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

2025 ANNUAL REPORT TO CONGRESS

OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Front Cover Photo: Aerial view of the National Synchrotron Light Source II (NSLS-II) at Brookhaven National Laboratory.
Credit for Front Cover Photo: Courtesy of the U.S. Department of Energy via Flickr.

U.S. Department of Labor

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

July 16, 2026

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

Dear Mr. President:

I am pleased to present the 2025 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Tonya H. Taylor
Ombudsman

Enclosure

U.S. Department of Labor

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

July 16, 2026

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

Dear Mr. Speaker:

I am pleased to present the 2025 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Tonya H. Taylor
Ombudsman

Enclosure

TABLE OF CONTENTS

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 2025, 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 2025 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Federal (EEOICPA) Procedure Manual (PM), Version 10.0 (v.10)

The DEEOIC published PM v.10 on December 18, 2025.[1]On December 18, 2025, DEEOIC also published EEOICPA Transmittal No. 26-01 to notify staff of the content edits in PM v. 10.[2]

Below are some of the changes to PM v.10:

- Chapter 15 – "Establishing Toxic Substance Exposure and Causation"
    - Exhibit 15-4, "Exposure and Causation Presumptions with Development Guidance for Certain Conditions," has been edited to correct a typographical error listing polyvinyl chloride instead of vinyl chloride as a toxic substance related to angiosarcoma.[3]
- Chapter 20 – "Establishing Survivorship"
    - Chapter (Ch.) 20.8a(1) - Version 9 of the PM discusses the definition of a "biological child." One type of biological child is "any person who can establish an actual genetic link to a deceased employee through the submission of probative DNA evidence that shows such a link."

      PM v.10 clarifies that "In order for DNA test results to be probative in establishing a genetic link between a biological child and a deceased employee under EEOICPA, a certified kinship DNA test must be conducted by an accredited DNA testing facility; wherein participants' identifications are verified, sample collections are witnessed by a third party, and the process includes a verifiable chain of custody of the samples submitted."

1 https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/PolicyandProcedures/procedure_manual_10.0-2025.12.pdf

2 https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/PolicyandProcedures/proceduremanualhtml/unifiedpm/Unifiedpm_transmittals/Transmittal_26-01.pdf

3 Federal (EEOICPA) Procedure Manual, Version 10.0, Exhibit 15-4(1), "Angiosarcoma."

- Chapter 21 – "Impairment Ratings"
    - Ch. 21.5 and Ch. 21.16 have been updated to reference a new claim form for filing for impairment and increased impairment, Form EE-10. Form EN-11A is no longer in use.
    - Ch. 21.9b-c has been edited to instruct staff that they may refer a claim to a contract medical consultant (CMC) when a claimant's physician offers an opinion that is contradicted by objective evidence or insufficient rationale.
    - Ch. 21.10 has been edited to include guidance to staff to direct impairment claims to a referee medical specialist to resolve conflicting impairment opinions that are found to be of equal weight, but not within 10 percentage points of one another.
- Chapter 22 – "Wage-Loss Determinations"
    - Ch. 22.6 and Ch. 22.17 have been updated to reference a new claim form for filing for wage loss, Form EE-10. Form EN-11B is no longer in use.
- Chapter 25 – "FAB Review Process"
    - Ch. 25.6 has been modified to align the hearing request process with C.F.R. § 30.314(a) regarding providing hearings through electronic means. The claimant/authorized representative (AR) now has the option to have a telephone or a video hearing.
    - Ch. 25.7 has been edited to provide clarity regarding the length of a hearing. "The FAB will schedule the hearing for a duration of one hour during which the claimant/AR may present their oral testimony. At the expiration of the allotted hour, the assigned hearing representative (HR) is to conclude the hearing and advise the claimant/AR that if they have additional argument or evidence for consideration, it must be submitted in writing. The HR is permitted to extend the duration of a hearing if the HR deems it necessary and appropriate."
- Chapter 26 – "FAB Decisions"
    - Ch. 26.3b(2)(a) has been added to incorporate guidance regarding an HR's processing of simple acceptances to allow for the HR to reference the case history as outlined in the recommended decision under consideration in place of a detailed Statement of the Case.
- Chapter 29 – "Ancillary Medical Benefits"
    - Ch. 29.4a-d has been modified to allow 30 calendar days for a response to medical benefit examiner (MBE) development letters to treating physicians. Previously, the treating physician was allotted 15 calendar days. With no response, the MBE would send a second development letter allotting another 15 days.

- Ch. 29.5a(3) has been edited to clarify that oxygen related equipment and supplies may be approved for up to 12 months.

- Ch. 29.7 has been updated to include guidance that was previously the subject of EEOICPA Bulletin No. 25-01 about issuing an Ancillary Medical Benefits (AMB) Decision.[4] This update provides guidance regarding the authorization of AMB, durable medical equipment (DME), and/or medical supplies, not to exceed 6-month increments.

- Chapter 30 – "Home and Residential Health Care"

  - Ch. 30.2h has been updated to clarify the definition of "homebound." The language in v.10 now reads: "Generally, homebound refers to the inability of a claimant to leave their place of residence, due to illness or injury. A claimant's homebound status may be permanent, transient, or temporary (e.g., short recovery period after hospital discharge) due to the nature of the employee's accepted condition. Claimants do not need to be totally immobilized or bedridden to be homebound but should only be able to leave their residence infrequently and for short durations. Any departure of the claimant from his/her residence must incur considerable and taxing effort."

  - Ch. 30.2q has been added to include the definition of "Medical Officers." Per v.10, "A Medical Officer is an OWCP qualified physician or pharmacist who may conduct a review of the case file records where a case involves complex medical issues, deviations from accepted medical standards, or the need to ensure any recommended treatment is in alignment with program regulations and guidelines. The Medical Officer may also conduct a review of cases designated as terminal, where timely analysis is critical."[5]

  - Ch. 30.5a(6) has been modified to include additional information on what is required in a physician's narrative and supporting documentation to demonstrate a claimant is primarily homebound. In addition to the documentation required previously, "[T]he physician's narrative and supporting documentation must demonstrate *[that]* the claimant is primarily confined to the home and any departure of the claimant from the residence must incur considerable and taxing effort."

  - Ch. 30.6c has been added to include additional guidance regarding Medical Officer referrals. "Upon receipt of a referral from a MBE, a Medical Officer or pharmacist may provide advice to allow the MBE to make an informed decision whether to authorize the request or undertake further development."

---

4 Ancillary Medical Benefits (AMB) include services and medical equipment or accessories that DEEOIC does not consider as routine or usually necessary for the treatment of an accepted medical condition and requires the submission of additional evidence before DEEOIC can pre-authorize or authorize reimbursement. Chapter 29.1 of the Federal (EEOICPA) Procedure Manual, Version 10.0.

5 OWCP - Office of Workers Compensation Program.

- Ch. 30.7 has been modified to eliminate the requirement that MBEs send two 15-day development letters within the 30 days provided for a response. The duration allocated by the MBE for the submission of necessary evidence to support a Home and Residential Health Care claim is 30 days.

