U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 10:

EEOICPA TRANSMITTAL NO. 26-01 December 18, 2025

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 10 (v10), which replaces PM v9.0, effective the date of publication of this Transmittal. Following are the content edits that make up PM v10:

- **Chapter 6 – Processing Mail**

  - Exhibit 6-1, FOIA Flow Chart, and any reference to this exhibit within the text of Chapter 6, have been removed. As such, the remaining exhibits of Chapter 6 have been renumbered accordingly.

- **Chapter 12 – Representative Services**

  - Ch. 12.2b has been updated to provide clarity regarding a claimant's appointment of an exclusive representation. The language in v9.0 previously read:

    b. Exclusive Representation. If a claimant chooses to have an AR, he or she may appoint only one representative at a time. The claimant has the ultimate decision-making authority to designate or remove his or her representative from acting on his or her behalf with regard to his or her claim. He or she can exercise this authority at any time and for any reason. In situations where a POA or court-issued instrument exists that grant someone legal decision-making authority regarding the interest of the claimant, that person has authority to appoint or remove a DEEOIC representative.

    It has been updated in v10 to:

    b. Exclusive Representation. If a claimant chooses to have an AR, he or she may appoint only one representative at a time. That representative may be an individual or an entity, such as a law firm or advocacy group. If the claimant designates an entity, a primary point of contact may be recorded, but any individual employed by that entity is entitled to communicate with staff regarding the claim. However, if the claimant designates a single individual as their AR, only that individual is entitled to act as the claimant's representative. The claimant has the ultimate decision-making authority to designate or remove his or her representative from acting on his or her behalf with regard to his or her

claim. He or she can exercise this authority at any time and for any reason. In situations where a POA or court-issued instrument exists that grant someone legal decision-making authority regarding the interest of the claimant, that person has authority to appoint or remove a DEEOIC representative.

- Ch. 12.4 has been edited to clarify DEEOIC practices regarding communication with claimants. The language in v9.0 previously read:

  4. AR's Role. The AR's role in the claims process depends on the scope of the authority that the claimant grants him or her. Unless the claimant's authorization specifies otherwise, a properly appointed AR has the authority, to the same extent as the claimant, to present or seek evidence, make factual or legal arguments, or seek medical authorization, interact with DEEOIC staff, and obtain information from the case file. Any notice or other communication from the DEEOIC that relays a requirement for claim adjudication is considered satisfied, if the DEEOIC sends it to a properly designated AR. The DEEOIC considers any communication sent to an AR the same as communication to the claimant. In most situations, the CE or FAB staff person is to relay information or other communications directly to the AR, with a copy going to the claimant. Where claimant contact information is unavailable, the CE or FAB staff person solely communicates with the AR. However, the CE or FAB staff person may choose to contact the claimant directly, if an AR is unresponsive, provides unclear guidance or direction, or a contradiction exists between information received from an AR versus the claimant. In any situation, the claimant is the final arbiter of any matter involving his or her claim. An appointed AR, who does not possess legal authority through a POA or court document to act on behalf of a claimant, does not have the authority to sign for a claimant in initiating a claim or sign an EN-20 Payment Form for the claimant.

It has been updated in v10 to:

4. AR's Role. The AR's role in the claims process depends on the scope of the authority that the claimant grants him or her. Unless the claimant's authorization specifies otherwise, a properly appointed AR has the authority, to the same extent as the claimant, to present or seek evidence, make factual or legal arguments, or seek medical authorization, interact with DEEOIC staff, and obtain information from the case file. Where claimant contact information is unavailable, the CE or FAB staff person solely communicates with the AR. However, the CE or FAB staff person may choose to contact the claimant directly, if an AR is unresponsive, provides unclear guidance or direction, or a contradiction exists between information received from an AR versus the claimant. In most situations, the CE or FAB staff person is to send written communications directly to the claimant, with a copy going to the AR. Any notice or other communication from DEEOIC that relays a requirement for claim adjudication is considered satisfied, if received by either the claimant or the AR. However, the claimant is the final arbiter of any matter involving his or her claim. An appointed AR, who does not possess legal authority through a POA or court document to act on behalf of a claimant, does not have the authority to sign for a claimant in initiating a claim or signing benefit payment forms.

