



RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL
VERSION 8.0:

EEOICPA TRANSMITTAL NO. 24-01

November 17, 2023

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this Transmittal to notify staff of the publication of Federal (EEOICPA) Procedure Manual (PM) Version 8.0 (v8.0), which replaces PM v7.1, effective the date of publication of this Transmittal.

Following are the content edits that make up PM v8.0:

- **Chapter 1 – Definitions**

- Ch. 1.2aaa has been edited to communicate an updated definition that aligns with guidance provided in EEOICPA Bulletin No. 23-06 – Directed Medical Examinations. The language in v7.1 previously read:

aaa. A Second Opinion (SECOP) Examination is a medical referral arranged by the DEEOIC which requires an employee to undergo a physical examination. The results of the examination, along with the Physician's review of pertinent medical documentation, facilitate the production of a narrative report describing the physician's independent medical opinion.

It has been updated in v8.0 to:

aaa. A Second Opinion (SECOP) Examination is a medical referral, arranged by DEEOIC, which requires an employee to undergo an in-person physical examination with a second qualified physician to facilitate the production of an independent medical opinion. A SECOP examination becomes necessary when the Claims Examiner (CE) or Medical Benefits Examiner (MBE) concludes that the claimant's initial medical opinion is not well-rationalized and thus is insufficient for reaching an adjudication decision and, that an in-person examination is the appropriate mechanism for obtaining a second, independent medical opinion.

- **Chapter 2 – The EEOICPA**

- Exhibit 2-1, DEEOIC Office Addresses (v7.1), has been removed. The remaining exhibit of Chapter 2 has been renumbered accordingly.

- Ch. 2.3b has been updated based on the removal of Exhibit 2-1. The language in v7.1 previously read:

b. District Offices (DOs). DEEOIC has four DOs, which are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington. Exhibit 2-1 contains a list of addresses, telephone numbers, and fax numbers for the DOs. Each DO is managed by a District Director (DD). The DD reports to the National Administrator of Field Operations (NAFO), who, along with the Deputy Administrator of Field Operations (DAFO), oversee field operations.

It has been updated in v8.0 to:

b. District Offices (DOs). DEEOIC has four DOs, which are located in Cleveland, Ohio; Denver, Colorado; Jacksonville, Florida; and Seattle, Washington. Each DO is managed by a District Director (DD). The DD reports to the National Administrator of Field Operations (NAFO), who, along with the Deputy Administrator of Field Operations (DAFO), oversee field operations.

- **Chapter 13 – Establishing Covered Employment**

- Ch. 13.10a(5)-(8) has been modified to replace references to outdated Social Security Administration (SSA) Form SSA-L460 with the reference to updated Form SSA-1826. The language in v7.1 previously read:

(5) Upon receipt and processing of an SSA-581, the SSA releases a statement of earnings, known as an SSA-L460. The SSA will mail the SSA-L460 to the DEEOIC CMR, located in London, Kentucky, where a contractor scans and indexes it into OIS.

6) If the CE does not receive a completed SSA-L460 within thirty (30) days of the faxed SSA-581, the CE calls the SSA to determine the status of the request. If the SSA indicates that the SSA-581 was not received, the CE must refax the SSA-581 in accordance with Step 4. After the SSA-581 is refaxed, the CE must follow-up with the SSA within 30 days. Otherwise, the CE obtains the status and monitors for SSA response.

(7) Inquiries to the SSA are made by calling one of six phone numbers (Modules) depending upon the last four digits of the relevant SSN (See Exhibit 13-1). When calling the SSA, the following information should be available to expedite the inquiry:

(a) SSA-issued job code (8015). The four-digit job code appears in the “Requesting organization” section of the SSA-581 form.

(b) Name of your organization.

- (c) *A copy of the SSA-581 or earnings statement in question.*
 - (d) *The full SSN of the number holder (employee), or the control number from the earnings statement.*
- (8) *Upon receipt of a completed SSA-L460, the CE documents receipt of the SSA response in ECS. Should the SSA fail to submit an SSA-L460 after following up within the established procedures, the CE proceeds with claim adjudication based upon the evidence contained in the case record.*

It has been updated in v8.0 to:

- (5) *Upon receipt and processing of an SSA-581, the SSA releases a statement of earnings, known as an SSA-1826. The SSA will mail the SSA-1826 to the DEEOIC CMR, located in London, Kentucky, where a contractor scans and indexes it into OIS.*
- (6) *If the CE does not receive a completed SSA-1826 within thirty (30) days of the faxed SSA-581, the CE calls the SSA to determine the status of the request. If the SSA indicates that the SSA-581 was not received, the CE must refax the SSA-581 in accordance with Step 4. After the SSA-581 is refaxed, the CE must follow-up with the SSA within 30 days. Otherwise, the CE obtains the status and monitors for SSA response.*
- (7) *Inquiries to the SSA are made by calling one of six phone numbers (Modules) depending upon the last four digits of the relevant SSN (See Exhibit 13-1). When calling the SSA, the following information should be available to expedite the inquiry:*
- (a) *SSA-issued job code (8015). The four-digit job code appears in the “Requesting organization” section of the SSA-581 form.*
 - (b) *Name of your organization.*
 - (c) *A copy of the SSA-581 or earnings statement in question.*
 - (d) *The full SSN of the number holder (employee), or the control number from the earnings statement.*
- (8) *Upon receipt of a completed SSA-1826, the CE documents receipt of the SSA response in ECS. Should the SSA fail to submit an SSA-1826 after following up within the established procedures, the CE proceeds with claim adjudication based upon the evidence contained in the case record.*