Other EEOICPA Updates:

- EEOICPA Circular No. 25-01, dated October 9, 2024, notified DEEOIC staff of a new Special Exposure Cohort (SEC) class designation for the Metals and Controls Corporation in Attleboro, MA (also known as Texas Instruments). The new designation included "All Atomic Weapons Employees who worked at Metals and Controls Corporation in Attleboro, MA, from January 1, 1968, through September 21, 1995, for a number of work days aggregating at least 250 work days, occurring either solely under this employment or in combination with work days within the parameters established for one or more other classes of employees included in the SEC."[6]

- On August 27, 2025, DEEOIC launched a new Employees' Compensation Operations & Management Portal (ECOMP) Notification Feature. If a stakeholder is registered with the ECOMP and has access to case imaging, ECOMP will send daily email notifications when new documents are added to any case they are registered to view. The stakeholder can choose to opt out of the notifications.[7]

- There is a new Emergency Authorization Request Process.[8] In urgent cases, after sudden changes in their condition or before hospital discharge, employees may need short-term Home or Residential Health Care (HRHC) or DME, such as oxygen concentrators. The DEEOIC reviews emergency requests for HRHC or DME—usually within 48 hours—once notified. Requests must include a letter of medical necessity linking the service or equipment to the employee's approved conditions.

  For HRHC services, providers should contact Acentra's Triage Nurse (1-866-272-2682, 8:00 a.m. – 8:00 p.m. ET). For DME needs, providers should call the Resource Center (1-866-888-3322, 8:30 a.m. – 8:00 p.m. ET, Monday-Friday). Once the triage nurse and/or the Resource Center obtains the required information, they will liaison with the MBE. In all circumstances, the MBEs strive to provide a timely response to all emergency HRHC and DME requests, typically within 48 hours.

6 https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/PolicyandProcedures/finalcircularhtml/EEOICPACircular25-01.pdf

7 ecomp_email_notifications_announcement_082525.pdf

8 https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Emergency_Authorization_Request_Process.pdf

- The Site Exposure Matrices (SEM) website has been updated and is now current through May 16, 2025.[9] New information is now available for eight U.S. Department of Energy sites with significant additions to the following:
    - Brookhaven National Laboratory – included five additional radiological toxins to the job category of Health Physics Technician, added information to the Well Drilling profile, and added generic Guard toxins.
    - Mound Plant – updated engineering labor categories information and added generic Guard toxins.
    - Trinity Nuclear Explosion Site – included additional Well Drilling profiles, added labor categories, and reworked substance exposures for explosion tests.
    - Y.-12 Plant – included additional Well Drilling profiles.
- On March 25, 2025, Executive Order (EO) 14247, "Modernizing Payments To and From America's Bank Account" was issued. The EO imposed a September 30, 2025, deadline to transition all paper checks to electronic payments.

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

On October 5, 1990, Congress passed the RECA under the Department of Justice (DOJ). 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.

By statute, the period to file a claim under RECA ended on June 10, 2024.

On July 4, 2025, RECA was reauthorized under the "One Big Beautiful Bill Act," Pub. L. 119-21.[10] This bill made significant changes to the eligibility criteria under RECA. Of note, as it relates to uranium workers, the bill expanded the covered employment period to include January 1, 1972 to December 31, 1990; added uranium workers who worked as core drillers and/or worked in remediation at a uranium mine or mill; permitted combined work histories to satisfy the statute's work requirement; and added primary renal cancer and chronic renal disease, including nephritis and kidney tubal tissue injury, as specified compensable diseases for *all* uranium workers.

RECA claims may be submitted to the DOJ through December 31, 2027.

9 https://www.dol.gov/agencies/owcp/energy/regs/compliance/sem_updated_06-30-2025 (Retrieved January 15, 2026).

10 https://www.congress.gov/bill/119th-congress/house-bill/1

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 2025.

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[11] 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.[12]
    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. 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).[13]
    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.

- 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.[14]

- Uranium workers or their survivors, who are awarded $100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note, are entitled under the EEOICPA to a lump-sum payment of $50,000 and to medical expenses for the accepted illness(es).[15]

Part D of the EEOICPA was administered by DOE. 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.

---

11 If the covered employee is deceased, eligible survivors of the covered employees listed below are entitled to $150,000 in lump sum compensation under Part B.

12 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).

13 Pursuant to Chapter 13.15 of the Federal (EEOICPA) Procedure Manual, Version 10.0, civilian employees of federal and state governments, other than direct employees of DOE or its predecessors, can potentially be considered DOE contractor employees.

14 Ibid.

15 RECA sunset on June 10, 2024. On July 4, 2025, RECA was reauthorized under the "One Big Beautiful Bill Act," Pub. L. 119-21.

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 10 to 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.

- Qualifying uranium workers 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 workers are eligible for compensation and medical benefits under Part E even if they did not receive compensation under RECA.[16]

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 claim process.

16 Federal (EEOICPA) Procedure Manual, Chapter 19.7, Version 10.0.

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; and
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 claim 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 21st 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.*

Historically, our Office conducted outreach activities as a member of the Joint Outreach Task Group (JOTG). The JOTG is made up of the DEEOIC and partner agencies that play a role in the administration of the EEOICPA. Participating agencies include the Department of Energy (DOE) and their former worker medical screening programs, the National Institute for Occupational Safety and Health (NIOSH), the Department of Justice (DOJ) Radiation Exposure Compensation Act (RECA) Program (dependent upon location), and the Offices of the Ombudsman for the EEOICPA and NIOSH.

However, in 2025, the Ombudsman's Office only participated in four outreach events because JOTG paused its outreach activities, which limited our opportunities. The in-person outreach events we attended provided an opportunity to acquaint claimants with our Office and the services we provide. These events allowed us to be more accessible to stakeholders, by connecting with them in their communities. Claimants and other stakeholders appreciated meeting with us and were eager to share their experiences with the EEOICPA claim process.

Individuals generally contact the Ombudsman's Office for assistance with their EEOICPA claims or to ask general questions about 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, the information gathered is often sufficient to provide guidance. In other cases, with the permission of the claimant, we will need to obtain claim file documents or a copy of the entire claim file.

Legislation mandates that the Ombudsman's Office 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 our 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 that was communicated to our Office. While we receive complaints, grievances, and requests for assistance from across the country, the "Contacts by Facility" Table is limited to those where the covered facility was specifically identified.[17]

To better understand our stakeholders' concerns, one must first understand the specific roles of DEEOIC staff members in the claim process. The district office claims examiner (CE) is responsible for the development of evidence and issuance of 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 policies. 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. Should a claim be accepted, the medical benefits examiner (MBE) addresses issues related to medical treatment, authorizations, and billing.

The 2025 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, and requests for the status of a claim. These challenges lead to confusion and frustration and are often compounded by unanswered phone calls and the lack of follow-up, which further erodes trust in the process.

Delays in claim processing, whether in adjudication, reimbursement of out-of-pocket expenses, authorizations for prescription/medical care, or any other request, represent a significant source of dissatisfaction. Stakeholders frequently expressed frustration over extended waiting periods and the absence of proactive notification regarding such delays. The impact of these delays is magnified by DEEOIC imposed deadlines, which place additional pressure on claimants, especially when communication barriers prevent timely resolution of outstanding issues. Communication barriers not only delay claim resolution but also contribute to negative perceptions of the program's responsiveness and transparency. Claimants report feeling uninformed and powerless.

