March 2024 DEEOIC Stakeholder Updates Webinar - Question & Answers

Submitted Question	Answer
Since February 21, 2024, we been having issues getting medications approved in a timely manner. Have the problems been worked out? In the future, if these problems re-occur what plans are there to override the system to not create a medical crisis because of lack of critical needed meds?	Most medications are approved automatically through our pharmacy bill contractor, and DEEOIC Medical Benefits Examiners are only involved for exception processing, if the pharmacy bill contractor denies payment for prescribed medications that the claimant and their physician claim are related to an accepted condition. We know that there have been difficulties first in the transition from Conduent to myMatrixx, and then back to Conduent, but we have been assured that most of those difficulties have been overcome.
How do we place our company on the DOL provider website?	All medical providers who are registered with our medical bill processor are automatically placed in the provider lookup tool, unless they request to be excluded. If you are not registered and would like to be, please contact our Resource Centers at 866-888-3322 and they will assist you in registering.
Is home health care an ancillary service? The Medicare Program does not classify it as ancillary. Please cite the portion of the Act that provides for the Agency to deny these medical benefits ordered by the treating physician.	Home Health Care (HHC) is a form of Ancillary Medical Service and the regulations related to HHC are located in 20 CFR § 30.403 (https://www.dol.gov/sites/dolgov/files/owcp/energy/regs/compliance/law/FinalRuleInRegister.pdf)
Emergency request - Is there a place that truly explains what is needed for a request . We have had some approved in 48 hours and other 3 week by which time hardly an emergency. We just did what we had to do for claimant hoping it would get approved If not knowing we would eat the cost.	DEEOIC's emergency services request process located on our website at: https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Emergency_Authorization_Request_Process.pdf
Is there a reason we can no longer see or have access to the pharmacy payment of benefits online?	Although claimants should be able to access their pharmacy payment information online using the pharmacy portal, unfortunately, that capability is currently unavailable and we are awaiting news about when it will become available again.
What necessitates a claim to be re-assigned to another medical benefits examiners? How does back log get reviewed without pushing back the time frame for another claim for another claimant?	Claims are reassigned for a variety of business reasons from one Medical Benefit Examiner to another. Those reasons can include but are not limited to, staff promotions, reassignments, or other times that they leave their position. Additionally, we may need to reallocate workloads for equity in workload distribution, among other business reasons.
Can you provide clarity on homebound status, per chapter 30 of the procedure manual, as it relates to the need for certification of medical need for Home Care and face to face examinations, in the setting of those claimants with advanced disease who are unable to leave their homes?	If a claimant is ambulatory, and can receive therapeutic services in a clinical environment, that is considered to be the best environment for them to receive those services. But, if a claimant is non-ambulatory, or is determined by their physician that travel to a clinical environment would put the claimant at greater risk, then we can authorize home based therapeutic services, if the services are comparable to the clinical services.
A married couple both have a white card- Can the wife be a family care giver for the husband with one homehealth agency and receive homecare services through another homehealth agency?	A provider of home health services should be able to provide for the physical needs of a claimant, and if a care provider is themselves so ill or physically incapacitated that they themselves required home health care, then it is not reasonable that they would be qualified to provide medically necessary or appropriate services to another.
For Home Care Aide benefits there is a bi-annual paper work update required. There is a Draconian date given for the submission of this paperwork, and the claimant is informed about this date. However, the forms must be submitted by the provider and medical professional working in conjunction with each other. These providers and health care professionals often seem overwhelmed and are always hard to reach. What are the consequences if they should miss a deadline?	DEEOIC works with claimants and providers regarding home healthcare recertifications to ensure they are timely and sufficient to approve continued care. We evaluate each case based on the unique circumstances of why the required paperwork cannot be submitted in a timely manner to come up with an appropriate, case specific solution. DEEOIC recommends that the claimant or provider begin the process to obtain prior authorization for the next period of care 60 days from the expiration of the current period which has been preauthorized.
Can you clarify what are the requirements for a family member to take care of the claimant as a private caregiver? i.e. medical certificates such as TB test, CPR certs, medical exam and taking vitals . Are all the above required by the DEEOIC?	Requirements vary from state to state regarding the certification of a family member as an aide. DEEOIC defers to HHC providers to follow the guidelines and regulations of the state that the claimant resides in.