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**

- Exhibit 15-4.9b has been edited to clarify that the eligibility begin date for COVID-19 cannot predate the claim filing date. The language in v7.1 previously read:
 - b. *Once DEEOIC claims staff verify that the claimant has a previously accepted primary occupational or covered illness that reasonably correlates to one of the underlying medical conditions identified by the CDC as increasing the risk of severe COVID-19, COVID-19 is presumed to be a consequence of that primary condition. As such, COVID-19 may be accepted as consequential to that primary illness under Parts B and/or E. When COVID-19 is accepted as a consequential illness, the eligibility begin date is the date of diagnosis of COVID-19.*

It has been updated in v8.0 to:

- b. *Once DEEOIC claims staff verify that the claimant has a previously accepted primary occupational or covered illness that reasonably correlates to one of the underlying medical conditions identified by the CDC as increasing the risk of severe COVID-19, COVID-19 is presumed to be a consequence of that primary condition. As such, COVID-19 may be accepted as consequential to that primary illness under Parts B and/or E. When COVID-19 is accepted as a consequential illness, the eligibility begin date is the date of diagnosis of COVID-19, but no earlier than the date of filing for the underlying accepted condition.*
- Exhibit 15-4 has been edited to add a new #18 that provides explicit instruction for accounting for an organ transplant in ECS as a consequential condition. Due to this addition, the remainder of the items in Exhibit 15-4 have been renumbered accordingly. The new language in v8.0 reads:

18. Organ Transplants: To ensure appropriate reimbursement of medical treatment costs including prescription medications, any organ transplant accepted by the Medical Benefits Branch as medically necessary due to a previously accepted condition is to be presumed as an accepted consequential condition and coded as such in ECS.

- **Chapter 21 – Impairment Ratings**

- Ch. 21.4c has been modified to add a new section (3) that discusses that a claimant's eligibility for an impairment award is not extinguished while awaiting an organ transplant. Based on this additional language, the remaining sections of Ch. 21.4c have been renumbered accordingly. The language in v7.1 previously read:
 - (3) *Multiple Covered Illnesses. In a case of multiple covered illnesses, where one condition is at MMI and another is not, the CE proceeds with a determination regarding impairment for the condition at MMI. If different covered illnesses affect the same organ or body function, and one condition is not at MMI, the CE*

cannot proceed with an impairment rating until all conditions in that organ or body function have reached MMI.

It has been updated in v8.0 to:

- (3) *Transplants. If the treating physician has declared an employee to be at MMI for a covered condition except for the possibility of treatment via a transplant of a vital organ, which includes the heart, lung, kidney, or liver, the CE should consider the employee to be at MMI and proceed with an impairment rating regardless of any pending transplant related medical procedures or outcomes.*
 - a. *If the employee seeks an impairment rating under this circumstance while awaiting treatment via organ transplant of an organ other than the heart, lung, kidney, or liver, the CE must obtain a well-rationalized medical opinion that documents that the transplant is a lifesaving treatment.*
- (4) *Multiple Covered Illnesses. In a case of multiple covered illnesses, where one condition is at MMI and another is not, the CE proceeds with a determination regarding impairment for the condition at MMI. If different covered illnesses affect the same organ or body function, and one condition is not at MMI, the CE cannot proceed with an impairment rating until all conditions in that organ or body function have reached MMI.*
- Ch. 21.6b has been updated to include a new procedure for the handling of claimant delays in scheduling or obtaining an impairment rating appointment with their chosen physician. The language in v7.1 previously read:
 - b. *Scheduling an Appointment with the Selected Physician. Upon receipt of the employee's written choice of physician, the CE sends a letter explaining that the employee is to schedule the impairment appointment within 30 days and the appointment is to occur within three months. The CE advises that the employee may request that the DO provide the rating physician with medical evidence in the case file to perform the impairment evaluation. The CE also explains that any appointment scheduled to occur later than three months may lead to denial of the impairment claim, unless there is a valid reason for the delay (for example, the earliest appointment available for a specialist was over three months).*

If after 30 days, the CE finds no evidence of an impairment evaluation or that the employee scheduled an appointment, the CE makes a phone call to determine the status of the appointment (whether it has been made or is in the process of being made, etc.). The CE advises the employee verbally of the need to schedule the appointment within the next 30 days and to provide written evidence of such to the CE. The CE also explains that if the appointment is not scheduled or the claimant has scheduled it to occur later than the three months period without a valid reason, a RD to deny the impairment claim may be issued. The CE records this

discussion in the phone calls section of ECS. After this phone call, the CE sends a written summary of the call to the employee.

If at the end of this total 60-day period no evidence exists to show progress in obtaining the necessary impairment evidence and the employee has not provided a valid reason for the delay (e.g., he/she was sick), the CE may issue a RD to deny the impairment claim.