Another significant area of concern raised by our stakeholders is the adjudication process for Part E claims. In 2025, the Ombudsman's Office 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 from a licensed physician to establish a link between their claimed condition and their workplace toxic substance exposures.

Claimants and ARs struggle to understand why their medical documentation, often from their treating physician, does not meet the program's "well-rationalized" standard. Many view denials as subjective and intentional to deny them compensation and benefits.

This is a brief overview of the complaints, grievances, and issues received by the Ombudsman's Office in 2025. The following chapters will provide a more in-depth discussion and analysis of our findings.

17 *See* Appendices 3 and 4.

CHAPTER 1 - ADJUDICATION

Overview

Claim adjudication under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) is a multi-faceted process. The Department of Labor's Division of Energy Employees Occupational Compensation (DEEOIC) is tasked with adjudicating claims filed by employees, former employees, and survivors under Parts B and E of the EEOICPA. The adjudication process requires DEEOIC to evaluate covered employment, potential occupational exposures, medical evidence, and causation before a final decision is issued.

The DEEOIC collaborates with outside federal agencies, such as the Department of Health and Human Services (HHS), the Social Security Administration (SSA), and the Department of Energy (DOE) throughout the adjudication process to obtain radiation dose reconstructions, as well as employment and exposure records. While it is DEEOIC's responsibility to assist with the development of evidence and the issuance of a final decision in line with applicable statutes, regulations, and internal procedures, it is ultimately the claimant's responsibility to submit sufficient documentation to establish their claim for benefits under the Act.

The Ombudsman's Annual Report to Congress is tasked with assessing the most common difficulties encountered by claimants and stakeholders with all aspects of the claim adjudication process. In 2025, the Ombudsman's Office was presented with several challenges. With the disbandment of the Joint Outreach Task Group (JOTG), our Office's outreach capabilities were limited.

During this reporting period, claimants and authorized representatives raised a myriad of concerns regarding the adjudication of EEOICPA claims. These concerns involved:

- delays,
- the evaluation of medical and employment evidence,
- consistent adherence to DEEOIC's policies and procedures,
- transparency in adjudicative decisions, and
- the claimant's burden imposed during the development of claims.

A recurring theme in claimant inquiries involved the development and consideration of evidentiary documentation, whether submitted by the claimant or the DOE, necessary for the issuance of a final decision. It was frequently reported that:

- The DEEOIC staff did not fully consider medical documentation submitted by the claimant's treating physician.

- Covered employment verification, which is critical for establishing eligibility, is often incomplete and requires extensive follow-up by the claimant.

- Stakeholders experienced challenges with reconciling employment history documentation/evidence, especially for work performed under complex contractor/subcontractor arrangements.

These difficulties often delay the claim adjudication process, which increases uncertainty in the transparency of the process.

Evaluation of Medical Evidence

As identified in precedent annual reports, the evaluation of medical evidence continues to be a source of confusion and frustration for claimants and their representatives. Concerns have been expressed regarding how the DEEOIC evaluates medical evidence, particularly in cases under Part E of the EEOICPA involving causation determinations. Claimants often report difficulty understanding which types of medical documentation are considered sufficient, and authorized representatives have expressed uncertainty about how causation is determined under Part E of the Act.

In one instance, an authorized representative (AR) contacted our Office indicating that they had several clients whose claims were denied under Part E of the Act due to their inability to meet the causation criteria as established by the DEEOIC. They asserted that there is a pattern of claims examiners (CE) arbitrarily dismissing the submitted medical documentation from the treating physicians. The AR maintained that the detailed medical opinions, which included scientific articles, were well-rationalized and sufficient.

While there was no obvious defect in the medical documentation submitted, the AR asserted that CEs routinely referred the file to a contract medical consultant (CMC)[18] for an additional causation opinion. The AR complained that the DEEOIC staff did not follow its established procedural guidelines by assigning greater weight to the CMC's opinion.

The proper development and weighing of medical evidence are essential to the sound adjudication of claims for benefits and to the comprehensive management of EEOICPA claims. Pursuant to DEEOIC's Federal Procedure Manual,[19] when a CE receives medical evidence from more than one source, they must evaluate the relative value, or merit, of each piece of medical evidence. The CE evaluates the probative value of the report and assigns greater value to:

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

2. An opinion based on a definitive test(s) and includes the physician's findings.

---

18 A CMC is a contracted physician who conducts a review of case records to render opinions on medical questions. Medical opinions from a CMC are essential to the resolution of claims due to ambiguous causation, lack of medical evidence, unique exposures, or other medical questions. The function of a CMC is to provide clarity to claim situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. Federal (EEOICPA) Procedure Manual, Chapter 16.9, Version 10.

19 Federal (EEOICPA) Procedure Manual, Chapter 16, Version 10.

3. A well-rationalized opinion over one that is unsupported by affirmative evidence. The term "rationalized" means the statements of the physician are supported by an explanation of how his or her conclusions are reached, including appropriate citations or studies.

Claims examiners are given broad latitude to determine the voracity of whether a physician's report is well-rationalized, resulting in CMC reviews. Claimants have indicated that in most cases, their treating physician's opinion is deemed insufficient by DEEOIC staff. The claimant's perception is that the CE assigned more weight to the CMC's opinion.

When the weight of medical evidence is determined to be equal between the opinion of the treating doctor and the CMC, a third, impartial physician review, known as a referee specialist, can be obtained. In these cases, the assigned referee physician evaluates both sides of the competing argument and makes the **definitive conclusion**. It is the claimant's perception that the referee's opinion is rarely in their favor.

Recommendations

The Ombudsman's Office has previously reported that the evaluation of conflicting medical reports remains a source of confusion and concern for claimants and their authorized representatives. Clear and consistent application of established procedures goes a long way in establishing trust and transparency with stakeholders.

Moreover, pursuant to programmatic guidance,[20] when the CE deems that the treating physician's causation opinion is insufficient, the CE should typically give the treating physician the first opportunity to review medical evidence from the file, such as a statement of accepted facts (SOAF) and other documents for the purpose of responding to claim questions. If the treating physician does not provide substantive responses to claim questions, the CE may consider the claim in posture for a CMC review. The CE should not view a medical referral as an automatic requirement, but an option available in situations where no other reasonable option exists to obtain a resolution to an outstanding medical question.

The Ombudsman's Office recommends that when a CE determines that the submitted medical documentation is not sufficient to establish a claim, a development letter should be sent to the claimant explaining why the medical documentation is insufficient, and as such, the file is being referred to a CMC for a review and opinion. Should the CMC report differ from the treating physician's report, the CE should allow the treating physician an opportunity to review the report and refute the findings. At the very least a referee specialist should be obtained.

20 Federal (EEOICPA) Procedure Manual, Chapter 16, Version 10.

Evaluation of Employment Evidence

The EEOICPA lays out a set of employment criteria which must be satisfied before a claim can be considered for compensability. The DOE online database of covered facilities provides a list of covered facilities and their dates of coverage.[21] These criteria, taken together, form the initial basis of covered employment. The Ombudsman's Office also received requests for assistance related to DEEOIC's evaluation of the employment evidence and the application of covered employment criteria. In one case, an employee filed a claim for benefits prior to their death. With the initial claim filing, the employee indicated that they were a DOE employee. A final decision was issued denying their claim, based on insufficient evidence establishing covered DOE employment. The Final Adjudication Branch (FAB) found that the employee was a DOE federal employee and determined that the employee did not have covered employment because they did not perform or provide "services" at a covered facility.