- Ch. 12.5a(2) has been modified to further clarify DEEOIC practices regarding communication with claimants and authorized representatives. The language in v9.0 previously read:

> *(2) In those situations where the CE determines that no prior attorney-in-fact memorandum is contained in the case file record, or if information identified by the CE requires an update to a previously completed attorney-in-fact file memorandum, the CE will draft an additional memorandum to file. The memorandum is to identify the name and contact information (if available) of any named attorney-in-fact possessing authority to act on behalf of a claimant. Additionally, for each named attorney-in-fact, the CE will describe concisely the extent of authority each attorney-in-fact has to serve on behalf of the claimant.*
>
> *In most instances, the CE will find that the attorney-in-fact either has broad authority to act on behalf of the claimant, or that their authority is limited in some manner to certain functions such as medical decision-making. Once the memorandum is completed, the CE is to upload a signed, dated copy of the memorandum to OIS that the CE is to index as "Other Documents, POA." In the document index note field, the CE includes a standard phrase, "POA Scope of Authority."*
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> *An attorney-in-fact with authority to act on behalf of a claimant is not necessarily the equivalent of a properly designated AR and might not be entitled to case file copies. In those situations, even with the identification of an attorney-in-fact, the only individuals entitled to engage with DEEOIC for matters relating to claim adjudication may be the claimant or his or her designated AR. An exception exists for a claimant with an attorney-in-fact who has broad authority to act on behalf of the claimant in connection with his or her litigation, property, or with claims for government benefits. Under that scenario, the attorney-in-fact should be considered the designated AR and will be the primary POC for any claim adjudication business and will be entitled to any and all aspects of the case file as if he or she were the claimant.*

It has been updated in v10 to:

> *(2) In those situations where the CE determines that no prior attorney-in-fact memorandum is contained in the case file record, or if information identified by the CE requires an update to a previously completed attorney-in-fact file memorandum, the CE will draft an additional memorandum to file. The memorandum is to identify the name and contact information (if available) of any named attorney-in-fact possessing authority to act on behalf of a claimant. Additionally, for each named attorney-in-fact, the CE will describe concisely the extent of authority each attorney-in-fact has to serve on behalf of the claimant. In most instances, the CE will find that the attorney-in-fact either has broad authority to act on behalf of the claimant, or that their authority is limited in some*

manner to certain functions such as medical decision making. The authority of an attorney-in-fact depends on the specific authority granted by the POA. An exception exists for a claimant with an attorney-in-fact who has broad authority to act on behalf of the claimant in connection with his or her litigation, property, or with claims for government benefits. Under this scenario, the attorney-in-fact is considered the primary POC for any claim adjudication and is entitled to any and all aspects of the case file. If a claim has both an attorney-in-fact with broad authority and an AR, they are both copied on correspondence.

Once the memorandum is completed, the CE is to upload a signed, dated copy of the memorandum to OIS indexed as "Other Documents, POA." In the document index note field, the CE includes a standard phrase, "POA Scope of Authority."

- Exhibit 12-1, Authorization for Representation / Privacy Act Waiver, and any reference to this exhibit has been removed from Chapter 12.

- **Chapter 13 – Establishing Covered Employment**

  - Ch. 13.11 has been edited to correct the hyperlink to the BTComp site for exclusive DOL use. The language in v9.0 previously read:

    11. <u>Center for Construction Research and Training</u>. The Center for Construction Research and Training, formerly known as the Center to Protect Workers' Rights and which continues to utilize the acronym CPWR, is a research, development and training arm of the Building and Construction Trades Department (BCTD) of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). The DEEOIC contracted with CPWR to maintain a database of contractor/subcontractor employers at certain DOE facilities.