It has been updated in v8.0 to:

- b. Scheduling an Appointment with the Selected Physician. Upon receipt of the employee's written choice of physician, the CE sends a letter explaining that the employee must schedule an impairment appointment within 30 days and that the appointment is to occur within three months, so that a completed impairment report is produced in a timely manner. The CE advises that the employee may request that the DO provide the rating physician with medical evidence in the case file to perform the impairment evaluation.*

After 30 days of the date of the CE's initial letter regarding choice of physician, the CE makes a phone call to the claimant to determine the status of the appointment (whether it has been made or is in the process of being made, etc.). If the claimant has scheduled an appointment, the CE documents the date in ECS and reminds the claimant to ensure the impairment report is submitted timely after the evaluation is completed. In situations where the claimant advises that an appointment has not been scheduled, the CE must notify the claimant of the need to schedule the appointment immediately. The CE must explain that if the appointment is not scheduled within the next 30 days, the claim will be put in a deferral status until such time as the claimant produces a completed impairment assessment by their chosen physician. The CE further advises the claimant to notify the CE of the date of the appointment once it is scheduled. The CE will advise the claimant of the option to forgo having their chosen physician conduct the impairment assessment in lieu of a CMC file review; however, the claimant must then submit a written statement agreeing to such.

After another 30 days has elapsed with no evidence of a scheduled appointment or the election of a CMC file review, the CE prepares a written notice to the claimant of the deferral on any further development of their claim for impairment until their chosen physician completes the evaluation and the CE receives a completed impairment assessment. The notice explains that should the claim remain in a deferral status for 365 days, a recommendation will be issued to deny the claim. Moreover, the notice will state that the CE will resume development of the claim for impairment only upon receipt of an impairment rating report by their chosen physician or the filing of a new claim involving a newly accepted condition that affects a new organ system. The filing of a new claim for impairment for the same covered illness(es) will not serve as a basis for resuming claim development.

- **Chapter 24 – Recommended Decisions**

- Ch. 24.4 has been edited to include new procedure describing the issuance of an EN-16 form with the publication of Recommended Decisions (RD) to accept. The language in v7.1 previously read:

4. Administrative Closures. Several situations exist that require administrative closure of a claim without the issuance of a RD. For example, situations where an administrative closure is necessary include (but are not limited to) the death of a claimant, failure to complete the OCAS-1, withdrawal of claim prior to the issuance of a RD, failure to obtain a proper, contemporaneous signature and date on the EE-1 or EE-2 and lack of response to a request for information regarding SWC or Tort payments. When the circumstances of the case lead to an administrative closure, a RD is not required for the affected claimant. Instead, when appropriate, the CE issues a letter to the claimant and/or his or her representative advising of the administrative closure, and the steps required to reactivate the claim.

When multiple claimants have filed for benefits and an administrative closure is required for one or more individual claims, the CE proceeds with the adjudication of the remaining active claims. The decision will describe the basis for any administrative closure, and the persons whose claims are closed will not be a party to the RD. If at a later date, the administrative closure ends and development resumes, the CE determines what affect the resumption of development may have on the case, including a potential need to vacate a prior FD to permit a new benefit entitlement decision involving all parties to the claim.

It has been updated in v8.0 to:

4. Administrative Closure. Several situations exist that require administrative closure of a claim without the issuance of a RD. For example, situations where an administrative closure is necessary include (but are not limited to) the death of a claimant, failure to complete the OCAS-1, withdrawal of claim prior to the issuance of a RD, failure to obtain a proper, contemporaneous signature and date on the EE-1 or EE-2 and lack of response to a request for information regarding SWC or Tort payments. When the circumstances of the case lead to an administrative closure, a RD is not required for the affected claimant. Instead, when appropriate, the CE issues a letter to the claimant and/or his or her representative advising of the administrative closure, and the steps required to resume the claim.

When multiple claimants have filed for benefits and an administrative closure is required for one or more individual claims, the CE proceeds with the adjudication of the remaining active claims. The decision will describe the basis for any administrative closure, and the persons whose claims are closed will not be a party to the RD. If at a later date, the administrative closure ends and development resumes, the CE determines what affect the resumption of development may have on the case, including a potential

need to vacate a prior FD to permit a new benefit entitlement decision involving all parties to the claim.

- a. *Response Regarding SWC, Lawsuit, and Fraud. Before a the CE can issue a RD for acceptance under the Act, the claimant must report whether a lawsuit was filed for exposure to the same toxic substance for which EEOICPA benefits are payable, whether a SWC claim was filed for the same medical condition(s), or whether the claimant has ever pled guilty to or been convicted of fraud in connection with an application for or receipt of federal or state workers' compensation. The claimant is required to report this information on Form EN-16. While the claimant must complete the EN-16 prior to the issuance of a final decision by FAB, the CE may proceed with a recommendation to accept a claim with a verbal attestation that no impediment exists based on information sought on the EN-16. Therefore, once the CE determines that the case is in posture for a recommended decision to accept, the CE may call the claimant to verify that the claimant has not filed a lawsuit, SWC claim, or pled guilty to or been convicted of fraud. With a negative response to the information requests, the CE may proceed with a recommendation to accept. Whether the CE speaks to the claimant or not, the CE must issue an EN-16 for completion by the claimant prior to, or on the same day as, the issuance of a recommendation to accept the claim.*

Completion of an EN-16 is necessary before the CE may issue a recommended decision to accept when the CE receives evidence that the claimant has received a tort or SWC settlement or has a possible fraud conviction. In the absence of a verbal attestation of the information sought on the EN-16 prior to a recommended acceptance, or the inability of the claimant to return the form when there is an indication of a tort or SWC settlement or possible fraud conviction, the CE is to administratively close the claim. Administrative closure is also necessary if the FAB remands a claim because the claimant did not complete an EN-16 to allow for the finalization of a recommended decision. With an administrative closure, the CE will send a letter to the claimant stating that their claim has been closed until such time as they comply with the requirement to produce a properly completed EN-16.

