a repository of information related to toxic substances potentially present at covered DOE sites and has information regarding site investigations and occupational exposure to hazardous agents to assist in determining the existence of causal links between covered employment, exposure to toxic substances during such covered employment, and the resultant illnesses arising out of such exposure."[37] Per Chapter 15.8(e)(1) of the PM, "If the CE produces a list of toxins that is greater than seven (7) based on

34. The Quality Assurance Unit is responsible for conducting reviews of adjudicatory activities produced by DEEOIC claims staff. Federal (EEOICPA) Procedure Manual, Chapter 2.3(a)(2)(d)(1), Version 9.0.
35. Federal (EEOICPA) Procedure Manual, Chapter 1.2(w), Version 9.0.
36. Federal (EEOICPA) Procedure Manual, Chapter 1.2(hhh), Version 9.0.
37. Federal (EEOICPA) Procedure Manual, Chapter 1.2(ddd), Version 9.0.

the facts surrounding the case, utilizing the necessary filtering functions, and recognizing any limitations of SEM, the CE should consult with the NO IH to identify which toxins on the list of substances were most likely to have been encountered and which would likely have the greatest impact on the claimant's claim, and include as many of those as is necessary."[38]

Based on the files our office reviewed, IHs routinely provide the names of seven or fewer toxins when asked to provide their exposure assessment, even when the evidence shows the claimant was exposed to a higher number of toxins. Claimants and ARs describe this process as limiting their opportunity to have all relevant toxic substances reviewed by the IH. Claimants also question why they are asked to complete an Occupational History Questionnaire (OHQ) when it does not appear to be taken into consideration by the IH.[39]

Additionally, claimants question why, when a medical opinion on causation is requested of a Contract Medical Consultant (CMC)[40] or the claimant's treating physician, these physicians are not always provided with the IH report and the OHQ. The claimants feel that the physicians should be provided the maximum amount of information when formulating their opinions.

In a June 13, 2024, letter to the Acting Secretary of Labor, Julie A. Su, the Advisory Board on Toxic Substance and Worker Health (Advisory Board) requested clarification on the selection of toxic substances for IH review and the ability of the IH to expand or narrow the scope of their review. This request also addressed the need for the OHQ to be provided to a CMC or treating physician when requesting an opinion on causation.[41]

In an August 9, 2024, response to the Advisory Board, the Director of the Office of Workers' Compensation Programs, Christopher J. Godfrey, indicated that the Department of Labor's (DOL) position "remains that the Occupational History Questionnaire (OHQ) should not be provided to a physician assessing causation. Submitting both the OHQ and the IH report to the physician could lead to situations where the physician is provided with conflicting or inconsistent data pertaining to toxic substance exposures. DOL continues to consider the findings of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) IH-produced exposure characterization to represent the best, most accurate information about the nature, extent, and frequency of occupational exposure to toxic substances. Therefore, DOL's position remains that physicians should be provided with the IH report (which is informed by the OHQ), but not provided with the OHQ document itself, which contains statements about exposure that DOL has not been able to confirm."[42]

Based on our review, as it relates to post-1995 toxic substance exposures, IH reports contain 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 include, but are not limited to, chemical hazardous material management programs, strong administrative and engineering controls,

38. NO is the acronym for National Office.
39. The function of the OHQ interview is to collect relevant information from the claimant about the named employee's work history involving atomic weapons. Specifically, the OHQ interview will seek information that the claimant is knowledgeable about the employee's work locations, job titles, work processes, or contact with specific toxic substances. Federal (EEOICPA) Procedure Manual, Chapter 10.5, Version 9.0.
40. A CMC is defined as "a contracted physician who conducts a review of case records to render opinions on medical questions." Federal (EEOICPA) Procedure Manual, Chapter 1.2(r), Version 9.0.
41. https://www.dol.gov/sites/dolgov/files/owcp/energy/regs/compliance/advboard/abtswh_recommendation061324.pdf
42. https://www.dol.gov/sites/dolgov/files/owcp/energy/regs/compliance/advboard/dol_response_advisoryboard080924.pdf

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."

EEOICPA Circular No.15-06 was issued on December 17, 2014. This circular stated, "After 1995, significant improvements in occupational safety and health programs, engineering controls, and regulatory enforcement existed throughout Department of Energy (DOE) facilities. These measures would have served to limit employees' exposures to toxic materials. Therefore, in the absence of compelling data to the contrary, it is unlikely that covered Part E employees working after 1995 would have been significantly exposed to any toxic agents at a covered DOE facility." This circular was rescinded by DEEOIC Circular No.17-04 on February 2, 2017.

Based on the language in the IH reports that our office reviewed, it appears that the substance of the reports has not been significantly altered from the guidance in EEOICPA Circular No. 15-06. Employees who worked at DOE facilities after 1995, maintain that their occupational exposures were not reduced after 1995, as indicated in their IH reports.

The CPWR concurred with this assessment. In a study funded by the DOE, "Mortality of older construction and craft workers employed at Department of Energy (DOE) nuclear sites: Follow-up through 2021,"[43] Dr. Knut Ringen and his associates studied the mortality experience of participants in the Building Trades National Medical Screening Program (BTMed). In part, the research confirmed excess risk for these workers who were first employed after 1990. Further, the report states, "Our finding that workers first employed after 1990 experience significant elevation in occupational mortality risk is important, because it challenges a common perception that after 1995, DOE facilities have been in full compliance with existing safety and health requirements…Our findings suggest otherwise. Applying such perceptions to subcontractor employees who typically have had less oversight and weaker safety and health performance is a particular concern. Our findings on construction trades workers compared to our internal comparison groups support this concern."

Further, in a paper, "Protecting Contract Workers: Case Study of the US Department of Energy's Nuclear and Chemical Waste Management,"[44] Drs. Gochfeld and Mohr discuss how "Reliable data on subcontractor occupational health and safety programs and performance are sparse. The US Department of Energy has an excellent safety culture on paper, but procurement practices and contract language deliver a mixed message—including some safety disincentives. Its biphasic safety outcome data are consistent with underreporting by some subcontractors and underachievement by others."

43. Ringen K, Dement J, Cloeren M, et al.
Mortality of older construction and craft workers employed at DOE nuclear sites: follow-up through 2021. *Am J Ind Med. 2024; 1-13.*
44. Gochfeld, M and Mohr, S. Protecting Contract Workers: Case Study of the US Department of Energy's Nuclear and Chemical Waste Management. *American Journal of Public Health. September 2007*. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2006.108795

During the May 8-9, 2024, Advisory Board meeting, the Advisory Board indicated its interest in "documentation in support of the assertion that environmental health and safety programs implemented in the mid-1990s greatly reduced exposures to workers (including contractors) at DOE facilities, and that any significant exposure events would have likely been documented."[45]

During the October 30, 2024, Advisory Board meeting, the DEEOIC provided documentation to show that numerous safety programs were implemented in the 1990's. However, based on the personal experiences detailed by employees, all DOE facilities were not fully compliant with these measures and toxins which were deemed injurious were not removed from the facilities in a timely manner. Employees have spoken of using the toxins for years after their alleged removal. The Advisory Board created a working group to discuss safety measures and toxic exposure.[46]

The Ombuds has no further recommendations beyond the Advisory Board recommendations.