    a. Web-accessible database. To substantiate the existence of a contract between DOE and a contractor, CPWR created a web-accessible database, which the CE can use in identifying and confirming the existence of contractor or subcontractor employers at certain covered facilities. Facilities for which CPWR has contractor and subcontractor information are identified in the EPOD as "CPWR." If the CE determines that the claimed employment involves subcontractor employment at a facility in which the EPOD indicates "CPWR has contractor/subcontractor information," the CE first reviews the EE-5, the Document Acquisition Request (DAR), and any material received from DOE. If this information is insufficient for a finding of covered employment, the CE reviews the CPWR database for any information linking the claimed employer to the claimed DOE facility, by following these instructions:

    (1) The CE goes to https://www.btcomp.org. A log-on screen appears. Each DO has been assigned one original username and password.

It has been updated in v10 to:

11. Center for Construction Research and Training. The Center for Construction Research and Training, formerly known as the Center to Protect Workers' Rights and which continues to utilize the acronym CPWR, is a research, development and training arm of the Building and Construction Trades Department (BCTD) of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). The DEEOIC contracted with CPWR to maintain a database of contractor/subcontractor employers at certain DOE facilities.

a. Web-accessible database. To substantiate the existence of a contract between DOE and a contractor, CPWR created a web-accessible database, which the CE can use in identifying and confirming the existence of contractor or subcontractor employers at certain covered facilities. Facilities for which CPWR has contractor and subcontractor information are identified in the EPOD as "CPWR." If the CE determines that the claimed employment involves subcontractor employment at a facility in which the EPOD indicates "CPWR has contractor/subcontractor information," the CE first reviews the EE-5, the Document Acquisition Request (DAR), and any material received from DOE. If this information is insufficient for a finding of covered employment, the CE reviews the CPWR database for any information linking the claimed employer to the claimed DOE facility, by following these instructions:

(1) The CE https://www.admin.btcomp.org/. A log-on screen appears. Each DO has been assigned one original username and password.

- **Chapter 14 – Establishing Special Exposure Cohort Status**

  - Ch. 14.7e(2) has been edited to remove outdated ICD codes. The language in v9.0 previously read:

(2) Lymphomas (other than Hodgkin's disease). Waldenstrom's macroglobulinemia is considered to be a type of non-Hodgkin's lymphoma. The ICD-10 code is C88.0. Waldenstrom's macroglobulinemia, when diagnosed by lymph node biopsy, can be called lymphoplasmacytoid lymphoma (ICD-10 codes C83.00 – C83.98). (Note: Lymphoma Waldenstrom is used as a pseudonym for many other disorders not included as a specified cancer. The acceptance of this condition as a specified cancer is to be based on the ICD code presented in the medical evidence or upon diagnostic clarification from a physician).

It has been updated in v10 to:

(2) Lymphomas (other than Hodgkin's disease). Waldenstrom's macroglobulinemia is considered to be a type of non-Hodgkin's lymphoma. Waldenstrom's

macroglobulinemia, when diagnosed by lymph node biopsy, can be called lymphoplasmacytoid lymphoma. (Note: Lymphoma Waldenstrom is used as a pseudonym for many other disorders not included as a specified cancer. The acceptance of this condition as a specified cancer is to be based on the ICD code presented in the medical evidence or upon diagnostic clarification from a physician).

- Ch. 14.7f has been updated to remove the ICD code. The language in v9.0 previously read:

  f. Carcinoid Tumors. These tumors are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer. Carcinoid tumors should be recorded by the organ of the specified cancer. For example, the CE should use the ICD-10 code of C7A.010 for a malignant carcinoid tumor in the duodenum section of the small intestine. Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

  It has been updated in v10 to:

  f. Carcinoid Tumors. These tumors are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer. Carcinoid tumors should be recorded by the organ of the specified cancer. Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

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

  - Ch. 15.11b(1) has been updated to include guidance regarding use of the new tabular Industrial Hygienist (IH) referral form. The language in v9.0 previously read:

    (1) IH Referral Form. The CE completes the IH Referral Form (Exhibit 15-5) and identifies the specific question(s) being posed to the IH based on the analysis and likely exposures an employee may have encountered. The CE will follow the instructions included with the IH Referral Form and submit the necessary documents.