- **Chapter 26 – FAB Decisions**

- Ch. 26.5d has been modified to include new procedure describing the issuance of an EN-16 form with the publication of a RD to accept. The language in v7.1 previously read:
 - d. *SWC/Tort/Fraud Statements (EN-16) Not Obtained. Where signed statements are required regarding tort lawsuits, SWC claims and any possible fraud committed in connection with an application for or receipt of any federal or SWC benefit, and the claimant has not submitted such statements within 30 days of the issuance of the RD, the FAB administratively closes the claim. A memo to the file is drafted explaining the reason for the closure, and a letter is sent to the claimant advising him/her of the administrative closure.*

In instances involving multiple claimants and one or more claimants have not submitted the required EN-16, the FAB issues a FD to the claimants who have submitted a signed EN-16, denoting the administrative closure of the claimant(s) who failed to submit an EN-16. The share of compensation of the claimant(s) whose claim(s) has been administratively closed will be held in abeyance.

When a consequential injury is to be accepted, the CE must get a new signed EN16 SWC/Tort/Fraud affidavit from the claimant for that consequential injury. FAB's responsibilities in obtaining the appropriate EN-16 forms are described in further detail in Chapter 31 - Tort Action and Election of Remedies and Chapter 32 – Coordinating State Worker's Compensation Benefits.

It has been updated in v8.0 to:

- d. *Non-receipt of EN-16 Form. A claimant must complete a Form EN-16 before the FAB can issue a FD awarding compensation benefit. In a multi-claimant situation, each claimant is responsible for returning an EN-16 for their respective claim. It is not necessary for FAB to obtain an EN-16 more often than once in a 6-month period unless there is a new exposure or illness (including consequential) involved with the acceptance. FAB will assess the utility of a previously signed EN-16 based on the date of the RD under consideration.*

With the issuance of a RD accepting a claim, the claimant must return a completed EN-16 prior to the HR finalizing of the recommendation. In those instances where an EN-16 is not received within the expected due date of a FD, the FAB must remand the recommendation to the district office for administrative closure. This is necessary to prevent the recommendation from finalizing because of the statutory provision that allows for a finalizing of a recommendation within one year of issuance.

To assist with timely decision making, in those instances where the claimant has not returned an EN-16 after the issuance of a RD, FAB must undertake action to obtain the form. Within 15 days of the issuance of the RD or immediately upon receipt of a completed waiver, a screening must occur to ascertain the status the EN-16 submission. With the receipt of the form, the FAB may proceed with adjudication based on routine timeliness goals. If a completed EN-16 has not been received, the HR must place a call to the claimant or their designated AR to solicit the form. The HR must explain the requirement for submission of the form, and the fact that the lack of its submission prevents the finalization of the RD. Moreover, the HR must explain that the claimant has either the remaining period allowed from the EN-16 issuance (30 days) or an additional 15 days, whichever is later, to return the form, or FAB must remand the claim to the district office for administrative closure. If attempts made to interact personally with the claimant or their AR are unsuccessful, the HR will send a written notice to the claimant about the matter including the expectations for timely return of the form. When

the claimant does not return the EN-16 within the allowed period, the FAB must remand the claim to the district office for administrative closure.

- **Chapter 27 – Reopening Process**

- Ch. 27.2 has been edited to note that the Director has the authority to vacate a recommended decision, when necessary. The language in v7.1 previously read:

2. Authority. Under 20 C.F.R. § 30.320, the Director of the DEEOIC has the authority to reopen a claim and vacate a FAB decision at any time after the FAB has issued a FD pursuant to 20 C.F.R. § 30.316. Also, under 20 C.F.R. § 30.320(a), the Director may vacate a FAB Remand Order. While any party to a FD may submit a written request for reopening, it may also occur at the discretion of the Director of the DEEOIC for administrative reasons, due to procedural error, or a change in the law, regulations, agency policy, or any other reason at the sole discretion of the Director. If the Director initiates such a review, the NO requests the case file from the District or FAB Office for the reopening to be handled locally or delegates the authority for the reopening to be handled at a DO through procedural directive. The Director’s decision to reopen a claim and vacate a FAB decision is not reviewable.

It has been updated in v8.0 to:

2. Authority. Under 20 C.F.R. § 30.320, the Director of the DEEOIC has the authority to reopen a claim and vacate a FAB decision at any time after the FAB has issued a FD pursuant to 20 C.F.R. § 30.316. Also, under 20 C.F.R. § 30.320(a), the Director may vacate a FAB Remand Order. Additionally, the Director has the authority to vacate a RD, if necessary, to allow for further development. While any party to a FD may submit a written request for reopening, it may also occur at the discretion of the Director of the DEEOIC for administrative reasons, due to procedural error, or a change in the law, regulations, agency policy, or any other reason at the sole discretion of the Director. If the Director initiates such a review, the NO requests the case file from the District or FAB Office for the reopening to be handled locally or delegates the authority for the reopening to be handled at a DO through procedural directive. The Director’s decision to reopen a claim and vacate a FAB decision or recommended decision is not reviewable.