Pursuant to programmatic guidance, "In order for an individual working for a subcontractor to be determined to have performed work or labor for the benefit of DOE within the boundaries of the facility. Examples of workers providing such services include janitors, construction and maintenance workers. The delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, including workers involved in the delivery and loading or unloading of goods for construction and/or maintenance activities."[22]

The employee's spouse filed a claim for survivor benefits. In support of their claim, they submitted numerous employment affidavits, demonstrating that the employee worked for the DOE, worked at multiple DOE facilities, and described the employee's multiple job titles and duties.

The district office issued a recommended decision that denied the survivor's claim; **AND** determined that because the employee's claim had been denied for insufficient employment evidence, the spouse was not entitled to survivor benefits. The spouse's AR contacted our Office regarding their disagreement with the denial.

After a thorough review of the case file, the Ombudsman's Office determined the following:

- The FAB established that the employee was a DOE federal employee.
- The FAB incorrectly applied subcontractor "services" criteria, which is not applicable or relevant to DOE federal employment.
- The employment evidence included documentation to support that the employee worked for a DOE subcontractor as an Armor Technician/Instructor at a covered DOE facility.
- The employee's and the survivor's claims were improperly adjudicated.

---

21 The DOE's Office of Environment, Health Safety and Security provides a DOE covered Facilities list at: https://ehss.energy.gov/Search/Facility/findfacility.aspx

22 Federal (EEOICPA) Procedure Manual, Chapter 13.13, Version 10.

For these reasons, our Office recommended that the AR file an objection to the recommended decision. The FAB issued a Notice of Final Decision Following a Review of the Written Record, upholding the district office's denial of survivor benefits.

It was apparent to our Office that the totality of the employment evidence still had not been given proper consideration. As such, our Office assisted the AR in establishing the basis for a request for reconsideration. The FAB granted the reconsideration request and remanded/returned the file to the district office for further development of ALL employment evidence, to include potential DOE subcontractor employment. The Ombudsman's Office will continue to monitor the file and make recommendations if the new final decision results in another denial.
Cases such as this demonstrate the complexity of applying the statutes, regulations, procedural guidelines, and sound judgement of the CE's review of the evidence, especially when employment may have occurred decades ago. Claimants and their representatives reported concerns regarding their burden of providing employment evidence and the difficulties in satisfying adjudicative requirements. Stakeholders reported that they were required to "jump through hoops" to submit extensive documentation in support of their claims. They expressed frustration that, despite submitting substantial documentation, and responding to multiple requests for additional evidence, their submissions were often determined to be insufficient, or those deficiencies were not addressed in any detail in the recommended or final decisions.

During the adjudication process, DEEOIC usually communicates to claimants via development letters. However, claimants sometimes found these letters to be less than helpful in navigating the process. Specifically, stakeholders reported the following development letter deficiencies:

- how DEEOIC evaluated conflicting medical evidence;
- why the submitted documentation was deemed insufficient; and
- how the employment criteria are established (i.e. differences between DOE contractor/subcontractor and atomic weapons employment).

Improved transparency in adjudicative reasoning could help claimants better understand correspondence (development letters, recommended decisions, and final decisions) and reduce the need for additional appeals and/or reopenings.

These difficulties have been addressed in prior Ombudsman's Annual Reports to Congress. We recognize that DEEOIC has reported taking appropriate steps to address our prior recommendations, which included providing training to claims staff, reinforcing procedural guidelines, and improving communication with claimants.

In its responses to prior reports, DEEOIC has stated that it evaluates claims in accordance with all applicable statutes, regulations and procedural guidance. They further stated that all relevant evidence is considered during the adjudication process. The DEEOIC reported that ongoing staff training is provided as it continues its efforts to improve communication with stakeholders.

Recommendations

Based on the inquiries and requests for assistance received from claimants during this reporting period, the Ombudsman's Office makes the following recommendations:

- The DEEOIC should continue to ensure consistent application of its procedures, especially when evaluating conflicting medical evidence and/or establishing covered employment.
- During the claim development process, DEEOIC should implement efforts to clearly communicate evidentiary requirements to claimants/authorized representatives to assist them in submitting relevant documents.
- The DEEOIC should ensure that recommended and final decisions clearly communicate the evidentiary requirements regarding the evaluation of medical and employment evidence and the basis for its determinations.

Overall Delays

During the 2025 reporting period, the Ombudsman's Office received inquiries from claimants and authorized representatives regarding delays at various stages of the adjudication process. The main concerns raised were the length of time required for claim development, delays following the submission of the requested evidence, and delays in the issuance of recommended and/or final decisions.

This Office received reports regarding the length of time required for DEEOIC to develop evidence and move claims forward in the adjudication process. The timely adjudication of claims is a critical component of the EEOICPA. The DEEOIC is responsible for reviewing claims, developing evidence, and issuing recommended decisions and final decisions in accordance with applicable statutes, regulations and procedures. The time required to adjudicate a claim varies depending upon several factors, such as the complexity of the claim, and the availability of medical, employment and exposure evidence. These factors determine the need for additional development, such as working with outside agencies to obtain information. This coordination could contribute to delays in the progression of the claim development.

In one case, after multiple attempts to contact their claims examiner, an octogenarian claimant requested assistance from the Ombudsman's Office to determine the status of their claim for survivorship. The claimant stated that it had been over a year since the claim had been filed. They reported that they submitted all the necessary evidentiary documentation (pathology reports, death certificate and marriage certificate). They also noted that they received a development letter from DEEOIC acknowledging receipt of said documents. However, they alleged that after six to seven months, they had not received any communication from DEEOIC.

Frustrated, this claimant reached out to their Congressional representative and our Office. After obtaining a signed privacy act waiver, we were able to contact DEEOIC to obtain an update. The claimant's file had been submitted to the National Institute for Occupational Safety and Health (NIOSH) for a dose reconstruction.

Due to unforeseen circumstances, and through no fault of DEEOIC, NIOSH was experiencing delays in the dose reconstruction process. Unfortunately, they were unable to advise us when the dose reconstruction process would be completed. By the time we were able to relay this information to the claimant, they were very upset and requested that their CE periodically "check in" with them to keep them abreast of the process. The DEEOIC advised this Office that someone would contact the claimant.

This Office has also received complaints regarding delays in the issuance of recommended and final decisions after the claim development process has been completed. In other cases, claimants reported significant time lapses between the issuance of a recommended decision and a final decision. These concerns were raised due to the impact of delays on elderly claimants or survivors who rely on the timely resolution of claims. These delays contribute to uncertainty, frustration, and eventually distrust. While some claimants reported that delays affected their ability to obtain compensation, others were concerned with the delay in their receipt of medical benefits.

This Office has routinely received complaints, grievances, or concerns, where claimants seeking medical treatment simply decided to use their private insurance, Medicaid or Medicare benefits, which ultimately resulted in billing confusion once their treatment was accepted.