45. Summary Minutes of the May 8-9, 2024, Advisory Board Meeting: https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/advboard/minutes_05082024.pdf
46. Transcript from the October 30, 2024, Advisory Board meeting: https://www.dol.gov/sites/dolgov/files/owcp/energy/regs/compliance/advboard/transcript_103024.pdf

CHAPTER 3 - MEDICAL BENEFITS AUTHORIZATION

When an employee's claim is accepted under the Energy Employees Occupational Illness Compensation Act (EEOICPA), the claimant has an expectation that they will be able to access medical care for the treatment of their accepted condition. In fact, the EEOICPA mandates that the Division of Energy Employees Occupational Illness Compensation (DEEOIC) provide medical benefits that are believed to be necessary to give relief or to treat the covered condition.[47] In addition, claimants expect that their request for medical services, such as prescription medication, durable medical equipment (DME), and rehabilitation services will be promptly and efficiently processed. As discussed in prior annual reports, claimants and their authorized representatives (ARs) contacted our office and relayed that they have encountered significant difficulties in either accessing medical treatment and/or obtaining authorization for essential healthcare services for the treatment of their covered conditions. As a result of these difficulties, treatment for approved medical conditions has been unnecessarily delayed or denied.

Medical Accessibility

There is a shortage of licensed physicians in the United States.[48] Although the shortage is nationwide, it is exacerbated in rural communities. Consequently, claimants living in these areas have encountered difficulty finding physicians within their community that accept the DEEOIC Medical Benefits Identification Card (white card).[49] The utilization of physician assistants (PAs) and nurse practitioners (NPs) to provide medical care is an attempt by the medical community to help alleviate the shortage of physicians and increase access to healthcare services. While the DEEOIC allows PAs and NPs to provide medical treatment, to be payable under the DEEOIC, those services must be performed under the supervision of a licensed physician.

While the DEEOIC allows physicians, chiropractors, and clinical psychologists to bill for the health services they provide, it does not permit PAs and NPs to bill for their services.[50] Under the DEEOIC, medical reports signed by either a PA or NP are not accepted unless countersigned by a licensed physician. However, despite this programmatic restriction, more than half the states permit licensed nurse practitioners to operate as an independent clinician.[51]

A number of claimants have brought the issue of medical accessibility into sharp focus during 2024. One claimant reached out to our office to express their frustration in obtaining medical services for their covered condition of pulmonary fibrosis. This claimant lived in a rural community where there were no physicians in the immediate area that accepted the DEEOIC white card. The closest pulmonologist that accepted the white card was approximately 110 miles away. The claimant was able to identify an independent NP in their area willing to accept the medical benefits card. However, as noted above, the DEEOIC does not approve treatment with this provider unless a licensed physician reviews their work.

47. *See* 42 U.S.C. § 7384t and 42 U.S.C. § 7385s-8.
48. Association of American Medical Colleges. https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage
49. See Appendix 4.
50. 20 C.F.R. §§ 30.400, 30.401, and 30.402.
51. Nurse Journal https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/

Because DEEOIC's regulations exclude independent nurse practitioners from billing for their services, this claimant had to make a difficult decision. The claimant either had to travel 220 miles round trip to treat with the "in network" physician; or they could opt to treat with the local nurse practitioner and incur out-of-pocket expenses related to the medical treatment provided. When they see a physician who accepts payment from the DEEOIC, it is not without significant cost. It requires the claimant to spend at least four hours roundtrip to travel to the physician's office. Driving for that length of time is exhausting, especially if a claimant is not well. There is also wear and tear on their vehicle. These are not nominal costs for claimants.

Another example involved a claimant whose treating pulmonologist was retiring. The physician had recently prescribed a new medication that required close medical monitoring. Because of the imminent retirement, the claimant needed to find a new treating physician. The claimant accessed the OWCPmed.dol.gov website to find a new pulmonologist.[52] The search identified five physicians. Of the five physicians, one was retiring, and two were not accepting new patients. The one physician accepting new patients was 65 miles away and there was a five to six month wait for an appointment. The claimant was not able to determine whether the fifth physician still accepted the DEEOIC white card. At a loss, the claimant contacted our office for assistance. Our office contacted the DEEOIC and was told that the claimant should expand their search to a radius of 75 miles.

The DEEOIC's suggested solution implicitly acknowledges that there is a lack of availability of medical services that are within a reasonable distance. As a result, this requires claimants, some of whom have significant medical conditions, to travel an inordinate distance to receive medical care.

The value of medical benefits is severely diminished if a claimant is unable to access medical care, or able to obtain it only after navigating difficult circumstances. The Office of Workers' Compensation Programs (OWCP) regulations permit the modification of procedures in emergencies and unusual circumstances. Given the lack of medical providers in certain regions, the Ombuds recommends that the DEEOIC allow nurse practitioners, who work in states that permit them to practice independently, to treat claimants and bill for their services without requiring the oversight of a licensed physician. Such a change would increase the number of qualified medical providers that are available to claimants and provide them with greater access to medical care. The DEEOIC already has set a precedent for applying state laws in the adjudication of certain claims. For example, in states where common law marriages are recognized, DEEOIC will rely on such practices in determining whether certain survivors meet the definition of a "covered spouse." [53]

In addition, it is the understanding of our office that some physicians do not want to enroll as providers, in part due to paperwork associated with medical authorizations. The Ombuds recommends that the DEEOIC establish a committee to review current requirements and processes to determine if there is a way to reduce the amount of required paperwork and interactions between the providers and the DEEOIC. Such a change, if feasible, may encourage more physicians to remain or enroll as providers.

The DEEOIC website contains essential information regarding benefits and services available under the EEOICPA. However, it lacks a significant feature that would be greatly beneficial to claimants: a clear and simple function for finding providers who accept the DEEOIC white card.

52. The OWCP Medical Bill Processing Portal includes a "Finding a Provider" search feature.
53. Federal (EEOICPA) Procedure Manual, Chapter 29.6, Version 9.0.

While both the DEEOIC and OWCP programs use the same list of participating medical providers, the ability to access and search this list is significantly more user-friendly on the OWCP website. On its homepage, the OWCP site presents a clearly labeled "Find a Medical Provider" portal, allowing claimants the ability to search for participating providers by using specific search criteria. In contrast, the same information is much harder to find on the DEEOIC website. DEEOIC's website does not have a prominently placed intuitive link to the provider search tool. Users are forced to navigate several pages before being able to access the link.

Given the importance of timely access to care, the Ombuds recommends that DEEOIC integrate an intuitive, user-friendly search function on its website homepage. This would improve accessibility for claimants seeking medical care and greatly enhance the user experience.