- **Chapter 29 – Ancillary Medical Benefits**

- Ch. 29.4c has been modified to integrate guidance provided in EEOICPA Bulletin No. 23-06 – Directed Medical Examinations. The language in v7.1 previously read:

c. CMC/ SECOP Medical Examinations. If the MBE determines that the AMB prescribed by the treating physician is unsupported by an appropriate medical rationale, and if attempts by the MBE are unsuccessful in clarifying the evidence with the treating physician, the MBE has the option of referring the claim to a CMC or obtaining a SECOP. A SECOP requires a physical examination of the

claimant and the SECOP physician's review of the available medical evidence.

It has been updated in v8.0 to:

- c. *CMC Review and SECOP Medical Examinations. If, after completion of appropriate development with the prescribing physician, the MBE determines that the AMB, or any other claimed medical benefit, is not supported by a well-rationalized medical opinion, and if attempts by the MBE are unsuccessful in resolving the matter, the MBE has the option of referring the claim to a CMC for a file review of the case records. If further clarification is required following a CMC file review, the MBE will follow the same development procedure for obtaining a SECOP examination as referenced in Chapter 30, Home and Residential Health Care.*
- o Ch. 29.7 has been updated to include language that ensures impacted providers are provided a copy of all decisions related to medical benefits. The language in v7.1 previously read:

7. Issuing an AMB Decision. Upon completion of all necessary development, including any review of the file by subject matter experts, the MBE is to evaluate the totality of the medical evidence, applying specific program guidance from this chapter as it pertains to AMB requests. The MBE must reach a conclusion as to whether the totality of the medical evidence results in a convincing and well-rationalized argument supporting justification for the claimed AMB, as requested for treatment of or relief from, the effects of a DEEOIC-accepted medical condition(s).

- a. *If the MBE decides that the evidence supports a medical necessity for the claimed AMB, the MBE prepares a letter to the claimant authorizing reimbursement for the requested AMB. The MBE sends a copy of the letter to the supplier/vendor designated by the claimant. The approval letter is to include the following information:*
 - (1) *Authorized billing code(s) relevant to the approval.*
 - (2) *Other specifics relevant to the authorization such as, billing period, number of units, frequency of visits, etc.*
 - (3) *Statement advising that fees are subject to the OWCP Medical Fee Schedule.*
 - (4) *Statement advising that if the authorization is for the rental of equipment, and that rental equipment is converted to a purchase, rental expenses incurred and paid will be deducted from the purchase price and only the difference will be reimbursed.*

b. *When the MBE finds it necessary to deny authorization for reimbursement of a claim for AMB, the MBE sends a letter to the claimant rejecting the claim. The letter decision must include a discussion of the steps that the MBE took to assist in obtaining information necessary to process the claim and describe the basis for concluding that the weight of medical evidence does not warrant authorization. The MBE sends a copy of the letter decision to the provider, where applicable.*

(1) *The letter decision must include the following language:*

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

(2) *RDs. If the claimant submits a written request for a RD in response to the denial of a requested AMB, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (with the exception of the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The author is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.*

It has been updated in v8.0 to:

7. *Issuing an AMB Decision.* *Upon completion of all necessary development, including any review of the file by subject matter experts, the MBE is to evaluate the totality of the medical evidence, applying specific program guidance from this chapter as it pertains to AMB requests. The MBE must reach a conclusion as to whether the totality of the medical evidence results in a convincing and well-rationalized argument supporting justification for the claimed AMB, as requested for treatment of or relief from, the effects of a DEEOIC-accepted medical condition(s).*

a. *If the MBE decides that the evidence supports a medical necessity for the claimed AMB, the MBE prepares a letter to the claimant authorizing reimbursement for the requested AMB. The MBE sends a copy of the letter to any impacted service provider awaiting the authorization, as well as the AMB prescribing physician. The approval letter is to include the following information:*

(1) *Authorized billing code(s) relevant to the approval.*

- (2) *Other specifics relevant to the authorization such as, billing period, number of units, frequency of visits, etc.*
- (3) *Statement advising that fees are subject to the OWCP Medical Fee Schedule.*
- (4) *Statement advising that if the authorization is for the rental of equipment, and that rental equipment is converted to a purchase, rental expenses incurred and paid will be deducted from the purchase price and only the difference will be reimbursed.*

b. *When the MBE finds it necessary to deny authorization for reimbursement of a claim for AMB, the MBE sends a letter to the claimant rejecting the claim. The letter decision must include a discussion of the steps that the MBE took to assist in obtaining information necessary to process the claim and describe the basis for concluding that the weight of medical evidence does not warrant authorization. The MBE sends a copy of the letter decision to any impacted service provider associated with the request, as well as the AMB prescribing physician.*

- (1) *The letter decision must include the following language:*

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

- (2) *RDs. If the claimant submits a written request for a RD in response to the denial of a requested AMB, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (with the exception of the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The MBE is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. Notice is to be provided to any impacted service provider associated with the request, as well as the AMB prescribing physician. While the servicing provider will be provided a copy of decisions, the claimant, or a properly designated authorized representative or attorney-in-fact, possesses the sole authority to file objections, or request reconsideration or reopening. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.*