Submitted Question	Answer
Is there a list of certified B readers available and regularly updated within the DEEOIC platform that can be referenced?	No, we do not maintain a list of certified B readers. Claimants should contact their treating physician for referrals.
Can you clarify the conflicting information on using teledoc visits for home health care certification. The COVID-19 bulletin expired, however there is a pre-existing circular on your website stating that the decision for teledoc visits is the purview of the physician related to the patients health status and barriers to ability to attend in office examinations.	Under 20 CFR §30.400 a claimant with a medical condition accepted under the EEOICPA is entitled to receive all medical services, appliances or supplies that a qualified physician prescribes or recommends and that OWCP considers necessary to treat the claimant's covered condition. The Letter of Medical Necessity (LMN) is the foundation of all claims for Ancillary Medical Benefits (AMB) and for Home and Residential Health Care (HRHC). OWCP can only determine the medical necessity of a request if the physician's opinion is based on the accurate and current medical needs of the claimant determined during an in-person assessment. To ensure that the physician's opinion in the LMN is derived from a recent physical assessment of the claimant's medical status, the physician must document that a face-to-face evaluation occurred between the claimant and prescribing physician. For HRHC, a recent face-to-face evaluation is one that has occurred within 60 days of the LMN. For AMB requests, a recent medical exam is one that has occurred within six months of the LMN. EEOICPA Circular No. 22-01 allows physicians to utilize telemedicine for non-emergency routine physician appointments. Routine physician appointments do not include physical assessments which are necessary to prescribe HRHC services or Ancillary Medical Benefits. Thus, EEOICPA Circular No. 22-01 does not apply to or supersede the DEEOIC requirements that LMNs for AMB or HRHC must document a recent face-to-face examination by the prescribing physician.
Can a claimant receiving home health services through the EEOICP also receive home health services through the VA for non covered conditions	There is no prohibition against claimants receiving HHC services for covered conditions through DEEOIC and receiving separate HHC services through other insuring agents for non-covered (comorbid) conditions. However, a provider cannot bill multiple payors for the same service provided during the same time period by the same home health aid or nurse.
Apologies - Can you discuss the following as it relates to the "programmatic decision" regarding telemedicine, unrelated to COVID pandemic? ------ EEOICPA CIRCULAR NO. 22-01 DATE: December 15, 2021 Subject: Telemedicine Services for Non-Emergency Routine Physician Appointments	Under 20 CFR §30.400 a claimant with a medical condition accepted under the EEOICPA is entitled to receive all medical services, appliances or supplies that a qualified physician prescribes or recommends and that OWCP considers necessary to treat the claimant's covered condition. The Letter of Medical Necessity (LMN) is the foundation of all claims for Ancillary Medical Benefits (AMB) and for Home and Residential Health Care (HRHC). OWCP can only determine the medical necessity of a request if the physician's opinion is based on the accurate and current medical needs of the claimant determined during an in-person assessment. To ensure that the physician's opinion in the LMN is derived from a recent physical assessment of the claimant's medical status, the physician must document that a face-to-face evaluation occurred between the claimant and prescribing physician. For HRHC, a recent face-to-face evaluation is one that has occurred within 60 days of the LMN. For AMB requests, a recent medical exam is one that has occurred within six months of the LMN. EEOICPA Circular No. 22-01 allows physicians to utilize telemedicine for non-emergency routine physician appointments. Routine physician appointments do not include physical assessments which are necessary to prescribe HRHC services or Ancillary Medical Benefits. Thus, EEOICPA Circular No. 22-01 does not apply to or supersede the DEEOIC requirements that LMNs for AMB or HRHC must document a recent face-to-face examination by the prescribing physician.
Can you outline the MD or DO role in cosigning f2f examinations when provider directly seeing the patient is an FNP or APRN?	Title 20 of the DEEOIC states a "physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law. Physician assistants and nurse practitioners are excluded from this definition." The DEEOIC requires a face to face (F2F) examination by a medical provider for HHC as described above, and specifically excludes PAs and NPs for this reason.