Prescription Denials

Once a claim is accepted under the EEOICPA, claimants are notified of their entitlement to medical benefits for their accepted condition(s). A recurring concern raised with our office involves the denial of reimbursement requests for prescription drugs intended to treat covered illnesses.

These denials often occurred because the prescribed medication was not included in the "treatment suite" associated with the accepted medical condition. According to the Federal (EEOICPA) Procedure Manual (PM), Chapter 29.6:

> At the core of the medical bill reimbursement process is the use of treatment suites. Treatment suites categorize those medical services that a physician or provider routinely and customarily uses to treat the effect of an accepted medical condition. Using that categorization, DEEOIC automates the payment of billed charges that align with services permitted under a treatment suite.

In other words, treatment suites define the medications and services that DEEOIC considers appropriate for managing a particular accepted condition. Medical benefits examiners (MBE) rely on this information when determining if a prescribed medication will be covered by the program.

However, neither claimants nor their treating physicians are given access to the contents of these treatment suites. As such, physicians may unknowingly prescribe medications that fall outside the suite's narrow parameters, thereby triggering a denial of coverage. The Ombuds finds that this lack of transparency places claimants and providers at a disadvantage, which leads to routine denials of payment or reimbursement for prescriptions that, while medically appropriate, do not meet the internal parameters of the treatment suite.

In 2024, a claimant with an accepted condition of diabetes contacted our office for assistance following the denial of a prescription related to their diabetes treatment. The claimant stated that their physician recommended adding a new medication to enhance their current diabetes management plan. In support of this request, the physician submitted a narrative report to the DEEOIC explaining their rationale for adding the drug, which was commonly prescribed for diabetes. This medication is also currently prescribed for weight loss.

The MBE assigned to the case referred the report to a program medical officer for review and opinion on whether the medication was medically justified. The medical officer opined that the drug was being prescribed for weight loss, rather than for the treatment of diabetes. Based on this opinion, the MBE denied the prescription request.

After receiving notification of the denial (which included a copy of the medical officer's report), the claimant contacted our office and expressed their frustration. It was their belief that the claim was inappropriately denied. Their treating physician had prescribed the medication in conjunction with another diabetes drug as part of a more effective treatment strategy. The claimant voiced concern that the opinion of a doctor who had never examined them was the basis for the denial.

We informed the claimant of the procedures available to challenge the DEEOIC's denial. Under the EEOICPA, claimants have appeal rights whenever a claim or request for treatment is denied. The claimant was advised to provide their doctor with a copy of the program medical officer's report and to request a rebuttal addressing any inaccuracies or omissions. The claimant was also advised to submit a written request for reconsideration to the MBE along with a copy of the physician's rebuttal.

After several months of attempting to resolve the issue, the claimant became frustrated with the lengthy and uncertain nature of the process. Subsequently, they advised us that they were no longer pursuing their appeal rights. They maintained that the DEEOIC should have covered the medication as part of their accepted condition. However, they ultimately chose to submit the claim to their private health insurance provider (an option that may not be available to all DEEOIC claimants).

Chapter 16.6 of the PM, entitled "Developing and Weighing Medical Evidence," offers guidance on evaluating medical evidence:

> Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the information on an accurate factual basis, has weight over a physician conducting a file review.

It does not appear that this policy was applied in this case.

In another instance, a claimant requested assistance when the DEEOIC denied their treating physician's request to change medication prescribed for the accepted condition of beryllium sensitivity. Our office contacted the DEEOIC and was informed that payment for the newly prescribed drug was denied because it was not within the treatment suite for the accepted illness. We were further advised that the MBE would contact the claimant to discuss an "exception" request – a process by which a claimant can seek to have their medication approved for treatment of their accepted illness even if the medication is not within the treatment suite for that condition.[54]

54. The exception process is a mechanism for manual review, by an MBE, to determine if the rejected service, prescription medication, or other medical benefit, is medically necessary for the care of an accepted illness, thus eligible for reimbursement authorization, by DEEOIC, on an exception basis. Federal (EEOICPA) Procedure Manual, Chapter 29.6, Version 9.0.

Two months later, the claimant contacted our office to inform us that the prescription denial had not been resolved. Upon their notification from the MBE that the submitted medical documentation had not been received, our office instructed the claimant to forward their documentation to us. In turn, our office forwarded the documents to the DEEOIC. The claim was again denied.

Our office informed the claimant that they could request a recommended decision from DEEOIC. By doing so, the claimant would receive a recommended decision providing a detailed explanation regarding the basis of the denial. The recommended decision would afford the claimant appeal rights and the opportunity to submit additional supporting medical evidence.

Our office notes that the downside to this approach is that the DEEOIC has no set timeline in which to issue a recommended decision. As such, without specific programmatic guidance, claimants are left wondering when to expect a decision. For some claimants, they elect not to wait for this process to play out, choosing to either pay for the prescription out-of-pocket or go without the medication.

This situation is not an isolated case and yet many claimants who find themselves in this position are not aware that there is a process by which they may seek an exception when their doctor prescribes a medication that is outside of the treatment suite. In this case, it was only after the claimant contacted our office for assistance that there was any mention of the exception process by the medical bill processing unit (MBPU). Based on our office's review, it does not appear that the DEEOIC takes sufficient measures to inform claimants that they can seek an exception when their claims are denied because the prescribed medication is outside of the treatment suite.

There is another apparent shortcoming in the utilization of treatment suite. The utilization of a treatment suite does not consider the scenario where doctors prescribe an "off-label" medication to treat a covered condition.[55] When this occurs, the off-label medication is automatically denied. Should the claimant wish to pursue authorization, they must undergo the process of requesting an exception. This places an additional burden on physicians who must often engage in multiple exchanges with the MBPU to pursue this request.

To promote greater transparency, the Ombuds recommends that when a claim is approved, the DEEOIC provides the claimant with a letter that lists all the medications in the treatment suite for the accepted condition. This would provide the claimant and their physician with clear guidance as to what medications would automatically be approved by the DEEOIC for the treatment of the accepted condition. The letter should also contain information regarding the exception process, that advises the claimant and their physician of the process to seek approval for medication outside of the treatment suite. The incorporation of this recommendation would significantly reduce the number of delays and denials.

Medical Treatment Delays

When a claim is accepted under the EEOICPA, claimants expect that their requests for necessary medical treatment, particularly when they are dealing with significant and potentially life-threatening conditions, will be processed expeditiously. Additionally, it is also expected that in dire situations, the MBE should

55. Off-label refers to the practice of prescribing a medication for a different purpose than those specifically approved by the FDA.

take additional steps to expedite the processing of a claim for medical benefits to ensure such benefits are timely received.

In 2024, our office was contacted by an AR seeking approval from the DEEOIC for a change in the medical treatment that was being provided to treat the claimant's accepted condition of non-Hodgkin's lymphoma. The AR advised our office that the claimant's cancer was not responding to the current treatment plan, and their treating physician was recommending a change in treatment.