In response to prior Ombudsman reports, DEEOIC reiterated that the time required to adjudicate claims varies depending on the complexity of the claim. The DEEOIC reported that continued efforts to improve claim processes and ensure timely adjudication remain their priorities. This Office will continue to remain vigilant in monitoring delays in the adjudication process and reporting on continued claimant concerns related to timeliness.

Recommendations

The Ombudsman's Office recognizes that DEEOIC has taken steps to improve the claim adjudication process, which included continued staff training, monitoring workloads and implementing procedural guidelines. However, based on the inquiries and complaints received during this reporting period, we make the following recommendations:

- The DEEOIC should continue to rely on Customer Experience surveys to determine where the need for improvement is derived from and to ensure that claims are adjudicated in a timely manner that is consistent with applicable legislation and procedures.

- The DEEOIC should enhance efforts to provide timely updates to claimants regarding their claim status, especially when claims remain pending for extended periods of time. As recommended in prior Annual Reports, enhanced communication with claimants would provide a sense of transparency and accountability.

- The DEEOIC should provide ongoing staff training and resource allocation efforts in support of timely claim adjudication.

CHAPTER 2 - MEDICAL BENEFITS

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) claimants recognize and appreciate the advantage of the medical benefits coverage for accepted conditions. When a claim is filed by an employee and it is accepted, the employee receives a Medical Identification Card (commonly referred to as the "white card").[23] This card is then presented to an enrolled Division of Energy Employees Occupational Illness Compensation (DEEOIC) medical provider. The enrolled medical provider then submits the bills to DEEOIC for payment. Medical benefits coverage removes the financial burden of co-payments or deductibles for the employee.

The EEOICPA Procedure Manual (PM) states, "Upon issuance of a final decision approving a work-related illness for a qualified living employee, DEEOIC is responsible for furnishing those services, equipment, and supplies prescribed or recommended by a qualified physician for an approved illness that the DEEOIC considers likely to cure, give relief, or reduce the degree or the period of that illness." The EEOICPA also provides for necessary and reasonable transportation and expenses incident to the securing of such services, appliances, and supplies. *See* 42 U.S.C. § 7384t(c).

The DEEOIC has contracted with Acentra Health for medical bill processing services and with Conduent for pharmacy bill processing services. The DEEOIC's Medical Bill Processing Unit (MBPU) oversees the medical bill processing systems, transactions, and coding necessary to assure prompt and accurate payment for approved medical benefits and works with the Office of Workers' Compensation (OWCP) and the bill processing administrator contractor (BPA) to develop and implement appropriate bill payment codes, procedures, and resolutions to related issues.

Each outstanding medical bill represents an EEOICPA claimant whose medical bill remains unpaid. While some providers work directly with DEEOIC regarding billing issues, it is ultimately the claimant's responsibility to determine how to best resolve these unpaid obligations. It is not uncommon for providers to refer an outstanding bill to collection agencies. Claimants need their bill to be paid to avoid outstanding debt and damage to their credit rating. Consequently, claimants may end up sending the bill to their private health insurance, Medicare, or paying the outstanding bill themselves.

In 2025, complaints regarding medical billing and payment issues were presented to our Office. A common complaint was the impact of poor communication with DEEOIC and its contractors. Stakeholders did not know who to contact when further assistance was needed. Health care providers, claimants, and authorized representatives contacted our Office after they experienced difficulties related to the processing and payment of prescribed treatment for an accepted condition.

23 The white card is comparable to a health insurance card. *See* Appendix 4.

In November 2025, a provider contacted our Office and DEEOIC for assistance in determining the reason for the denial of a previously approved prescription for nutritional support. The DEEOIC informed the provider that there was a treatment suite/coding issue. The bill coding used by the provider was for tube feeding not for oral intake (as prescribed by the treating physician). The DEEOIC advised the provider that they were looking into how providers should request authorization for the oral nutritional supplement. As of January 2026, the resolution for billing of the employee's nutritional support remained unresolved.

In another example, an employee contacted our Office for assistance in getting their 90-day prescription approved. The prescription was for Prednisone, which had been prescribed for their organ transplant. The DEEOIC had approved this prescription for a 90-day supply for over a decade. However, in 2025, DEEOIC advised the employee that they would no longer approve a 90-day supply without a letter of medical necessity (LMN).[24] The employee would only be approved for a 30-day supply. This change presented an undue burden on the employee.

Our Office contacted DEEOIC and we were advised that this medication was now considered non-maintenance and consequently, was set for 30-day supply refills. We were also advised that the claim would be forwarded to the clinical team for an authorization review of the 90-day supply request. The DEEOIC's clinical team completed the review and advised our Office that the employee had been authorized to receive a 90-day supply of Prednisone, that the bill from the provider was initially denied due to a provider error, and that the provider had resubmitted the bill for payment.

During this reporting period, claimants also informed us that they were experiencing delays or denials with their requests for reimbursement for out-of-pocket expenses. Our Office was contacted by another employee in 2024 with the same issue regarding the denial of their 90-day supply of several medications prescribed for treatment of an organ transplant. To assist the employee in resolving the issue, our Office communicated with DEEOIC. Even with our assistance, it took approximately one year for the issue to be resolved. The same employee also received denials on several requests for travel reimbursements for treatment and/or complications related to their organ transplant.

The employee continues to work with DEEOIC to resolve the pending travel reimbursement requests. Unfortunately, this employee not only has the difficulty of dealing with a serious health condition, but also with the onerous burden of responding to delays/denials of prescriptions and reimbursement requests.

We were contacted by an employee who was previously approved for massage therapy treatments for their approved condition. The employee did not understand why the payments for these treatments were suddenly being denied. Our Office contacted DEEOIC and was told that the medical benefits examiner (MBE) had requested a review by the medical officer, and additional medical notes had been requested from the massage therapist. The employee informed our Office that the massage therapist was told there was a "policy change" that required medical notes from the therapist for each session to ensure that the treatment was based on the LMN. Upon receipt of the requested documentation, the denied massage therapy sessions were eventually approved.

---

24 Pursuant to the Federal (EEOICPA) Procedure Manual, Chapter 29.3(a), Version 10.0, an LMN is a narrative statement prepared and signed by the employee's treating physician which includes "an explanation of the claimant's medical need for treatment, services, or accessories necessary to provide relief for the DEEOIC-accepted medical condition(s)."

In this reporting period, stakeholders contacted our Office seeking assistance with delays in authorizing home health care (HHC). Upon receipt of a request for HHC authorization, MBEs refer to guidance outlined in Chapter 30 of the PM. However, the PM does not mention a timeline or timeframe by which the MBE is to process HHC claims. The lack of an expected timeframe leaves both claimants and HHC providers uncertain of how long the authorization process will take.

In one instance, DEEOIC had authorized an employee for 24 hours per day for 7 days per week of in-home skilled nursing care. The employee was unhappy with the care they were receiving from their current HHC provider and decided to make a change. They sent a letter to DEEOIC to inform them that they were terminating the services with the current provider and identifying the new provider that they wished to use. The DEEOIC acknowledged the request to make the change. However, DEEOIC reduced the employee's skilled nursing care by 12 hours per day for 7 days per week. Due to the reduction in their care, the employee contacted our Office for assistance.