Submitted Question	Answer
Who should be contacted DOL or Ascentra when issues arise with ICD 10 codes? Codes not accepted although reflected in the clients profile.	Only DEEOIC can make changes to accepted conditions. If you are having an issue billing with an accepted condition, please reach out to us at deeoicbillinquiries@dol.gov. We are aware of the recent changes to expand the ICD code for Parkinson's disease and updates to all impacted cases were just completed.
when you upload in the EDP, is the CE notified automatically that something has been added to the case or does it just get added to the case and hope the CE sees it?	For documents uploaded using “Upload Document to Existing Case” and forms submitted through “Complete Benefit Payment Forms”, or “Complete Impairment or Wage Loss Forms”, the document is uploaded immediately into the imaging system with a status of unreviewed, so that the CE (or Fiscal Officer for the EN-20) is aware action needs to be taken on the document. For new claims submitted through “File A New Claim” (Form EE-1, EE-2, and EE-3) the forms are not immediately available to the CE, but first routed through our case create clerks to be added in to the Energy Compensation System (ECS). This process normally takes 2-10 days.
Where can I find the presentation?	The presentation can be found - https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Outreach/Outreach Presentation/stakeholder_update032824.pdf
Is there a way to fax or submit electronically a change of address?	You may submit a document requesting a change of address (including new address, phone number, name, and signature) within the Energy Document Portal. You would use the "upload document to existing case file" feature. Here is the link - https://eclaimant.dol.gov
Can you put the phone# for Conduit in the Chat?	Conduent 1-866-664-5581
What phone number do I call to report fraud billing against my claims account?	If anyone believes someone is making false claims or criminally misleading statements please contact the Department of Labor, Office of the Inspector General, which is the sole criminal investigator within DOL by calling them at 800-347-3756 or by emailing at LaborOIGinfo@oig.dol.gov
42 USC 7384l(8) that a covered beryllium illnesses is beryllium sensitivity or established CBD or an injury, illness due to beryllium sensitivity, or CBD. So please define beryllium sensitivity under this program?	Beryllium Sensitivity is defined in Chapter 18.5 of the Federal (EEOICPA) Procedure Manual as an allergic reaction of the immune system to the presence of beryllium in the body because of contact with beryllium dust particles or fumes. As noted in the question, the Program abides by the statute, which specifically states: The term “covered beryllium illness” means any of the following: (A) Beryllium sensitivity as established by— (i) an abnormal beryllium lymphocyte proliferation test performed on either blood or lung lavage cells; or (ii) three borderline beryllium lymphocyte proliferation
What is the definition of sunset?	Sunset law, also known as sunset provision, is a law that automatically terminates an agency, a law, or a government program, that fails to procure legislature approval beyond a fixed period of time.
Are the recent changes to the manual already published & distributed or do we need to ask for a copy?	The updated procedure manual can be found here - https://www.dol.gov/agencies/owcp/energy/regs/compliance/Policy and Procedures/Consolidated Procedure Manual
I lost my connection and missed part of this- will this recording be posted so I can watch it later and where? Thanks in advance	Today's webinar is not recorded, however, you can reference the presentation from today for any part you may have missed: https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Outreach/Outreach Presentation/stakeholder_update032824.pdf
Is there a phone number or email address available for the Outreach Unit?	deeoic-outreach@dol.gov
Are there any webinars that are recorded located on the a website?	At this point in time, webinars are not recorded. Presentations are available on the website (https://www.dol.gov/agencies/owcp/energy/regs/compliance/Outreach/Outreach_Presentation) and your feedback has been recorded.
When is the next AR workshop? Can AR's attend two a year?	The outreach schedule can be found here - https://www.dol.gov/agencies/owcp/energy/deeoic_in_person_outreach_2024.

Submitted Question	Answer
So we are permitted to attend as many as we need?	There is generally only one AR workshop a year, it is two days. There will only be one AR workshop this year, held in July in Illinois. The invitations are typically sent to AR's in the region first, before opening it up nationwide. This is done so that we can keep the events small and try to reach out to various regions each year.