The AR was informed by the MBE that the program medical officer approved the new treatment plan. After a delay of one month, the AR contacted our office because the claimant had not undergone the newly approved procedure. The AR requested our assistance as there appeared to be miscommunication between the medical facility and the MBE. The AR indicated that the hospital was waiting for a letter from the MBE confirming that the procedure had been approved by the DEEOIC, and that the MBE was waiting for the hospital to perfect its paperwork before providing written authorization. As a result, the claimant's treatment was delayed.

The Ombuds contacted the DEEOIC confirming that the MBE and the medical facility were unsuccessful in their efforts to reach each other. A supervisory MBE contacted the AR and advised them that they would continue their attempts to reach the facility. The facility was verbally notified of the approval, and the authorization letters were mailed five days later.

This case demonstrates that procedural guidelines can have elasticity. In situations where the medical conditions are clearly serious in nature, as they were in this case, the MBE should make every effort to handle these matters as expeditiously as possible and not let these types of issues impede swift resolution. A central factor in the resolution of this case involved the engagement of a supervisory MBE, whose actions were critical in resolving this matter. The Ombuds recommends that the DEEOIC consider the continued use of supervisory MBE monitoring in similar instances where immediate approval of medical treatment is required.

CHAPTER 4 - MEDICAL BILLING

Medical Identification Cards

Once the Division of Energy Employees Occupational Illness Compensation (DEEOIC) accepts a claim, the covered employee is entitled to medical benefits for the accepted illness. The DEEOIC is responsible for covering the cost of treatment of the accepted illness. The regulations mandate that the Office of Workers' Compensation Programs (OWCP) uses a fee schedule that sets the amounts payable for many medical services.[56] When a health care provider submits their bill to the DEEOIC for payment, the reimbursement shall not exceed a maximum allowable charge for such service as determined by the OWCP fee schedule and the claimant cannot be asked to pay the difference. However, when the claimant directly pays a medical provider for services out of their own pocket, they risk being partially reimbursed for those expenses if the amount they paid to the provider for a service exceeds the maximum allowable charge set by the OWCP fee schedule.

For a claimant to provide proof of coverage for the accepted illness, a Medical Benefits Identification Card (white card) is mailed to the claimant. The white card is comparable to a health insurance card and should be presented to medical providers and pharmacies so that the costs associated with the accepted illness are billed to, and paid by, the DEEOIC.[57]

It is mandatory that a medical provider be enrolled with the DEEOIC to receive payment for their services. Any medical provider enrolled in the DEEOIC program will receive payment for services directly. When the medical billing process works as intended, the bills are presented to the DEEOIC, and the submitter is reimbursed. If a physician or medical provider has not enrolled with the DEEOIC, they may contact the DEEOIC medical bill processing agent or a DEEOIC resource center (RC) for enrollment information. Billing inquiries that require additional or escalated assistance (including provider billing inquiries, claimant requests for medical reimbursements, denial explanations/appeals, overpayments, provider enrollment requests, or questions related to billing codes or fee schedules) can be submitted via e-mail to DEEOICbillinquiries@dol.gov.

In February 2024, the OWCP entered into a new contract with Conduent to process pharmacy benefits for DEEOIC claimants. DEEOIC's website indicates that by March 15, 2024, all recipients of medical benefits under the program should have received a new card containing the new pharmacy information. Effective March 15, 2024, the pharmacies were not able to accept the old medical benefits identification card and were required to electronically submit their pharmacy transactions to Conduent for payment.

This new process would be beneficial to providers and claimants by reducing potential delays when filling prescriptions and reducing the number of requests for reimbursement of out-of-pocket expenses for

56. OWCP administers worker's compensation programs under four federal Acts: the Federal Employees' Compensation Act (FECA), the Longshore and Harbor Workers' Compensation Act (LHWCA), the Federal Black Lung Benefits Act (FBLBA), and the EEOICPA. The OWCP Medical Fee Schedule applies to FECA, EEOICPA and LHWCA; a modified version is used for the FBLBA.
57. See Appendix 4.

claimants. However, it is unclear if this information was communicated in writing to the pharmacies that are currently enrolled as DEEOIC providers.

It was brought to our office's attention that there were significant problems with the roll out of the new white card. These problems raised concerns and confusion when claimants attempted to have their prescriptions filled. Because pharmacies were unfamiliar with Conduent's new pharmacy benefit procedures, some claimants experienced delays in getting their prescriptions filled. As a result of these delays, and because of the immediate need for their prescription medications, some claimants were forced to pay for their medication out-of-pocket and then request reimbursement from the DEEOIC.

Simply notifying claimants that a change is going to take place is not always sufficient. A claimant shared that they encountered difficulties when they went to have a prescription refilled. They were told that their white card had been rejected. Claimants informed our office that when their pharmacy contacted the DEEOIC, they were told that they needed to re-enroll as a DEEOIC provider. Claimants were frustrated because they did not know what they needed to do to get their prescriptions filled. Pharmacies also found the process frustrating because many were unaware of the steps that were required to ensure a seamless transition to the new process. Our office would recommend that the DEEOIC give the stakeholders a more detailed explanation about any new process on their website. Claimants should be fully informed by the DEEOIC about any new medical billing processes that will affect them or their providers.

Our office was also contacted by a nurse case manager because several of their clients informed them that many pharmacies were having difficulties with submitting bills. The nurse case manager also informed our office that claimants did not know why they received a new white card when it had not been requested. The claimants were unaware of how the new cards were associated with the rollout of a new system that allowed them to access their prescription benefits.

During an outreach event in Livermore, California, our office was advised that Kaiser Permanente of Northern California did not accept the new white card, while their counterpart in Southern California did accept the new card. Our office was also informed that claimants were experiencing the same difficulty with other medical conglomerates in Northern California. The claimants did not know what actions were needed to resolve this issue. The Ombuds does not know if this is a regional or nationwide issue. However, even if it is only occurring in California, this not only creates a barrier to accessing treatment, but it impacts the confidence that the claimants have with using the medical benefits card. The DEEOIC is aware of this issue, but our office does not know if or how it was addressed.

The Ombuds recommends that any future changes to the medical benefits process that may impact the claimant community be thoroughly evaluated prior to implementation. When changes of this magnitude are made, the DEEOIC should notify both claimants and providers in writing, ensuring they have sufficient time and opportunity to seek clarification or additional information if needed.

To minimize disruptions in service for claimants, DEEOIC should issue a detailed letter to medical providers outlining any changes to the reimbursement or enrollment process. This communication should include

clear guidance on any required steps to maintain their status as enrolled providers. Proactively informing providers would increase the likelihood that both providers and claimants are aware of procedural changes and allow them to adapt accordingly. Had the DEEOIC provided timely and thorough notification to both claimants and providers regarding upcoming the white card changes, much of the confusion would have been avoided.