- **Chapter 30 – Home and Residential Health Care**

- Ch. 30.6c has been edited to integrate guidance provided in EEOICPA Bulletin No. 23-06 – Directed Medical Examinations. The language in v7.1 previously read:

- c. *SECOP and Referee Medical Examinations. A SECOP will require a physical examination of the claimant and the SECOP physician’s review of available medical evidence. If the MBE determines that HRHC prescribed by the treating physician is unsupported by an appropriate medical rationale, and if attempts by the MBE are unsuccessful in clarifying the HRHC needs of the claimant with the claimant’s treating physician, the MBE proceeds with obtaining a SECOP. A referee examination is only necessary when a conflict of medical opinion arises between the claimant’s treating physician and a SECOP.*

It has been updated in v8.0 to:

- c. *CMC File Review, and Second Opinion (SECOP) and Referee Medical Examinations. If, after completion of appropriate development with the prescribing physician, the MBE determines that the HRHC prescribed by the treating physician is not supported by a well-rationalized medical opinion, and if attempts by the MBE are unsuccessful in resolving the matter, the MBE refers the case to a CMC for a file review of the case records. If, after a CMC file review, further clarification is required, the MBE may refer the claimant to a second opinion (SECOP) examination which requires a physical examination of the claimant and the SECOP physician’s review of the available medical evidence. When the MBE determines that there are two equally weighted, but competing, opinions regarding the medical necessity for HRHC, a referee file review is required.*
- Ch. 30.7b(2)-(a) has been removed and replaced by guidance at Ch. 30.7c that integrates guidance provided in EEOICPA Bulletin No. 23-06 – Directed Medical Examinations. As such, the remaining subsections of Ch. 30.7 have been renumbered accordingly. The language in v7.1 previously read:
 - (2) *SECOP Examination. In those instances where development with the prescribing physician has not produced evidence necessary to establish the medical appropriateness of the prescribed HRHC, the MBE is to refer the claimant to a SECOP examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for HRHC. The MBE must make every effort to expedite a SECOP examination referral to resolve an outstanding HRHC request.*
 - a. *Once the SECOP examination is complete and the report received, the MBE will then need to conduct a full examination of the case evidence, including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the care prescribed by the*

claimant's physician, the MBE is to authorize reimbursement of the prescribed care. If the SECOP examination results in an opinion that recommends a reduction or termination of the requested HRHC, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of SECOP physician is of greater weight than that of the treating physician, the MBE authorizes care at the level prescribed by the SECOP physician. In any instance where the MBE is authorizing HRHC at a level that is less than that prescribed by the claimant's physician (including no HRHC being necessary), the MBE is to proceed with the issuance of a RD explaining the basis for the authorization reducing or denying any prescribed care.

It has been updated in v8.0 to:

- c. Scheduling a directed medical examination to obtain a SECOP and obtaining a referee medical opinion. Upon completion of development (including providing the claimant's physician opportunities to clarify supporting medical rationale), if the MBE determines the file does not contain a sufficiently well-rationalized medical opinion necessary to authorize the requested care, the MBE will proceed with additional development adhering to the following medical development process:*
- (1) CMC File Review. The MBE prepares a referral to a CMC for a file review of the case evidence. If, upon completion of the CMC file review, the MBE determines that any component of the requested HRHC is medically necessary, the MBE authorizes reimbursement up to the level established by the weight of medical evidence. Should the CMC file review determine that there is no recognized medical need for the claimed HRHC or DME, or suggests a reduction in the services previously authorized, the MBE must proceed with a SECOP directed medical examination.*
 - (2) SECOP Examination. In those instances where development with the prescribing physician and a CMC file review have not produced the evidence necessary to establish the medical appropriateness of the prescribed HRHC, the MBE is to refer the claimant to an in-person SECOP examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for HRHC. The MBE must make every effort to expedite a SECOP examination referral to resolve an outstanding HRHC request.*
 - (a) Once the SECOP examination is complete and the report received, the MBE then needs to conduct a full examination of the case evidence, including any medical evidence submitted by the treating physician.*
 - (b) If the SECOP examination results in a validation of the care*

prescribed by the claimant's physician, the MBE is to authorize reimbursement of the prescribed care.

- (c) *If the SECOP examination results in an opinion that recommends a reduction or termination of the requested HRHC, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of SECOP physician is of greater weight than that of the treating physician, the MBE authorizes care at the level, if any, prescribed by the SECOP physician. In any instance where the MBE is authorizing HRHC at a level that is less than what was previously authorized, or it is determined that no HRHC care is medically necessary, the MBE is to proceed with the issuance of a RD explaining the basis for the authorization of reduced care or a decision denying any prescribed care.*
- (3) *Referee Examination (File Review). If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the SECOP physician, and there is a conflict regarding the claimant's needed HRHC, the MBE is to proceed with a referral for a referee examination of the competing medical reports. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving a conflict of medical opinions.*

- Ch. 30.9 has been changed to ensure impacted providers are provided a copy of all decisions related to medical benefits. The language in v7.1 previously read:

9. Issuing Recommended Decisions to Deny or Reduce Authorized HRHC. A recommended denial of authorization occurs when the MBE identifies a deficiency in the medical evidence and after the MBE has taken appropriate development steps, as described in this chapter. A RD to deny is only appropriate under certain circumstances:

- a. *Denial of a claim for initial HRHC in its entirety. Where the medical evidence for an initial claim does not support an authorization for any of the claimed HRHC, the MBE issues a RD to deny authorization.*
- b. *A reduction of previously authorized HRHC. For either an ongoing, or renewing authorization for HRHC, should the evidence support an authorization at a level, frequency, or duration of care that is less than previously authorized by the MBE, a RD is necessary. Under this circumstance, the MBE issues a recommendation explaining the evidence that warrants a reduction in the level, frequency, or duration of HRHC previously authorized. Within the recommendation, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the FAB determines whether to finalize the RD.*

When issuing a RD in these circumstances, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (with the exception of the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The author is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. As with all RDs, the FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.