May I ask you to add DOJ contact info in chat?	You may contact the Department of Justice, Radiation Exposure Compensation Act Program at RECA Program at civil.reca@usdoj.gov or calling 1-800-729-7327.. You may also access their website at https://www.justice.gov/civil/common/reca
can someone put that email in the chat?	If this is for billing, use DEEOICbillinquiries@dol.gov. Other contact info can be found here. HTTPs://www.dol.gov/agencies/OWCP/energy/regs/compliance/contact_deeoic
I have several cases I have submitted the appropriate forms so that I can gain access to their case file in Ecomp per my client's request, a lot of these are not making it onto my caseload in Ecomp but the DOL customer rep does state that I am the assigned AR on the case and then transfers me to the CE to get this fixed, the CE keeps saying they cannot fix any caseload appearing in Ecomp or not a	You may direct your ECOMP questions to Support@ecomp.dol.gov
Can the DOL make simple flow charts of the processes for things like filing for impairment, asking for durable equipment etc.	Please check out the journey maps under "Other Projects" on this page - https://www.dol.gov/agencies/owcp/energy/regs/compliance/customer_experience_survey
Where would we go on the website to view past presentations?	https://www.dol.gov/agencies/owcp/energy/regs/compliance/Outreach/Outreach_Presentation
Since the former FAB chief refused to learn the statute or the regulations will the new FAB chief be required to follow the statute and the regulations over the procedure manual?	There is no evidence that the former FAB Chief failed to follow the statute or the regulations, and any FAB Chief chosen will follow the laws, regulations and procedures for the DEEOIC.
Under the Administrative procedure Act, the FAB should have separation of functions, therefore the FAB must report to OWCP and not to the DEEOIC Director or the policy branch. Will this be corrected?	The requirement in the APA to separate certain functions only applies when a statute requires that adjudications be made "on the record." Since EEOICPA is silent on this point, OWCP was free to set up DEEOIC in the way it currently exists in the regulations. Any provision for separation of duties in those regulations means that the District Offices and FAB are separate sections within the Program.
Have the CE's been trained to evaluate the medical evidence for the statutory criteria to be met under Part B? Is a well rationalized medical report with ICD coding required under Part B?	All claims examiners are trained in how to evaluate and weigh factual and medical evidence within a case file. They are also trained on the requirements for coverage under both Parts of the Program. Under Part B, medical evidence is required to support any diagnosis (including ICD codes). Statutory criteria under Part B differs depending on the condition claimed.
At times, CE's ask for justification that was already submitted or ask for items that do not pertain to the claim filed. Can you please explain why this happens often? Just trying to understand the claims process better. Thank you.	We train all claims staff that when developing a claim to obtain additional supportive information, they are to first review what has already been submitted before sending out letters. Sometimes, especially with newer claims examiners, template letters are used to request information. We strive to avoid that and continuously work with examiners to ensure that they only request what is needed.
How would you advise to respond to a Claims Examiner prematurely sending a claim to CMC, not in accordance with the guidelines?	If a claimant has a concern with how the assigned claims examiner is developing the case, they should either call and speak to the claims examiner about the concern, or ask to speak to the claims examiner's supervisor.
Can a claimant request to have a different Claims Examiner	With the volume of work that we must assign using a random round-robin assignment method, it is not possible for claimants to pick and choose their claims examiners. However, if a claimant or stakeholder has a concern with their assigned claims examiner, they should ask to speak to the supervisor to resolve any issues.

Submitted Question	Answer
Recently CE's have been assigned the duty to analyze scientific data submitted by the claimant's chosen physician. This job duty previously was assigned to DEEOIC Health scientists qualified in the principles of epidemiology and toxicology. Is it fair and within their job duties to require this level of analysis by Claims Examiners?	It has always been the claims examiner's job to review and analyze factual and medical evidence submitted in support of their claim; this is not new. Within the last couple of years, we have received an influx of medical reports that contain references to scientific articles. Claims examiners are capable of reviewing those articles to determine whether they are relevant to the claimed condition or exposure. If the articles do relate to the claimed condition and exposure, and are scientifically technical in nature, the claims examiner may still go to the DEEOIC health scientists for review.
Will claimants be notified of the analysis and provided with an opportunity to respond to the findings prior to a decision? Will the new PM reflect the changes? Please cite the regulations that provide for this.	For all claims, claims examiners provide their rationale and analyses of the case file evidence in the recommended decisions, which are sent to the claimants/authorized representatives. If the claimant disagrees or objects to the recommended decision, the claimant has the right to object to the Final Adjudication Branch (FAB). The PM and the regulations already allow for claims examiners to analyze evidence and issue recommended decisions, so no changes are required.