The Ombuds recommends that DEEOIC ensures that all enrolled providers are informed in advance of any policy or procedural changes. These notifications should include specific instructions on how providers can comply with the updated requirements, particularly when changes affect the reimbursement process or provider eligibility.

Also, if not already a standard practice, the DEEOIC should provide claimants with a copy of the Medical Benefits Brochure at the time medical benefits are awarded. This brochure offers a clear overview of the DEEOIC medical benefits process, including (but not limited to) the types of covered medical services, how to locate enrolled providers, the issuance of medical benefits cards, and the procedures for reimbursing out-of-pocket medical expenses.

Medical Bill Coding Issues

Another issue brought to the attention of the Ombuds involved the challenges in resolving medical bill coding issues. Based on the type of medical billing error, the steps taken to resolve the issue can vary. A solution to coding problems could be as simple as manually updating a medical diagnosis code, or it could involve conducting a detailed review to determine the cause of the error and to determine what steps need to be taken to process the bill. Our office has found that the incorrect application of medical billing codes due to human error or outdated systems can lead to delayed or denied payments. Each medical billing issue represents a DEEOIC claimant whose medical bill is not being paid. Claimants may only become aware of problems with the payment of their medical bills when they are notified by the provider of an outstanding bill.

The DEEOIC incorporates the use of treatment suites in the medical bill payment process. Treatment suites identify the medications and services that the DEEOIC has determined to be the appropriate course of medical treatment for an accepted condition. It was brought to our attention that the processing of medical bills can be delayed or denied if a medication or procedure is not included in the treatment suite.[58]

In addition, the DEEOIC procedures state that when a billed service charge is denied, the bill processing agent, Acentra Health, issues an Explanation of Benefits (EOB) to the billing provider informing them of the reason(s) for the bill rejection. There are various reasons why a bill may be rejected. Some reasons for rejection of a bill can include incomplete documents, inaccurate or improper coding, or duplicate billing, etc. In these situations, it is necessary for the provider to correct the error and resubmit the bill for processing.

There are also situations when the EOB might communicate that the billed treatment, service, or prescription drug is not included in one of the OWCP treatment suites for the claimant's accepted conditions.

58. Federal (EEOICPA) Procedure Manual, Chapter 28.4, Version 9.0.

If this happens, a claimant may choose to submit a claim requesting to have the rejected charge evaluated for "exception" approval by the DEEOIC. This exception process results in a manual review by a medical benefits examiner (MBE) to determine if the rejected service, prescription medication, or other medical benefit, is medically necessary for the care of an accepted illness on an exception basis. This can be problematic for claimants or providers because it can delay the receipt of the medical treatment and the processing of payments. The lack of familiarity in navigating the medical bill process often leaves claimants feeling exasperated.

In one instance, a claimant contacted our office because their prescription for treating idiopathic pulmonary fibrosis was denied. The DEEOIC had accepted the claimant's conditions of asbestosis and interstitial lung disease. The claimant was confused as to why the prescription was not covered under the DEEOIC program and requested our assistance.

We contacted the pharmacy and were advised that OWCP's pharmacy bill processing agent, Conduent, indicated that the denial occurred because the diagnosis code submitted by the treating physician did not match the approved diagnosis code. Upon investigation by the claimant's authorized representative (AR), it was discovered that the physician's office had billed the medication using an ICD-10 code, while Conduent was using an ICD-9 code for processing. Although the coding discrepancy was resolved, the medication was still not authorized. This was due to the fact that the DEEOICs treatment suite for asbestosis did not identify the prescribed medication as one typically associated with treatment for the covered condition. As a result, the drug/diagnosis mismatch led to a continued denial, requiring exception processing to move forward.

Once the exception processing was completed, the prescription was approved. However, by that time, the original prescription had expired. The claimant had to obtain a new prescription from their physician, which was eventually filled.

Delays of this nature force claimants to choose between paying out-of-pocket for necessary medication and either seek reimbursement or wait for resolution before obtaining treatment. To support quality customer service, it would have been reasonable for DEEOIC to notify the claimant or their AR that the exception processing would cause a delay in filling the prescription.

In another example, our office was contacted by a claimant in June 2023 because they experienced delays in obtaining out-of-pocket reimbursement for prescriptions based on the covered condition, lung transplant. They were frustrated with the delays and did not understand why the reimbursements were taking so long. The DEEOIC informed the claimant that they needed to amend the treatment suite for lung transplant. Six months later, the claimant informed our office that no action had been taken on their prescription reimbursements.

In January 2024, the claimant contacted our office to let us know that payment for approximately 18 outstanding prescription reimbursements had been issued. If in fact the delay was because the DEEOIC needed to adjust the treatment suite, it should not have taken six months for this information to be communicated to the claimant. The DEEOIC should have informed the claimant on how long it would take to amend the treatment suite. These types of delays are medically and financially taxing on claimants.

The Ombuds recommends that the DEEOIC identify a process that communicates the treatment suite information to the claimants and providers, possibly adding information to the DEEOIC website as it relates to the existence of a treatment suite. If it is not currently in place, our office recommends that the DEEOIC conduct regular quality assurance audits to review and offer feedback and training on medical billing issues. Our office recommends that the DEEOIC consider establishing a unit of MBEs that can triage and prioritize medical billing issues. The DEEOIC should also develop a process where management periodically reviews denials with a focus on tracking, analyzing, and ensuring that the denials were properly adjudicated.

Locating Medical Providers

In prior annual reports, the Ombuds discussed the difficulties that claimants experience when trying to find, keep, or access medical care. Sometimes the issues were the result of health care providers not knowing that they needed to be enrolled with the DEEOIC program; the provider deciding for various reasons that they would no longer treat DEEOIC patients; or the claimant feeling that they had to travel too far to be seen by a doctor enrolled in the DEEOIC program.

For example, our office was contacted by claimants in the Washington State Tri-Cities area (Pasco, Richland, Hanford) who informed us that an enrolled pulmonologist was no longer accepting the DEEOIC white card. The claimants were unable to locate a pulmonologist within 50 miles and were faced with travelling long distances for treatment. Our office contacted the DEEOIC for assistance in locating a pulmonologist and we were informed that there were several enrolled pulmonologists within 75 miles of the Tri-Cities area. This information was shared with the claimants, one of whom found that traveling 150 miles round trip for medical treatment could be a significant strain due to their poor health.

The Hanford Site is one of the largest Department of Energy (DOE) nuclear weapons facilities. It employed, and continues to employ, thousands of people. A significant number of DEEOIC claimants suffer from pulmonary diseases that have been accepted under the EEOICPA. Thus, it is reasonable to conclude that many current and former employees of this facility will need medical care from a pulmonologist in the Tri-Cities area. This is problematic because they may elect to pay for their medical services out-of-pocket and risk the possibility that the treatment may not be fully reimbursed by the DEEOIC, or they may elect not to pursue treatment for the accepted condition until their health deteriorates to the point where they can no longer ignore their symptoms.