    It has been updated in v10 to:

    (1) IH Referral Form. The CE completes the IH Referral Form (Exhibit 15-5) and uses the tabular format to indicate to the IH the covered facility/site name, labor category, dates worked in the labor category, and the relevant toxic substance(s)

that the employee may have been exposed to while working in that labor category for which the CE wishes the IH to provide an exposure assessment. The CE follows the instructions included with the IH Referral Form (Exhibit 15-5) to submit the IH referral package and includes all necessary documents as outlined in that exhibit.

- Exhibit 15-4, Exposure and Causation Presumptions with Development Guidance for Certain Conditions, has been edited to correct a typographical error listing polyvinyl chloride instead of vinyl chloride as a toxic substance related to angiosarcoma. The language in v9.0 previously read:

*1. **Angiosarcoma**: Part E causation can be presumed for angiosarcoma, also known as hemangiosarcoma, of the liver once all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but does have some indicators of polyvinyl chloride exposure and a diagnosis of angiosarcoma/ hemangiosarcoma of the liver, development is to include an IH referral on nature, extent, and duration of exposure to polyvinyl chloride (e.g., an exposure presumption does not exist) and a medical opinion on causation.*

a. Medical: The file contains a diagnosis of angiosarcoma/hemangiosarcoma of the liver.

b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant polyvinyl chloride exposure. This can be determined by an IH assessment.

c. Latency: The diagnosis of angiosarcoma/hemangiosarcoma of the liver was made at least 20 years after initial exposure to polyvinyl chloride in covered employment.

It has been updated in v10 to:

*1. **Angiosarcoma**: Part E causation can be presumed for angiosarcoma, also known as hemangiosarcoma, of the liver once all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but does have some indicators of vinyl chloride exposure and a diagnosis of angiosarcoma/ hemangiosarcoma of the liver, development is to include an IH referral on nature, extent, and duration of exposure to vinyl chloride (e.g., an exposure presumption does not exist) and a medical opinion on causation.*

a. Medical: The file contains a diagnosis of angiosarcoma/hemangiosarcoma of the liver.

b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant vinyl chloride exposure. This can be determined by an IH assessment.

c. *Latency: The diagnosis of angiosarcoma/hemangiosarcoma of the liver was made at least 20 years after initial exposure to vinyl chloride in covered employment.*

- Exhibit 15-5, Industrial Hygienist Referral Form, has been updated to include the new tabular version of this form.

- Exhibit 15-6, Toxic Development Complete Memo, and any reference to this exhibit within the text of Chapter 15, have been removed.

- **Chapter 19 – Eligibility Requirements for Certain Uranium Workers**

  - Ch. 19.2 has been updated to reflect the amended statutory filing deadline for Radiation Exposure Compensation Act (RECA) claims. The language in v9.0 previously read:

    2. RECA Background. On October 5, 1990, Congress passed RECA, providing for payments to individuals who contracted certain cancers and other serious diseases because of their exposure to radiation during above-ground nuclear weapons tests or because of their exposure to radiation as part of their employment in the uranium industry, including work in mining, milling and ore transportation. Congress designated the DOJ to administer claims under RECA.

    With the enactment of the EEOICPA, Congress stipulated that certain uranium workers, or the survivors of such workers covered under RECA Section 5, be treated the same as covered DOE workers under Parts B and E of the EEOICPA.

    a. Section 5 of the RECA covers uranium workers employed in the mining, milling or transportation of ore. DOJ will make a payment of $100,000 to eligible workers or their survivor(s) if it finds them qualified under Section 5 of the RECA. Criteria for RECA Section 5 compensability include the following:

    (1) Individuals employed in above-ground or underground mines; employed in a uranium mill or employed in transport of uranium ore or vanadium-uranium ore from mines or mills.
    (2) Employment occurred in uranium mines or mills located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon, and Texas.