All Part E claims appear to be going to an IH for level of exposure (not supported by the Act). Only seven known toxic exposures from the Site Profiles (SEM) are included in the IH referral. Claimants that submitted claims five years ago did not get this level of scrutiny. Is level of exposure required by the Act?	Not all claims are sent to an IH. Oftentimes when a claim is sent to an IH, the number of toxic substances the IH is asked to evaluate is limited to seven toxic substances, but sometimes more. Under Part E, "a Department of Energy contractor employee shall be determined for purposes of this part to have contracted a covered illness through exposure at a Department of Energy facility if— (A) it is at least as likely as not that exposure to a toxic substance at a Department of Energy facility was a significant factor in aggravating, contributing to, or causing the illness; and (B) it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility." In order to meet this standard, medical evidence must support that the exposure was a significant factor, and thus the physician evaluating the case must have an accurate assessment of the exposure levels.
Does the Act require significant exposure or does the Act require that exposure at a DOE site was a significant factor in causing contributing to or aggravating an illness? Were the Site Profiles clearly meant to assist with this determination?	As stated in the response above, a physician must be able to make a causation determination that the exposure was a significant factor in development of the disease, and thus a level or extent of exposure is appropriate in order for the physicians to make an accurate assessment. We developed the Site Exposure Matrices (SEM), which is NOT the same thing as a "site profile" that is conducted by the National Institute for Occupational Safety & Health (NIOSH), in an effort to assist the claimants in determining the employee's exposures. Without the SEM, many claimants, particularly survivors, would be unable to meet their burden of proof to establish exposure.
Is SEM mandated by the Act under 7384w-1? The Act defines "Site profiles" to mean an exposure assessment of a facility that identifies the toxic substances or processes that were commonly used in each building or process at the facility, and the time frame during which the potential for exposure existed? The unpublished SEM listed timeframes and meets the Acts definition of a "Site Profile" If Congress intended the profiles to be used then what justifies the expense of IH reviews?	No, the SEM is not mandated by the Act under 7384w-1. That section of the Act solely pertains to Part B, and directs NIOSH to prepare site profiles, which are solely used for radiation exposure for dose reconstructions for cancer. As indicated above, we created the SEM on our own in an effort to assist claimants in meeting their burden of proof to establish exposure to toxic substances other than radiation under Part E.
Does every Part E claim require an IH assessment even when contemporaneous probative evidence of exposure is used to support physicians well-reasoned opinions?	No. Not every Part E claim requires an IH assessment.

Submitted Question	Answer
The IH references Books on Industrial Hygiene that are burdensome for claimants to purchase. The IH does not reference chapter or page. For transparency's sake would you consider including the quote from the book that justifies level of exposure for DOE specific job processes and titles?	DEEOIC IH staff use the totality of information available about a claim to inform judgements about the extent to which an employee had occupational exposure to toxic substances. IH's apply their own professional subject matter expertise in the best, most reasonable manner, to arrive at an estimate of toxic substance exposure. The literature referenced by the IHs form the basis for the overall approach for assessing occupational exposure and it does not provide guidance about levels of exposure for each scenario encountered during case reviews. Such analysis is explained in the IH assessment, which is made available to the claimant to evaluate.
The Act 7384 reads (in 2001) "Unique dangers" and "documented unmonitored exposures to beryllium with continuing problems at the sites Nationwide". Congress recognized "No other federal activity was carried out under such sweeping powers of self-regulation". Is it fair and equitable to ignore the concerns of Congress by using DEEOIC IH's to refute any significant exposure after 1995?	We follow the EEOICPA as written with regard to the requirement to establish exposure and causation under Part E.
Is a well rationalized medical report required under Part B? The Act reads that physicians are to be used for Part E only. Once the Part B Criteria is met, is the Agency required to approve the claim in a timely manner or must they continue development in order to validate the findings of the claimants chosen physician? This is currently happening.	As indicated in the response above, Part B contains specific criteria for eligibility depending on the illness being claimed. The DEEOIC follows the law as written, and claims staff develop claims using the criteria described under each Part of the Act. Under both Parts B and E, and medical evidence is required.
How should physicians handle the request for full studies by the Agency in support of their medical opinions? Copyright laws do not allow for dissemination. Will the Agency be paying for studies that are referenced in the medical reports?	If physicians are relying on specific medical studies to support their opinions regarding causation, they should be prepared to submit the entire study so that our staff can properly analyze it to decide whether statutory criteria for coverage is met.