The DEEOIC advised our Office that the basis for the increase in care was questionable, and the MBE needed to complete a file review. The MBE referred the file to a contract medical consultant (CMC),[25] and after approximately four months, the employee was approved for HHC as the treating physician had originally requested (24 hours per day for 7 days per week). This delay directly resulted in an interruption of prescribed care during the review period.

It would be beneficial for claimants and HHC providers to be given the status of their requests for HHC benefits with updates containing more details than simply advising them that the requests are pending. Moreover, it would be helpful for claimants and HHC providers to be notified with updates when an authorization request was delayed. Claimants and HHC providers should also be given a reasonable expectation of when the final determination will be issued (e.g., given a specific timeframe of when they could expect a final determination).

Claimants and HHC providers have expressed their frustration to the Ombudsman's Office that they must submit evidence under timelines set by DEEOIC, yet it appears DEEOIC does not hold itself to adjudication timelines for making a determination on requests for authorization of HHC. Absent reasonable timelines, claimants have no sense of when DEEOIC has taken longer than necessary to decide, or when there is a serious problem or communication error within DEEOIC that is causing the delay of their request.

In our 2024 Annual Report to Congress, our Office made several recommendations to DEEOIC regarding medical benefits processes. The report discussed how the delays can negatively impact claimants and enrolled providers. One of our recommendations was for DEEOIC to conduct regular quality assurance audits to review medical billing issues and provide MBE's training on the issues that were identified. In DEEOIC's Response to the Office of the Ombudsman 2024 Annual Report to Congress, they agreed with the recommendation and stated that supervisors in the MBPU carry out routine sampling of completed work and DEEOIC Quality Assurance Analysts perform regular audits on payments for medical services. In their

25 A CMC is a contracted physician who conducts a review of case records to render opinions on medical questions. Medical opinions from a CMC are essential to the resolution of claims due to ambiguous causation, lack of medical evidence, unique exposures, or other medical questions. The function of a CMC is to provide clarity to claim situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. Federal (EEOICPA) Procedure Manual, Chapter 16.9, Version 10.

response to our 2024 Annual Report to Congress, DEEOIC also stated MBPUs effectively triage and prioritize medical billing concerns and DEEOIC has systems in place to resolve issues. Their response further stated that they conduct a regular monthly sampling to verify that denials are appropriately developed and adjudicated.

In DEEOIC's Response to our 2024 Annual Report to Congress regarding delays and communications when claimants utilize their medical benefits, DEEOIC indicated when a condition is accepted under EEOICPA, entitlement to medical benefits is communicated to the claimant through a final decision or letter decision. Their response also indicated that when a new condition is accepted, claimants receive a medical benefits white card along with supplementary information on their medical benefits coverage.

Our Office acknowledges that DEEOIC has processes in place regarding medical benefit claims, yet in 2025, we were contacted by claimants with the same concerns and issues regarding denials and delays in the processing of their medical benefits that have been presented to us in the past.

Overall, in 2025, our Office was contacted by claimants, authorized representatives (ARs) and health care providers when medical bills and/or treatment were denied or not paid in full. They were frustrated and discouraged because they did not know who to contact to resolve their issues. Claimants continually tell us that it is difficult to get the status of their medical claims, and they would like to know what to expect when they are pursuing their medical benefits.

Claimants have made extraordinary sacrifices for our country and feel that the program is not truly concerned about their health or medical treatment. It is our recommendation that the resource centers submit a monthly report to DEEOIC identifying the number of calls/visits they receive that pertain to a claimant's difficulties in processing their medical benefits coverage. Based on the results of the resource center reports, DEEOIC should review and consider implementing new or additional processes to address the issues that continue to have a negative impact on the claimant community. It is our Office's ongoing mission to assist the stakeholders in resolving their complaints, grievances, and concerns.

CHAPTER 3 - CUSTOMER SERVICE

Outstanding customer service is an essential element for the success of any organization that serves the public. A core responsibility of the Ombudsman's Office is to evaluate the effectiveness, accessibility, and responsiveness of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) staff in serving their stakeholders. During 2025, our Office continued to receive and assess feedback from claimants, authorized representatives, medical providers, and other stakeholders regarding their experience with DEEOIC customer service.[26] Several recurring areas of concern were identified: inability to contact DEEOIC personnel, DEEOIC's lack of commitment to timely and responsive assistance, and insufficient clarity in communications from DEEOIC.

2025 offered significant challenges for the EEOICPA program. Traditionally, the Joint Outreach Task Group (JOTG) scheduled outreach events and informational webinars. Outreach events and informational webinars serve as proactive efforts to bring services, information, and support directly to communities, individuals, or organizations. Often DEEOIC will provide claim staff services at these events. In 2025, JOTG events and webinars were suspended.

Stakeholders also reported to our Office that they were unaware of procedural changes that could impact their claims. They also expressed their concern about their claims being re-assigned without notification. Consequently, EEOICPA stakeholders found communicating with DEEOIC increasingly difficult.

A significant number of DEEOIC's claim population is older and unwell. Moreover, many stakeholders reside in rural or underserved areas where technology is limited. These factors should be considered by DEEOIC employees with every communication. Individuals expressed concern that communication with DEEOIC is difficult; often requiring claimants to independently seek information regarding their claims or program eligibility. This resulted in confusion, delays in claim development, and reduced trust in the program.

During this reporting year, an employee contacted our Office for assistance with getting prescriptions approved. The employee stated that medications that had previously been approved by DEEOIC for over 10 years were suddenly being denied, as were their doctor's visits. The claimant was frustrated because they made multiple unsuccessful attempts to reach their claims examiner (CE), they were never advised that their claim had been reassigned to a new CE, and they were never told about DEEOIC's Branch of Medical Benefits. This employee grew frustrated after several weeks of receiving conflicting information regarding who was handling their claim and sincerely believed that DEEOIC was cutting their benefits for no reason. Upon our inquiry with DEEOIC, we were quickly able to ascertain the reason for the denial, which was due to treatment suite coding issues. We provided the claimant with the appropriate contact information for future reference.

---

26 DEEOIC's Outreach and Customer Experience Unit (OXCU) gathers customer feedback via surveys, phone interviews, and focus groups. The results are published in quarterly reports. *See* https://www.dol.gov/agencies/owcp/energy/regs/compliance/customer_experience_survey

In another instance, an employee contacted our Office for assistance with the development of their claim. The employee received notification that the district office was having difficulty in establishing claimed employment. The claims examiner advised the employee that a request for employment documentation had been submitted to the Social Security Administration (SSA) which could "take a while." After months of waiting for a response from the SSA, the employee decided to go directly to their local SSA office to obtain the information for themselves. Upon contacting our Office, we were able to suggest alternate employment documentation, and we obtained a copy of the employee's file from DEEOIC. After our Office's thorough review of the employee's records, it was determined that there was overwhelming evidence to support covered employment. The employee was advised of the file material that should be highlighted for the CE's attention. Subsequently, DEEOIC determined that the evidence in the file was sufficient to establish covered employment.

Another prominent concern raised in 2025 involves challenges in communicating directly with DEEOIC personnel, specifically claims examiners. Similar concerns were raised regarding medical benefits examiners (MBE), who are responsible for authorizing and processing medical care and related billing. Providers and claimants reported significant challenges in obtaining timely responses to inquiries about billing approvals/denials, payment status, and coverage determinations.