Our office recommends that the DEEOIC conduct outreach events in the Tri-Cities area with enrolled providers to determine why other potential providers (their colleagues) are hesitant to enroll as DEEOIC providers. In addition, the DEEOIC should also attempt to find out why providers disenroll and what, if anything, can be done to curtail the disenrollments. Based on the input and recommendations from the providers, the DEEOIC should identify and implement processes that will increase the number of providers that are enrolled in the Tri-Cities area. This problem is not limited to the Tri-Cities area. Therefore, any lessons learned or improvements that can be made in the Tri-Cities area can hopefully be applied in other areas of the country.

Delays/Communication

Another common complaint with medical billing issues involves the lack of assistance or the inability for a claimant to speak with their assigned MBE. Our office receives complaints from claimants trying to obtain reimbursement for out-of-pocket expenses, as well as from claimants trying to avert a collection action for an unpaid invoice or to avoid a break in treatment. In many instances, before contacting our office, these claimants tried to resolve the issue on their own but were limited by their lack of familiarity with the medical bill pay process. It is not uncommon for our office to receive complaints alleging that when some claimants attempted to contact their MBE to discuss billing issues, their calls were not returned, or they experienced delays when trying to contact someone who could assist with these matters. By the time they contact our office, claimants are often upset and looking for someone who can help them resolve these matters right away.

An example of a delay in medical billing was brought to our attention in 2024. The claimant advised us that in 2022, they underwent extensive diagnostic testing and surgery for the accepted condition. The claimant had not received any invoices for these services and was concerned that the facilities had not been paid. The claimant requested our assistance, as they were concerned about being billed directly for the services provided.

Our inquiry to the DEEOIC medical benefits processing unit (MBPU) revealed that the bills were denied because the medical diagnosis codes were not related to the accepted condition. The MBPU representative stated that their office would follow up with the treatment facilities. The issue in this case is that these bills were outstanding for a significant period before the claimant was able to obtain assistance. Prior to receiving an inquiry from our office, the MBPU representative had not followed up with either of the facilities or the claimant.[59]

It should be noted that OWCP limits the time to submit bills for payment. Pursuant to Chapter 28.11 of the PM, OWCP may not issue payment for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was provided; or more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later. Claimants may be unaware of this policy, which could result in them being responsible for the payment of their medical services. Moreover, unpaid bills could potentially be sent to collections, leaving the claimant with no recourse but to pay the entire balance out-of-pocket.

The Ombuds recommends that when a medical condition is approved under the DEEOIC, a separate letter should be sent to the claimant and/or the medical provider advising them of the submission deadlines for payments. The DEEOIC should also consider how they can reduce the number of unanswered and unreturned phone calls. Exceptional customer service should be the ultimate goal and the DEEOIC should engage with their front-line employees to see what resources and tools are needed to achieve this standard.

59. The MBPU oversees the medical bill processing systems, transactions, and coding necessary to assure prompt and accurate payment for approved medical benefits and works with OWCP and the BPA (bill processing agent) contractor to develop and implement appropriate bill payment codes, procedures, and resolutions to related issues.

CHAPTER 5 - CUSTOMER SERVICE

The task of performing exceptional customer service is paramount to the success of any organization. The means of achieving this goal require clear and concise communication between Division of Energy Employees Occupational Illness Compensation (DEEOIC) stakeholders and DEEOIC claims staff. When such communication does occur, DEEOIC claims staff should not only address the issue being raised by the DEEOIC stakeholder but also identify any potential obstacles that may delay resolution of the inquiry. The DEEOIC must show a certain level of flexibility in determining the best method of relaying information to its stakeholders. DEEOIC stakeholders are comprised of multiple generational groups, meaning that the most effective method of communication will vary.

Access to Claim File Information

When our office receives an inquiry related to an existing claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), a review of the relevant claim file information is necessary. This is to ensure our recommendations for resolution are based on an accurate assessment of the claim file. Since the Ombuds does not have access to the online DEEOIC claims database, the initial step for resolving case specific matters requires the claimant or their designated AR to provide our signed Privacy Act Waiver, giving our office permission to obtain information and documents from the DEEOIC. Our office then forwards the waiver to the DEEOIC and requests a copy of the claim file information which is relevant to the inquiry.

The DEEOIC interacts with multiple federal agencies to obtain information that is contained in the employee's claim file. To ensure that personally identifiable information (PII) is not released, the DEEOIC reviews and redacts sensitive case file information. Given the size of DEEOIC case files (containing more than a thousand pages is not uncommon), the task for redacting PII is both challenging and time consuming.

The case file information is converted into a password protected compact disc (CD) format and sent to our office via United States Postal Service. The DEEOIC takes additional precautions to prevent the release of PII by mailing a separate letter, that includes password information giving access to case file records within the CD. It takes approximately four weeks from submission of the signed Privacy Act Waiver to our office's receipt of the complete CD/password packet. Our office then conducts a through review of the case file information and provides the stakeholder with our recommendation for resolving their issue.

Our recommendation for expediting this process is for the DEEOIC to create a platform which would grant our office direct access to relevant claim file information. The Office of Workers' Compensation Programs (OWCP) currently maintains a secure online website known as the Employees' Compensation Operations & Management Portal (ECOMP), which allows DEEOIC claimants and their ARs the ability to view case file information. Allowing our office "read only" access to this system would significantly reduce waiting times for obtaining case file information, which in turn would expedite our response time to stakeholders.

Furthermore, accessing records through a secure Department of Labor (DOL) online portal reduces the risk of PII violations.[60] Moreover, DEEOIC resources would be available to address other program initiatives.

Delays in Claim Status Communications

Claimants and ARs have voiced concerns regarding delays in the claim adjudication process. Our office receives inquiries from claimants following attempts to address outstanding issues with the DEEOIC resource center (RC) staff or the DEEOIC claims staff. Callers have expressed frustration with the lack of communication from the DEEOIC, specifically in providing case status updates following the submission of requested documentation in support of their claim.

In one such instance, our office received an inquiry regarding reimbursement of expenses related to treatment at a memory care facility due to a covered illness. The caller indicated that the initial request was forwarded to the DEEOIC in November 2023. A nurse at the memory care facility contacted the DEEOIC by phone for case status, and was correctly advised that they could only provide case status information to the claimant or their designated AR. Subsequently, between March 2024 and September 2024, the claimant's AR contacted the DEEOIC via telephone on five separate occasions, with no response. Due to the lack of response, on September 9, 2024, the AR submitted a written request for a status update via the Energy Document Portal (EDP). After receiving no response to their inquiry, the AR contacted our office for assistance in resolving this matter.

Our office forwarded an inquiry to the DEEOIC on November 5, 2024. In response to our inquiry, the DEEOIC advised our office on December 20, 2024, that the employee's son had been working with the memory care facility and the RC to obtain evidence supporting the need for assisted living. The RC staff has taken initial steps to have the memory care facility enrolled within the DEEOIC Bill Pay System, a requirement for all approved DEEOIC medical providers. We advised the AR to contact us if they had any additional concerns.