Does the PM bind the public in any way? Are the CE's to rely on the newest version of the PM to develop/adjudicate claims? Do other Agencies change their PM's this often?	The Procedure Manual supplements the statute and regulations, providing more specific procedures for claims staff to follow when developing and adjudicating claims. In an effort to be as transparent as possible, the PM is made available to the public, but it is not a guidance document for the public, it is simply procedures that assist claims examiners in proper development and adjudication. The PM is updated twice a year to incorporate changes that occur based on changes to the statute (e.g. the beryllium standard), recommendations from the Advisory Board, improvements in technology etc.
Employment at the Yucca Mountain Characterization Project is frequently not considered part of the Nevada Test Site for part B claims; however, it is located in Area 25 of the Nevada Test Site. Will consideration for part B be updated to cover this project given its location on site?	The Department of Labor is collaborating with officials with the Department of Energy to definitively address the question about Yucca Mountain being considered within the boundary of the Nevada Test Site. Any update to the facility description will be made on the covered facility listing available online - https://ehss.energy.gov/search/facility/search
Why are there constant changes in the PM? How do these changes provide for fair and consistent adjudication when the rules/guidance change every six months?	As indicated above, changes to the PM are made based on various updates that occur throughout a given year. The Program has not made sweeping changes to the PM unless there is a change to the statute.
If a claimant submits evidence sufficient to meet the statutory criteria to establish Part B claims, is it solely at the discretion of the FAB, tryer of fact, to decide on a Reversal? We are never getting reversals under these circumstances. The FAB director weighs in on the decision without review of the entire file. It is unfair to adjudicate the question of a Reversal without the claimants having the opportunity to respond prior to a Remand.	This question is a little unclear. The FAB does issue reversals, but only in cases that have been denied and evidence is submitted that supports an acceptance. Any cases that do not meet that criteria, but for which the FAB determines require additional development, will be remanded.

Submitted Question	Answer
Prior claimants were given citations in the conclusion of law portion of the RD's and then with little explanation this policy was changed. Claimants attend hearings without legal notice as to the basis for a decision. Is it fair to withhold citations on Agency decisions? because they are not final? A Final Decision is often not "Final" for claimants have the opportunity to request Reconsideration. The explanation for withholding the citations makes no sense.	In the recommended decisions, claims examiners provide the rationale for the decision in the "Explanation of Findings" section. There is no requirement that citations be provided in the recommended decisions since they are not final agency decisions. The claimants still have the opportunity to object to any of the findings in the recommended decisions while the case is at the FAB.
The new rule addressing Beryllium Sensitization has restricted the criteria to establish BeS, a covered beryllium illness, under the Act. The law prior to this change allowed for AN ABNORMAL Beryllium lymphocyte proliferation test performed on blood or lung lavage cells. Now that the issue of borderline tests has been added it restricts what abnormal is and defines it more stringently than the Act required. Why was this done? If a physician finds that one result is "abnormal" will the Agency accept the findings.	The amendment to the statute does not restrict the criteria for establishing beryllium sensitivity. One "abnormal" BeLPT test still meets the criteria. The amendments simply add ANOTHER option for acceptance. So a claimant can now either have one abnormal test, or 3 borderline tests in order to meet the eligibility criteria for beryllium sensitivity.
Is One BeLPT "abnormal"?	A physician determines whether the beryllium test is normal, abnormal, or borderline.
Will you be making any other changes to the Regulations?	The only changes to the regulations currently being contemplated are to accommodate the amendments to the statute that were made in December 2023 related to the criteria for beryllium sensitivity, but no rulemaking has began yet.
Borderline tests are abnormal right?	Under the new criteria, if a claimant has 3 borderline tests conducted over a period of three years, they can meet the eligibility criteria for beryllium sensitivity.
Under the EEOICP only one abnormal test is needed to establish CBD, DOE requires 2 abnormal , not DEEOICP. So what is borderline under the EEOICP?	Beryllium sensitivity tests are interpreted by a physician to either be normal, abnormal, or borderline.
Why do the borderline tests have to be consecutive? Please cite the scientific reference in support of this policy?	In the amendments to the statute, Congress simply said that the new criterion was for "three borderline beryllium lymphocyte proliferation tests performed on blood cells over a period of 3 years," and we are bound by the language Congress used.