Both roles (CE and MBE) are vital to the administration of claims and the processing of medical benefits under the EEOICPA. Limited availability and accessibility to these employees, have a direct impact on the stakeholder's experience and efficiency of the program. Claimants and their representatives frequently reported having difficulty reaching claims examiners and other staff. Common issues included unreturned calls, delayed responses, and limited availability of staff to address case specific inquiries. DEEOIC's policy does not allow the employees to communicate with claimants or authorized representatives by email.

The DEEOIC has claimant resources in place, such as their general inquiry email.[27] However, claimants have indicated that in some cases this general inquiry email address and/or DEEOIC Resource Centers were unable to provide sufficient information, thereby requiring further attempts to contact the assigned staff. This layered communication structure may contribute to inefficiencies and an increased burden on the claimant.

While DEEOIC has developed several tools to assist claimants, such as the Energy Document Portal (EDP) and the DEEOIC's Employees' Compensation Operations & Management Portal (ECOMP) website, these resources are only available online.[28, 29]

Claimants with limited, or no access to internet, are frequently not aware that these resources exist and/or do not have the ability to access these resources. Additionally, having access to the internet does not guarantee that claimants will be aware of the various online tools and resources. In our experience, even when they had access to the internet, many claimants rarely, if ever, visited DEEOIC's website.

---

27 DEEOIC-public@dol.gov

28 The EDP is an electronic document submission system that allows EEOICPA claimants to file a new claim, file a consequential claim, complete benefit payment forms, electronically submit documents to their existing case file, and/or verify that documents were successfully submitted.

29 ECOMP is a secure online website that provides DEEOIC claimants and authorized representatives access to view case information, such as recent actions and compensation information.

Moreover, it appears that most claimants do not receive a comprehensive overview of the program's processes when they file their claim. This lack of an overview not only means that many claimants proceed with their claim without a good understanding of the claim process, it also means that many claimants are never aware of the resources and tools that have been developed to assist them.

Pursuant to Chapter 12, "Under 20 C.F.R. §§ 30.600 and 30.601, a claimant may authorize any person, not otherwise prohibited by law, to represent him or her. The authorization includes allowances for communicating with claims staff, accessing case file documentation, receiving copies of decisions, submitting objection(s), filing appeals, and seeking medical authorizations."

Chapter 12.8 of the PM further states:

> A representative may charge a claimant a fee for services associated with representation before DEEOIC. Under 20 C.F.R. § 30.602, the OWCP is not responsible for any fee charged by a representative of an EEOICPA claimant, nor will it reimburse the claimant for any fees paid to the representative. Other than issues relating to the allowable fee under the EEOICPA, disputes over payment of fees, the quality of services rendered, or collection of monies owed are a personal matter between the claimant and his or her AR.
>
> a. Fee Limits. Under 20 C.F.R. § 30.603, for services rendered in connection with a claim pending before DEEOIC, a representative may not receive more than the following percentages of a lump-sum payment made to a claimant:
>
> (1) 2% for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus
>
> (2) 10% of the difference between the lump-sum payment made to the claimant and the amount proposed in the RD with respect to objections to the RD.
>
> b. Limitations. These maximum fee limitations apply even if the claimant and representative have agreed to other amounts in a contract or otherwise. Any such representative who violates this section shall be fined up to but not more than $5,000. Pub. L. 106-398, Title XXXVI, § 3648; Pub. L. 107-107, § 3151(a)(6).

When an authorized representative is designated, the DEEOIC sends a letter to the AR with a copy to the claimant. The letter outlines AR fees, permissible charges, and conflict of interest policy.

Claimants have reported confusion with the fee schedule regarding the percentages and when and/or how they are applied. Stakeholders do not understand what constitutes "the filing of an initial claim with OWCP." They question whether they are responsible for additional fees associated with lump-sum payments for impairment and wage-loss. Claimants do not understand why they are charged for fees over and above the 2% and 10%. Our Office is also seeking clarification regarding DEEOIC's AR fee schedule.

When these AR fee issues are brought to our attention, our Office forwards the case specific information to DEEOIC. Our Office has no further contact with DEEOIC regarding the outcome.

Due to these uncertainties regarding AR fees, our Office recommends that DEEOIC should provide additional AR training. In the past, JOTG provided an annual AR workshop, and we recommend that this training be reinstated. Additionally, during JOTG Town Hall outreach presentations, DEEOIC should include a discussion about the AR process and the applicable fee schedule.

Lastly, it may be beneficial if the DEEOIC brochure, "Information for Claimants Regarding Authorized Representative (AR) Services" is provided to individuals who designate an AR.[30]

Claimants often complain about communication with DEEOIC. Communication barriers can be particularly impactful in the context of medical benefits, where delays can affect access to care. Claimants have described situations in which medical providers were not able to secure authorization or clarification in a timely manner, potentially leading to postponed treatment due to billing disputes. In some cases, providers express reluctance to continue treatment due to the uncertainty regarding reimbursement. This places an additional strain on claimants seeking medical care.

In one instance, a home health care (HHC) provider contacted our Office regarding increasing the employee's HHC hours. In early July, the HHC provider was advised that the file was going to be sent to a CMC.[31] The HHC provider made several unsuccessful attempts to obtain an update. Two months later, the HHC provider finally spoke with a supervisor who told them that the file had not been sent to a CMC and would now be processed for a CMC referral. The next month, the CMC approved the HHC hours as requested. The employee was in their nineties and was experiencing a notable decline in their health. Delays such as these can be detrimental to elderly claimants and their families.

In another case, a child of a deceased employee contacted our Office. According to the survivor, a recommended decision was issued to the employee. The survivor indicated that due to a three-month delay, the employee died before the final decision was received. The survivor was advised that based on DEEOIC's policy, for potential benefits to be awarded, the employee's survivor would have to file a claim.

In our communications with stakeholders, the Ombudsman's Office determined that there was a need for extended outreach to ensure program awareness, program transparency, and equal access to covered benefits. We are pleased to announce that in 2026, JOTG resumed its outreach events and informational webinars.

In 2025, the Ombudsman's Office consistently experienced delays in obtaining case file documents from DEEOIC. Our Office shared our concerns with DEEOIC leadership, who were very receptive and responsive to our concerns. The DEEOIC developed the "Ombudsman Inquiry Tracker" system. This system allows our Office to receive documents and case files electronically. While the Tracker system was not implemented until 2026, our Office would like to highlight the successful collaboration between DEEOIC and the

30 https://www.dol.gov/sites/dolgov/files/owcp/energy/regs/compliance/ brochure/Claimants_RepServices.pdf

31 A CMC is a contracted physician who conducts a review of case records to render opinions on medical questions. Medical opinions from a CMC are essential to the resolution of claims due to ambiguous causation, lack of medical evidence, unique exposures, or other medical questions. The function of a CMC is to provide clarity to claim situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. Federal (EEOICPA) Procedure Manual, Chapter 16.9, Version 10.

Ombudsman's Office. A case file request that previously took approximately four to six weeks, currently takes only a few days. This new process allows our Office to receive file requests and responses to inquiries from DEEOIC in a more expeditious and cost-efficient way.