In another instance, an employee's AR advised our office that a request for home modifications had been sent to the DEEOIC in July 2023. The AR left voicemails for the DEEOIC claims staff on October 13, 2023 and October 24, 2023. The calls were not returned. The AR then submitted a written case status request to the DEEOIC on October 30, 2023, with no response. Between the period of December 7, 2023 and September 6, 2024, a total of five failed attempts for case status updates were initiated either via voice mail message or through written request via electronic filing. Following an inquiry from the Ombuds on November 5, 2024, the DEEOIC advised that the employee's request for home modifications was approved by letters dated December 3, 2024 and December 10, 2024.

Another inquiry involved reimbursement for over-the-counter (OTC) medications due to an accepted illness. During a September 27, 2023 outreach event, the employee expressed frustration with having to pay out-of-pocket for medication that should have been covered by the DEEOIC. They advised our office that they had unsuccessfully attempted to resolve this issue with the RC.

60. According to the DEEOIC's website, ECOMP is a secure online website that provides DEEOIC claimants and ARs access to view case file information, such as recent actions and compensation information. The website further notes that certain types of records (e.g. records received from NIOSH or records received from the Department of Energy), which are part of the claimant's case file, are not included in ECOMP because these records may contain PII of other individuals who worked at the same facility. It also indicates that if the claimant wishes to obtain documents that they are not able to view in ECOMP, they can submit a Privacy Act request to the district office claims examiner.

Our initial contact with the DEEOIC revealed that reimbursement requests were denied because the OTC medications were not considered as part of the treatment suite for the employee's accepted illness. Our office noted that this information was not communicated to the employee.

After we contacted the DEEOIC, the matter was referred to a contract medical consultant (CMC) who concluded that the need for these OTC medications was appropriate. On January 12, 2024, the DEEOIC advised our office that all of the previously denied reimbursement requests would be processed for payment.

Subsequently, the employee contacted our office and informed us that the prescription reimbursement issue remained unresolved. We again contacted the DEEOIC and were advised that there was a manufacturer pricing issue needing to be resolved before reimbursement could be issued. On March 4, 2024, the DEEOIC advised our office that the employee's reimbursement payments for dates of service between December 2022 and September 2023 would be issued on March 7, 2024.

As part of our recommendations, it is worth noting that the 2023 Annual Report contained a recommendation regarding the use of ECOMP to allow for communication between the DEEOIC staff and its stakeholders. The first two incidents in this section highlight our office's recommendation for using ECOMP as a tool for providing case status updates. The use of this system would be ideal in instances where case status inquiries are received in electronic form, as users are familiar and comfortable with the process.

These incidents also highlight the importance of providing timely responses to case file inquiries, as failure to do so results in stakeholders' frustration. Moreover, delays in addressing medical treatment could potentially impact an employee's overall health. Finally, claims staff should always be aware of situations where potential delays in receipt of benefits and/or claims adjudication could occur and make an effort to inform all interested parties of the delay in a timely manner.

Access to DEEOIC Web Portals

DEEOIC claimants, ARs, and health care providers can submit claim file information, process bill payments, and request reimbursement for claim related expenses electronically. This allows for both expedited bill processing and bill payment compared to non-electronic filing methods. Our office advocates for electronic submission of any information related to an EEOICPA claim during interactions with claimants. However, most claimants are unaware of the ability to submit case file information electronically. Other claimants indicated they experienced problems navigating the site to obtain relevant information.

The DEEOIC has dedicated several areas on its website for instruction and guidance in navigating each of the options available for electronic filing of EEOICPA claim information: ECOMP, the Employee Document Portal (EDP), and the Medical Bill Processing Portal (MBPP). Each website provides a detailed explanation of the purpose for each site, step-by-step instruction for accessing the site, registration information, and contact information for addressing problems while navigating the site. In particular, the design and the layout of the MBPP shows great attention to detail by sorting topics based on specific DEEOIC interest groups (e.g. resource tools used mainly by claimants or medical providers). The DEEOIC homepage includes a "How to Guides" section for accessing ECOMP. However, no such option is available for the EDP or MBPP.

Our office recommends extending the "How to Guide" section of the DEEOIC home page to include access links and instructions for navigating both the EDP and the MBPP. Given the advanced age of many DEEOIC claimants, this action would be considered a more "user friendly" method for website users and increases the likelihood of DEEOIC stakeholders successfully submitting claim information electronically. If implemented, this recommendation should reduce the volume of inquiries received by the claims staff.

APPENDICES

APPENDIX 1 - ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

AEC	Atomic Energy Commission
AMB	Ancillary Medical Benefits
AWE	Atomic Weapons Employer
BCC	Basal Cell Carcinoma
BeLPT	Beryllium Lymphocyte Proliferation Test
BeLTT	Beryllium Lymphocyte Transformation Test
BPA	Bill Processing Agent
BTMed	Building Trades National Medical Screening Program
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CGRA	Complaints, Grievances, and Requests for Assistance Table
CMC	Contract Medical Consultant
CPWR	Center for Construction Research and Training
DAR	Document Acquisition Request
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
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
ECOMP	Employees' Compensation Operations & Management Portal
ECS	Energy Compensation System
EDP	Energy Document Portal
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
EOB	Explanation of Benefits
EPOD	Employment Pathways Overview Document
FAB	Final Adjudication Branch
FDA	U.S. Food and Drug Administration
FECA	Federal Employees Compensation Act
FWP	Former Worker Program

HHC	Home Health Care
HHS	Department of Health and Human Services
HP	Health Physicist
HR	Hearing Representative
ICD-9	International Classification of Diseases, 9th Edition
ICD-10	International Classification of Diseases, 10th Edition
IH	Industrial Hygienist
IOM	Institute of Medicine
JOTG	Joint Outreach Task Group
LMN	Letter of Medical Necessity
MBAU	Medical Benefits Adjudication Unit
MBE	Medical Benefits Examiner
MBPP	Medical Bill Processing Portal
NDAA	National Defense Authorization Act
NIOSH	National Institute of Occupational Safety and Health
NNSA	National Nuclear Security Administration
NO	National Office
NRSD	NIOSH Referral Summary Document
Ombuds	Office of the Ombudsman for the EEOICPA
OTC	Over-the-Counter (medications)
OWCP	Office of Workers' Compensation Programs
PGDP	Paducah Gaseous Diffusion Plant
PII	Personally Identifiable Information
PM	Federal (EEOICPA) Procedure Manual
PoC	Probability of Causation
PPE	Personal Protective Equipment
RC	Resource Center
RECA	Radiation Exposure Compensation Act
SCC	Squamous Cell Carcinoma
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SERT	Secure Electronic Records Transfer system
SSA	Social Security Administration