Will the Case Examiner send a copy of the Statement of Facts to the claimant and physician?	No this is not the typical process.
What justifies an IH review when Congress intended Site Profiles of toxic exposures to be used for exposure assessment?	See responses above. Congress did not mandate the SEM. "Site profiles" are conducted by NIOSH related to radiation dose reconstructions for cancer claims under Part B.
What is the budget for IH reviews?	IH reviews are conducted as part of claims adjudication and are charged by the case.
What portion of Part E claims with diagnosis submitted go to an IH review?	We do not have a specific percentage of Part E cases that go to IH for review.
Why aren't webinar's recorded? The slides are of little value without hearing the discussion.	We will consider recording the webinars.
Where in the manual does it say the DOL can arbitrarily move up due dates on response requests that have already been issued?	This questions is unclear. We would need specifics.
Can you provide clarity on homebound status, per chapter 30 of the procedure manual, as it relates to the need for certification of medical need for Home Care and face to face examinations, in the setting of those claimants with advanced disease who are unable to leave their homes?	DEEOIC will pay for medical transportation to the level and extent necessary to safely and effectively transport a claimant from their home to medical appointments or for medical treatment. Thus, even a claimant who is not able to leave their home under normal circumstances will be able to be seen, in person, by their treating physician for purposes of an assessment to serve as the basis for a letter of medical necessity prescribing home or residential health care or ancillary medical benefits.
Is an audiologist considered a physician for the purposes of diagnosing hearing loss?	Physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law.

Submitted Question	Answer
Who are affected by the RECA Sunset?	The RECA sunset applies to individuals who file claims with the Department of Justice under the Radiation Exposure Compensation Act.
Why do I have to reauthorize every 3 or 6 months for a covered illness that I am going to have rest of my life.	HHC requires reauthorization every 6 months, due to the unique nature of home health care services, DEEOIC wants to assure that the claimants are receiving the appropriate care based upon their medical necessity and that is best determined by their physician, requiring re-examination and submission to DEEOIC every 6 months.
Is there a reason the conditions like hearing loss are in the Procedure manual but not the SEM?	Most hearing loss cases involve noise exposure, which is not a toxic substance. Therefore, the only way that hearing loss can be covered under the EEOICPA is if there is concurrent exposure to solvents that causes the hearing loss. Since there are very specific criteria that would cause hearing loss related to noise and solvents, the criteria had to be described in the PM and is not appropriate for the SEM.
Can you please provide a list of what titles are acceptable as a signing medical professional? (Ex: MD, DO, Optometrist, Chiropractor, Dentist, etc.) Thank you.	Physician includes surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors and osteopathic practitioners, within the scope of their practice as defined by state law.
What qualifications does a CE have to disagree with a MD?	Claims examiners are trained in evaluating and weighing medical evidence. If they have a question about a report, or the report lacks the legal criteria for acceptance of a claim, the claims examiner will either go back to the treating physician or obtain an opinion from a contract medical consultant.
does the at least as likely as not burden also apply to consequential conditions?	No. Consequential conditions are conditions that arise out of conditions that have already been accepted, and therefore the only criteria that must be met is that the physician must provide a well rationalized medical opinion that the consequential condition is causally related to the condition that we have accepted.
We have been told that a claimant will not be processed until they are in their last 2 months of life who sets this standard.	I believe this question relates to when a case will be classified as a terminal case, requiring expedited handling. The Program goes to great lengths to ensure that a person who is at the end stage of their life who has a pending claim receives expedited handling of their claim. This means that claims staff from claims examiners to hearing representatives to fiscal office staff drop everything to ensure that if a claimant can get paid before death, they are paid. As such, it is important that the evidence establish that such expedited processing is necessary.
If NPs are not considered physicians, why are they located on the provider list?	The provider list includes a variety of providers, some who enrolled as a nurse practitioner (NP) *on their own* or they were listed within the provider enrollment documentation for that provider as a NP.