It has been updated in v8.0 to:

9. *Issuing Recommendation to Deny or Reduce Authorized HRHC.* *A recommended denial of authorization occurs when the MBE identifies a deficiency in the medical evidence and after the MBE has taken appropriate development steps, as described in this chapter. A RD to deny is only appropriate under certain circumstances:*

- a. *Denial of a claim for initial HRHC in its entirety. Where the medical evidence for an initial claim does not support an authorization for any of the claimed HRHC, the MBE issues a RD to deny authorization.*
- b. *A reduction of previously authorized HRHC. For either an ongoing, or renewing authorization for HRHC, should the evidence support an authorization at a level, frequency, or duration of care that is less than previously authorized by the MBE, a RD is necessary. Under this circumstance, the MBE issues a recommendation explaining the evidence that warrants a reduction in the level, frequency, or duration of HRHC previously authorized. Within the recommendation, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the FAB determines whether to finalize the RD.*

When issuing a RD in these circumstances, the MBE prepares the RD in accordance with existing DEEOIC procedures provided in Chapter 24 – Recommended Decisions (except for the requirement at Ch. 24.7a(1) that the RD specify whether the benefit is being awarded under Part B or Part E, as this distinction is inconsequential in an AMB RD). The MBE is to ensure the narrative content in the Explanation of Findings includes a well-written narrative explaining the justification for the denial of authorization. The MBE is to provide notice of the RD to any impacted HRHC service provider associated with the request and the HRHC prescribing physician.

The FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD. In considering whether to finalize a recommendation, the FAB must weigh any new evidence received to determine if it is sufficient to overcome the finding of the MBAU. Either the FAB decides that the weight of the new evidence is not sufficient to change the outcome and it finalizes the recommendation, or it issues a remand to require additional examination of the

claim. FAB is to provide notice of its decision to the same recipients identified in the recommendation, including any impacted HRHC provider and the prescribing physician. Even though the servicing providers are receiving a copy of the recommended decision, they do not possess the authority to file objection or request an oral hearing before FAB. An objection requiring FAB consideration must originate from the claimant, or a properly designated authorized representative or attorney-in-fact.

- **Chapter 31 – Tort Action and Election of Remedies**

- Ch. 31.3, Signed Response Regarding Lawsuit, SWC Claim and Fraud, has been removed from Chapter 31 and replaced with guidance located at Ch. 24.4a, as well as supplemental guidance pertaining to the non-receipt of Form EN-16 at Ch. 26.5d. As such, the remaining sections of Chapter 31 have been renumbered accordingly.

- **Chapter 32 – Coordinating State Workers’ Compensation Benefits**

- Ch. 32.6, Signed Response Regarding Lawsuit, SWC Claim and Fraud, has been removed from Chapter 32 and replaced with guidance located at Ch. 24.4a, as well as supplemental guidance pertaining to the non-receipt of Form EN-16 at Ch. 26.5d. As such, the remaining sections of Chapter 32 have been renumbered accordingly.

- **Chapter 33 – Compensation Payments**

- Ch. 33.3d has been edited to ensure the validation of the presence of a raised stamp on certain legal documents. The language in v7.1 previously read:

d. Signature by POA. If the EN-20 contains a signature by a POA, the designated DEEOIC staff person responsible for payment validation, including the CE or FO, conducts a document review to ascertain whether the individual who signed the EN-20 has the legal authority to sign on behalf of the payee. To accomplish this, they must identify and review the legal document authorizing an individual as POA. If such a document does not exist in the case file, the designated staff person undertakes development to obtain this information. Upon receipt of a document identifying the designated POA, the designated staff person prepares a cover memorandum and sends the memorandum, the EN-20, and the POA documents (via facsimile) to the NO Policy Branch, for referral to the SOL. The DO memorandum requests a review of the POA documents to determine their legal sufficiency as they pertain to the signing of an EN-20. The person preparing the memorandum ensures that it is uploaded into OIS. At the time of referral to the Policy Branch, the designated staff enters a 7-day “reminder” in ECS.