APPENDIX 2 - COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE TABLE

Complaints, Grievances, and Requests for Assistance	Number of Complaints/Concerns
Unsure Who to Contact for Assistance	150
Delays	54
Customer Service	51
Behavior of DEEOIC Staff/Management	49
Claims Development	35
Request for Status of Claim	33
Part E Causation	28
Pre-Authorization or Authorization for Treatment	24
Prescriptions	21
Home Health Care	20
Out-of-Pocket Expense Reimbursement	19
Telephone Communication Issues	19
DEEOIC Decisions and Waivers	18
NIOSH Dose Reconstruction	17
Toxic Exposure	17
Non-Cancerous Conditions	16
Billing Issues with Medical Billing Contractor	15
Consequential Conditions	15
Outreach	15
Unaware of How to File a Claim	15
Claim Adjudication	14
Impairment Benefits	14
Part B Causation	13
Recommended Decisions	13
Health Care Provider Issues	12
Industrial Hygienist (IH)	12
Contract Medical Consultant (CMC)	11
Presumption Exposures	11
Site Exposure Matrices (SEM)	11

Complaints, Grievances, and Requests for Assistance	Number of Complaints/Concerns
Authorized Representative	10
Employment Records	10
DOE Contractor Employment	9
FD Following Hearing/Review of Written Record	8
Finding a Health Care Provider	8
Part E Eligibility Issues	8
SEC (Special Exposure Cohort)	8
Survivor Claims	8
Treating Physician/Claimant Medical	8
Unaware Can Request Copy of File or Document	8
Cancer	7
Consequential Illness Issues	7
Lack of Communication	7
Medical Benefits	7
Reopening Decisions	7
Representative Fee/Expenses	7
Authorization/Reimbursement for Medical Travel	6
Coding Issues	6
DOE Subcontractor Employment	6
Subsequent Impairment Evaluations	6
Unaware of EEOICPA	6
Beryllium Sensitivity	5
Chronic Silicosis	5
Development of Medical Evidence	5
Home Modifications	5
Medical Records	5
Medicare/Private Health Insurance Reimbursement	5
Presumptive Illnesses	5
Remand Orders	5
SEC Class	5
Specified Cancer	5
Biological Child	4

Complaints, Grievances, and Requests for Assistance	Number of Complaints/Concerns
Causation/Burden of Proof	4
Chronic Beryllium Disease (CBD)	4
Covered Employment	4
Presumptions	4
Spouse	4
Weighing of Evidence	4
Behavior of Billing Contractor Staff	3
Durable Medical Equipment (DME)	3
Part B Eligibility Issues	3
Scientific Studies	3
Affidavits (Exposures)	2
Behavior of Resource Center Staff	2
Beryllium Vendor	2
Classified Information (Exposures)	2
Conflict of Interest	2
DOE/DAR Records	2
Exposure Records	2
FWP Screening Program	2
Medical Bills	2
Medical Evidence of Wage Loss	2
Billing Issues with Prescription Billing Contractor	2
Part B Post-1993	2
Part B Pre-1993	2
Power of Attorney	2
Problems with Energy Document Portal (EDP)	2
RECA 5 Causation	2
RECA 5 Illnesses	2
Reconsideration Decisions	2
Relationship to Employee	2
Selection of Rating Physician	2
Terminal Status	2
Wage Loss Benefits	2

Complaints, Grievances, and Requests for Assistance	Number of Complaints/Concerns
Waivers	2
DOE Federal Employment	1
Election of Benefits	1
Grandchild	1
Limited Representation	1
Offset of Benefits, Tort Action/Lawsuit	1
Part E CBD	1
Remediation Employment	1
Stepchild	1
Third-party Exposure	1
U.S. District Court appeals	1
Wage Loss Evidence	1
TOTAL	**1047**

APPENDIX 3 - CONTACTS BY FACILITY TABLE

Facilities	Number Identified
Amchitka Island Nuclear Explosion Site	1
Ames Laboratory	2
Bendix Aviation (Pioneer Division)	1
Brookhaven National Laboratory	1
Brush Beryllium Co. (Cleveland)	1
Brush Beryllium Co. (Elmore)	1
BWX Technologies, Inc. (Virginia)	1
Combustion Engineering	1
Feed Materials Production Center (FMPC)	5
Fermi National Accelerator Laboratory	1
Hanford	11
Harshaw Chemical Co.	1
Idaho National Laboratory	3
Iowa Ordnance Plant (Line 1 and Associated Activities)	7
Kansas City Plant	13
Kerr-McGee	1
Lawrence Livermore National Laboratory	16
Los Alamos National Laboratory	14
Lovelace Respiratory Research Institute	1
Massachusetts Institute of Technology	1
Mound Plant	4
Nevada Test Site	18
Oak Ridge Gaseous Diffusion Plant (K-25)	14
Oak Ridge Institute for Science Education (ORISE)	1
Oak Ridge National Laboratory (X-10)	4
Pacific Northwest National Laboratory (PNNL)	1
Pacific Proving Ground	1
Paducah Gaseous Diffusion Plant	8
Pantex Plant	11

Facilities	Number Identified
Portsmouth Gaseous Diffusion Plant	33
Rocky Flats Plant	11
Sandia National Laboratories	3
Savannah River Site	18
Speedring, Inc.	2
Tonopah Test Range	2
W.R. Grace (Tennessee)	1
W.R. Grace and Company (Maryland)	1
Waste Isolation Pilot Plant	2
West Valley Demonstration Project	1
Y-12 Plant	14
TOTAL	233

APPENDIX 4 - DEEOIC MEDICAL IDENTIFICATION CARD (WHITE CARD)

Sample DEEOIC Medical Identification Card

Front

US Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Medical Benefits Identification Card

John Doe

Case Number: 1234567890
Pharmacy BIN: 610084
DEEOIC Group ID#: OWCP1222

No Co-Pay/No Deductible

MISUSE OF CARD IS PUNISHABLE BY LAW

Back

1. This card is the property of the U.S. Government and its counterfeiting, alteration or misuse is a violation of Section 499, Title 18, U.S. Code.
2. Carry the card with you at all times and show it to your doctor, clinic, pharmacist or hospital when you are in need of medical services for your accepted condition(s).
3. Medical treatment authorized under the Energy Employees Occupational Illness Compensation Program Act is paid for by the U.S. Department of Labor. Call toll free (866)-272-2682 for specific information related to medical services. Call toll free (866)-664-5581 for specific information related to pharmacy services.
4. All bills should be submitted to the U.S. Department of Labor OWCP/DEEOIC, P.O. Box 8304, London, KY 40742-8304.
5. If found, drop in mailbox. Postage guaranteed. Return to: U.S. Department of Labor OWCP/DEEOIC, P.O. Box 8306, London, KY 40742-8306.
6. When using the DOL OWCP website **(http://owcpmed.dol.gov)** to request an authorization for medical services or to verify eligibility, your doctor must use the Case Number located on the front of the card. Claimants can also use the Case Number to access the DOL OWCP website.

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UNITED STATES DEPARTMENT OF LABOR

Scan Me!

dol.gov/agencies/ombudsman