Can you direct me to the specifics of the DEEOIC procedure relating to therapies and homebound status? I am unable to locate that in either Chapter 29 or Chapter 30.	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. DEEOIC defines Rehabilitative Therapy Services as therapeutic services, for which a provider charges a fee to render care, that are outside the scope of routine and customary medical care generally provided by a qualified physician. EEOICPA Circular No. 22-01 allows physicians to utilize telemedicine for non-emergency routine physician appointments. Rehabilitative Therapy Services are not routine physician appointments, thus are not included in the type of services outlined in EEOICPA Circular No. 22-01. Thus, requests for these services must be supported by a Letter of Medical Necessity documenting a recent face-to-face examination of the claimant by the prescribing physician. DEEOIC will pay for medical transportation to the level and extent necessary to safely and effectively transport a claimant from their home to medical appointments or for medical treatment. Thus, even a claimant who is not able to leave their home under normal circumstances will be able to be seen, in person, by their treating physician for purposes of an assessment to serve as the basis for a letter of medical necessity prescribing home or residential health care or ancillary medical benefits.
why not in have hearing loss in SEM for solvents ?	This question is answered above.

Submitted Question	Answer
Is a positive hit on SEM required prior to sending claim to IH for review? Can the claim be referred anyway?	No, a Claims Examiner may make a referral to an IH without any validation of an occupational exposure using SEM. Other records may provide a reasonable basis for an IH characterization of exposure without positive SEM results including records about contact with a particular substance within employment records, the Occupational History Questionnaire (OHQ), physician narrative, or other records obtained during claim development.
Are there statistics available on the office's success in meeting the stated 6th month processing timeline goal for new claims?	We measure processing of new claims via our 'initial processing' metric, which states that inital processing will be completed within 145 days 92% of the time. "Initial Processing" is defined as the time between receipt of a case to either a referral to NIOSH or a recommended decision. Over the past 6 quarters we've averaged 92%, posting 93% for the most recent quarter that closed March 31st. FY23 Qtr 1: 92% FY23 Qtr 2: 89% FY23 Qtr 3: 91% FY23 Qtr 4: 94% FY24 Qtr 1: 91% FY24 Qtr 2: 93%
The Act clearly addressed toxic exposure development by mandating Site Profiles supported by NIOSH, DOE and FWP. SEM is the result of this mandate supported by the same. Ruling (PM) that all Part E claims even if supported fully by SEM go to an IH is unfair and unequal treatment under the Act. Is SEM mandated and if so why are additional criteria required (IH) without going through the rulemaking process?	Please see responses above. The SEM is not mandated by the Act. Site profiles are defined under Part B of the Act and conducted by NIOSH under Part B for the purposes of conducting dose reconstructions.
I have submitted objections to the Agency that include reports of suspected fraud by a CMC. These objections have gone unaddressed. What is the process for reporting fraud by the CMC's to the Agency and what will be done when multiple reports come in related to a specific physician? Will you continue to employ him?	Fraud is a criminal offense that must be investigated by the Department of Labor's Office of the Inspector General (OIG) and any complaints of fraud against any medical provider billing OWCP should be submitted to the OIG using their hotline at 800-347-3756 or online at: https://www.oig.dol.gov/hotline.htm
The Act clearly addressed toxic exposure development by mandating Site Profiles supported by NIOSH, DOE and FWP. SEM is the result of this mandate supported by the same. Ruling (PM) that all Part E claims even if supported fully by SEM go to an IH is unfair and unequal treatment under the Act. Is SEM mandated and if so why are additional criteria required (IH) without going through the rulemaking process?	No, the SEM is not a statutorily mandated resource. SEM is a assistive tool meant to facilitate the collection of exposure information that a claimant would otherwise need to provide on their own. The program funds the SEM to assist claimant's meet their burden of documenting that an exposure likely occurred. IH characterization of toxic substance exposure permits a qualified physician to have an accurate understanding about the extent of exposure to formulate a well-rationalized opinion about causal relationship.
I have submitted objections to the Agency that include reports of suspected fraud by a CMC. These objections have gone unaddressed. What is the process for reporting fraud by the CMC's to the Agency and what will be done when multiple reports come in related to a specific physician? Will you continue to employ him?	Any allegation of potential impropriety by a CMC will be investigated and appropriate action take to address the matter with the CMC contractor. You may notify the assigned CE about any case-specific instance warranting review, or you may submit complaints to U.S. Department of Labor, DEEOIC 200 Constitution Avenue, NW, Room C-3510 Washington, DC 20210.