    (3) Employment occurred at a covered mine or mill from January 1, 1942, to December 31, 1971.

    (4) Compensable diseases are primary lung cancer, renal cancer, and other chronic renal diseases including nephritis and kidney tubal tissue injury, and the following nonmalignant respiratory illnesses:

pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to pulmonary fibrosis, silicosis, and pneumoconiosis.

It has been updated in v10 to:

2. <u>RECA Background</u>. On October 5, 1990, Congress passed RECA, providing for payments to individuals who contracted certain cancers and other serious diseases because of their exposure to radiation during above-ground nuclear weapons tests or because of their exposure to radiation as part of their employment in the uranium industry, including work in mining, milling and ore transportation. Congress designated the DOJ to administer claims under RECA. With the enactment of the EEOICPA, Congress stipulated that certain uranium workers, or the survivors of such workers covered under RECA Section 5, be treated the same as covered DOE workers under Parts B and E of the EEOICPA.

The RECA Extension Act of 2022 terminated RECA on the date that was 2 years after the law's enactment, June 7, 2022. Accordingly, the statutory filing deadline for RECA claims is June 8, 2024. As this date falls on a Saturday, RECA claims that bears a date of June 10, 2024, or earlier, on the postmark or stamp by another commercial carrier, are considered timely filed. However, claims bearing a date on or after June 11, 2024, as indicated by the postmark or stamp by another commercial carrier, will be returned by DOJ to the submitting party due to untimely filing. This has no effect on DEEOIC's responsibility to adjudicate EEOICPA claims for uranium workers, if DOJ has issued the necessary award.

a. Section 5 of RECA covers uranium workers employed in the mining, milling or transportation of ore. DOJ will make a payment of $100,000 to eligible workers or their survivor(s) if it finds them qualified under Section 5 of RECA. Criteria for RECA Section 5 compensability include the following:

(1) Individuals employed in above-ground or underground mines; employed in a uranium mill or employed in transport of uranium ore or vanadium-uranium ore from mines or mills.

(2) Employment occurred in uranium mines or mills located in Colorado, New Mexico, Arizona, Wyoming, South Dakota, Washington, Utah, Idaho, North Dakota, Oregon, and Texas.

(3) Employment occurred at a covered mine or mill from January 1, 1942, to December 31, 1971.

(4) Claim filing bearing a postmark or stamp by another commercial carrier of June 10, 2024, or earlier.

(5) Compensable diseases are primary lung cancer, renal cancer, and other chronic renal diseases including nephritis and kidney tubal tissue injury, and the following nonmalignant respiratory illnesses: pulmonary fibrosis, fibrosis of the lung, cor pulmonale related to pulmonary fibrosis, silicosis, and pneumoconiosis.

- **Chapter 20 – Establishing Survivorship**

  - Ch. 20.8a(1) has been edited to clarify that a probative DNA test results to establish a genetic link between a biological child and a deceased employee requires a certified kinship DNA test by an accredited DNA testing facility; wherein participants' identifications are verified, sample collections are witnessed by a third party, and the process includes a verifiable chain of custody. The language in v9.0 previously read:

    (1) Biological Child. The term "biological child" is broad and refers to all persons with either a presumed or established genetic link to a deceased employee. Because a recognized natural child is presumed to have a genetic link to a deceased employee, a recognized natural child is one type of biological child. Another type of biological child is a person whose birth certificate lists the deceased employee as their mother or father, because these persons are also presumed to have a genetic link to their listed mother and father. However, these two presumptions may be rebutted if substantial evidence exists that rebuts the existence of the genetic links, consistent with 20 C.F.R. § 30.111(d). The final type of biological child is any person who can establish an actual genetic link to a deceased employee through the submission of probative DNA evidence that shows such a link.