- (1) The Policy Branch fiscal staff acts as the NO POC for any follow-up inquiries from the DO. Staff within the Policy Branch are responsible for routing POA requests to the SOL for review and response. Upon review, the SOL responds directly to the requesting DO, via facsimile.*

- (a) *If the SOL determines that the POA documentation is deficient for any reason, the CE sends a letter to the claimant (with a copy to the POA), advising that the SOL has determined the POA documents to be unacceptable, and stating the reason why. The CE does not send a copy of the Solicitor’s opinion to the claimant. Upon notification to the claimant, of a deficient POA, the CE deletes the “AOP received date” from ECS.*
- (b) *All documents pertaining to the acceptance or rejection of a POA are imaged and stored in OIS, separate from the payment documents, and are specifically identified as POA documents.*

It has been updated in v8.0 to:

- d. *Signature by POA. If the EN-20 contains a signature by a POA, or a court-appointed guardian or conservator, the designated DEEOIC staff person responsible for payment validation, including the CE or FO, conducts a document review to ascertain whether the individual who signed the EN-20 has the legal authority to sign on behalf of the payee. To accomplish this, they must identify and review the legal document authorizing an individual to sign on behalf of the payee. If such a document does not exist in the case file, the staff person undertakes development to obtain this information. Upon receipt of a document identifying the designated POA, guardian, or conservator, the staff person prepares a cover memorandum and sends the memorandum, the EN-20, and the POA documents, via a designated email distribution group, to the NO Policy Branch, for referral to SOL. The DO memorandum requests a review of the POA documents to determine their legal sufficiency as they pertain to the signing of an EN-20. The person preparing the memorandum ensures that it is uploaded into OIS. At the time of referral to the Policy Branch, the designated staff person enters a 7-day “reminder” in ECS.*
 - (1) *Designated Policy Branch staff act as the NO POC for all communication between the DO and SOL, including any follow-up inquiries or communication. Should SOL require additional information regarding the documents under review, requests are routed, via email, through the Policy Branch, to the requesting DO. DO responses are returned, through the Policy Branch, in the same manner. Upon completion of review, SOL prepares a memorandum, with findings, and forwards it to the Policy Branch, via email. The Policy Branch forwards the SOL memorandum to the DO for continued adjudication of the case.*
 - (a) *If SOL determines that the POA documentation is deficient for any reason, the CE sends a letter to the claimant (with a copy to the POA), advising that SOL has determined the POA documents to be unacceptable, and stating the reason why. The CE does not send a copy of the Solicitor’s findings to the claimant. Upon notification*

to the claimant, of a deficient POA, the CE deletes the “AOP received date” from ECS.

- (b) SOL may encounter a legal document which requires the presence of a “raised seal” for the document to be held as legally valid. In these instances, SOL will return the referral documents to the Policy Branch POC advising of the need for authentication of a “raised seal” on the document. The NO will return the referral documents to the originating DO advising of the need for confirmation of the existence of a raised seal. DO office staff should contact the authorized representative, conservator, or legal guardian, by telephone, and confirm that the individual is in possession of an original document which contains a “raised seal.” Once confirmation is obtained, the telephone conversation and attestation by that individual, confirming the presence of a raised seal on the document, is recorded in an ECS phone note. The DO updates the POA referral memorandum and returns the referral documents to the Policy Branch, for forwarding to SOL, where the SOL approval process continues.
- (c) All documents pertaining to the acceptance or rejection of a POA are imaged and stored in OIS, separate from the payment documents, and are specifically identified as POA documents.
- Ch. 33 has been edited to include a new section #18 that provides a procedure for ensuring follow-up actions are taken to ascertain the reason for an unreturned EN-20 form. This content incorporates guidance provided in EEOICPA Bulletin No. 23-07. The new language in v8.0 reads:

18. Following Up on Unreturned Form EN-20. If a claimant does not return an accurately completed EN-20 within 21 days since its issuance, the Chief of Operations will refer the claim to a staff person designated by the DD (e.g., CE or CA) for the purpose of facilitating a call to the claimant or designated AR. The function of the call will be to assess the reasons for the unreturned EN-20 and facilitate solutions for the submission of the form.

If an EN-20 is not returned within 45 days of decision issuance, the Chief of Operations must refer the case to a Fiscal Operations Specialist (FOS) for further development. The FOS will query the Do Not Pay (DNP) portal. A record of the search outcome is to be imaged into OIS. If a DNP search reveals the death of the payee, the FOS must notify the CE. The CE is then to undertake the necessary steps to initiate an administrative closure of the claim. After the search of the DNP portal, the FOS will send an email notification to the Chief of Operations about the search outcome. If there is no evidence of a payee’s death, the Chief of Operations will request a final attempt be made to contact the claimant/AR by telephone. If efforts to solicit a completed EN-20 are ultimately unsuccessful after prescribed development actions are attempted, then the staff person

handling the matter is to send a letter to the claimant/AR describing the actions taken to obtain a completed EN-20 and requesting that the claimant/AR submit the form for payment processing.

- a. If the claimant/AR communicates that they do not intend to complete the EN-20, the staff person handling the matter must call the claimant/AR to ascertain any options for obtaining the form and to explain that the form may be submitted later if necessary. The staff person will then prepare a written letter to the claimant/AR documenting the outcome of the conversation.*
- b. Should a claimant/AR communicate information that the claimant has changed residence and has not received the EN-20, the staff person handling the matter will request the claimant/AR submit a written/signed request for an official change of address. The staff person is to explain that DEEOIC must receive a written/signed official change of address request before an EN-20 can be mailed to the new address. The assigned staff person will check on the status of the address change within 30 days. In the absence of an acceptable notice of address change, the assigned staff person will again call the claimant/AR soliciting an official written/signed change of address request to allow for a copy of the EN-20 to be mailed.*

RACHEL D. POND
Director, Division of
Energy Employees Occupational
Illness Compensation