The concerns identified in 2025 underscore the importance of consistent, transparent, and accessible customer service practices. Customer service issues permeate all aspects of the claim process. While DEEOIC continues to process a high volume of claims within a complex statutory framework, the claimant experience remains a critical component of the effectiveness of the program.

The Ombudsman's Office recommends the following opportunities to improve customer service:

- evaluating staffing and resource allocation to support increased accessibility;
- expanding outreach efforts to better educate claimants; and
- enhancing communication protocols to ensure timely/reliable responses to claimant inquiries.

Addressing these issues would improve stakeholder satisfaction by reducing administrative inefficiencies and strengthening confidence within the program.

APPENDICES

APPENDIX 1 - ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

AMB	Ancillary Medical Benefits
AR	Authorized Representative
AWE	Atomic Weapons Employer
BPA	BBill Processing Agent
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CGRA	"Complaints, Grievances, and Requests for Assistance" Table
CMC	Contract Medical Consultant
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DME	Durable Medical Equipment
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
ECOMP	Employees' Compensation Operations & Management Portal
EDP	Energy Document Portal
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
EO	Executive Order
FAB	Final Adjudication Branch
HHC	Home Health Care
HHS	Department of Health and Human Services
HR	Hearing Representative
HRHC	Home or Residential Health Care
JOTG	Joint Outreach Task Group
LMN	Letter of Medical Necessity
MBE	Medical Benefits Examiner
MBPU	Medical Bill Processing Unit
NIOSH	National Institute of Occupational Safety and Health
OMBUDS	Office of the Ombudsman for the EEOICPA
OWCP	Office of Workers' Compensation Programs
PM	Federal (EEOICPA) Procedure Manual
RECA	Radiation Exposure Compensation Act

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	64
Delays	50
Customer Service	57
Behavior of DEEOIC Staff/Management	36
Claim Development	22
Request for Status of Claim	34
Part E Causation	32
Pre-Authorization or Authorization for Treatment	12
Prescriptions	13
Home Health Care	23
Out-of-Pocket Expense Reimbursement	15
Telephone Communication Issues	20
DEEOIC Decisions & Waivers	20
NIOSH Dose Reconstruction	11
Toxic Exposure	19
Non-Cancerous Conditions	12
CNSI Billing Issues (Medical Bill Contractor)	1
Consequential Conditions	7
Outreach	6
Unaware of how to file a claim	4
Claim Adjudication	17
Impairment Benefits	11
Part B Causation	13
Recommended Decisions	7
Health Care Provider Issues	4
Industrial Hygienist (IH)	9
Contract Medical Consultant (CMC)	13
Presumptions	2
Site Exposure Matrices (SEM)	8

Complaints, Grievances, and Requests for Assistance	Number of Complaints/ Concerns
Authorized Representative	9
Employment Records	7
DOE contractor employment	6
FD Following Hearing & Review of Written Record	4
Finding a Health Care Provider	5
Part E Eligibility Issues	3
SEC (Special Exposure Cohort)	11
Survivor Claims	19
Treating Physician/Claimant Medical	2
Unaware Can Request Copy of File or Document	4
Cancer	24
Consequential Illness Issues	2
Lack of Communication	5
Medical Benefits	25
Reopening Decisions	7
Representative Fee/Expenses	3
Authorization/Reimbursement for Medical Travel	7
Coding Issues	5
DOE subcontractor employment	2
Subsequent Impairment Evaluations	4
Unaware of EEOICPA	3
Beryllium Sensitivity	3
Chronic Silicosis	0
Development of Medical Evidence	3
Home Modifications	7
Medical Records	5
Medicare/Private Health Insurance Reimbursement	3
Presumptive Illnesses	2
Remand Orders	3
SEC Class	6
Specified Cancer	5
Biological Child	2

Complaints, Grievances, and Requests for Assistance	Number of Complaints/ Concerns
Causation/Burden of Proof	16
Chronic Beryllium Disease (CBD)	3
Covered Employment	14
Presumption (Exposures)	6
Spouse	0
Weighing of Evidence	3
Behavior of CNSI or myMatrixx Staff	1
Durable Medical Equipment (DME)	2
Part B Eligibility Issues	5
Scientific Studies	2
Affidavits (Exposures)	2
Behavior of Resource Center Staff	5
Beryllium Vendor	1
Classified Information (Part B)	1
Conflict of Interest	0
DOE/DAR Records	1
Exposure Records	0
FWP Screening Program	2
Medical Bills	13
Medical Evidence of Wage-Loss	0
myMatrixx Billing Issues Rx Bill Contractor	3
Part B Post-1993 (CBD)	2
Part B Pre-1993 (CBD)	1
Power of Attorney	0
Problems with Energy Document Portal (EDP)	1
RECA 5 Causation	2
RECA 5 Illnesses	2
Reconsideration Decisions	0
Relationship to Employee	2
Selection of Rating Physician	2
Terminal Status	4
Wage-Loss Benefits	1

Complaints, Grievances, and Requests for Assistance	Number of Complaints/ Concerns
Waivers	0
DOE Federal Employment	4
Election of Benefits	1
Grandchild	1
Limited Representation	0
Offset of Benefits, Tort Action/Lawsuit	1
Part E CBD	1
Remediation Employment	1
Stepchild	0
Third-party Exposure	0
U.S. District Court appeals	0
Wage-Loss Evidence	0
TOTAL	**844**

APPENDIX 3 - CONTACTS BY FACILITY TABLE

Facilities	Number Identified
Allied Chemical Corp. Plant	1
Area IV of the Santa Susana Field Laboratory	2
Argonne National Laboratory- West	1
Atomics International	1
Battelle Laboratories-King Avenue	1
Bendix Aviation (Pioneer Division)	1
Brookhaven National Laboratory	3
Brush Beryllium Co. (Cleveland)	1
BWX Technologies, Inc. (Virginia)	1
Canoga Avenue Facility	1
Feed Material Production Center (FMPC)	7
General Electric Company (Ohio)	1
Grand Junction Facilities	1
Hanford	12
Harshaw Chemical Co.	2
Idaho National Laboratory	2
Kansas City Plant	6
Lawrence Livermore National Laboratory	6
Los Alamos National Laboratory	6
Lovelace Respiratory Research Institute	2
Mallinckrodt Chemical Co., Destrehan St. Plant	1
Massachusetts Institute of Technology	1
Metals and Controls Corp.	1
Mound Plant	3
Nevada Test Site	13
Oak Ridge Gaseous Diffusion Plant (K-25)	10
Oak Ridge Institute for Science Education (ORISE)	1
Oak Ridge National Laboratory (X-10)	4
Paducah Gaseous Diffusion Plant	7

Facilities	Number Identified
Pantex Plant	4
Pinellas Plant	2
Portsmouth Gaseous Diffusion Plant	18
Rocky Flats Plant	7
Sandia National Laboratories	2
Savannah River Site	11
Speedring, Inc.	3
Toponah Test Range	2
Uranium Mill in Mexican Hat	1
Wah Chang	3
Waste Isolation Pilot Plant	2
Y-12 Plant	9
TOTAL	**165**

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.

OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Scan Me!

dol.gov/agencies/ombudsman