  It has been updated in v10 to:

    (1) Biological Child. The term "biological child" is broad and refers to all persons with either a presumed or established genetic link to a deceased employee. Because a recognized natural child is presumed to have a genetic link to a deceased employee, a recognized natural child is one type of biological child. Another type of biological child is a person whose birth certificate lists the deceased employee as their mother or father, because these persons are also presumed to have a genetic link to their listed mother and father. However, these two presumptions may be rebutted if substantial evidence exists that rebuts the existence of the genetic links, consistent with 20 C.F.R. § 30.111(d).

    The final type of biological child is any person who can establish an actual genetic link to a deceased employee through the submission of probative DNA evidence that shows such a link. In order for DNA test results to be probative in establishing a genetic link between a biological child and a deceased employee under EEOICPA, a certified kinship DNA test must be conducted by an accredited DNA testing facility; wherein participants' identifications are verified, sample

collections are witnessed by a third party, and the process includes a verifiable chain of custody of the samples submitted.

- Exhibit 20-1: Sample Letter to Potential Survivor, and any reference to this exhibit within the text of Chapter 20, have been removed, and is being made available in CCAT. As such, the remaining exhibit of Chapter 20 has been renumbered accordingly.

- **Chapter 21 – Impairment Ratings**

  - Ch. 21.5 has been updated to remove all references to outdated Forms no longer used by the DEEOIC and replace them with reference to updated Form EE-10. The language in v9.0 previously read:

    5. How a Claimant Files an Impairment Claim. After the FAB issues a Part E FD to an employee with a positive causation determination, the CE sends Form EE-11A/EN-11A to solicit impairment claims from employees who are potentially eligible for impairment benefits. See Section 16 of this chapter for developing a claim for increased impairment two years after the initial impairment FD.

    a. Impairment Letter and Response Form (Form EE-11A/EN-11A). Form EE-11A contains information explaining impairment benefits and that the employee may be eligible for an award based on permanent impairment.

    b. Words of Claim. If the employee submits written words of claim for impairment, the CE must follow up with the employee to obtain a signed Form EN-11A or Form EN-10. The impairment forms must be signed by the employee, the AR, or the employee's POA.

    (1) Request for Impairment Claim. Form EE-11A provides information that the employee must advise the DEEOIC in writing as to whether or not he/she wishes to claim impairment for a covered illness or illnesses. Form EN-11A is a response form on which the employee claims impairment.

    (2) Physician Choice. Form EE-11A includes instruction that the employee may choose to have his/her own qualified physician, or a CMC perform an impairment evaluation. CMCs are DEEOIC contracted physicians qualified to perform impairment evaluations. The employee indicates this choice on Form EN-11A. If the employee requests his/her own physician to perform the impairment rating, the employee must provide the physician's name, address, and phone number. Form EN-11A contains a space for this information.

    (3) Timeframe. The CE allots 60 days for the employee to respond to Form EE-11A/EN-11A, with a follow up request sent to the

employee at the first 30-day interval. The CE uses Form EE-11A/EN-11A for the follow up request, but the form must be marked "Second Request." The CE does not develop the impairment issue until he or she receives a completed Form EN-11A.

(a) If the employee does not respond to Form EE-11A/EN-11A within 60 days, the CE sends a final Form EE-11A/EN-11A marked as a "Final Request" to the employee. After the CE sends the final request Form EE-11A/EN-11A, the CE updates the ECS) to indicate the employee is not claiming impairment. If at any time, the employee informs the CE that he/she does not want to pursue a claim for impairment, the CE sends a letter to the employee advising that the DEEOIC will not undertake further development of the claim for impairment. The CE also notifies the employee of his/her right to claim impairment in the future.

(b) If the employee responds by Form EN-11A claiming impairment, the CE updates ECS appropriately. The impairment claim date is the postmark date of the form, if available, or the date the DO, FAB, CMR, or RC receives the form, whichever is the earliest determinable date.

(c) The employee may only choose one physician or CMC to perform an impairment evaluation. If the employee does not indicate on the EN-11A form who he or she would like to perform the impairment evaluation, or there is some other discrepancy including conflicting requests involving multiple EN-11A forms, the CE calls the employee for clarification. The CE advises the employee to document the resolution of the matter in a signed, written statement submitted to the DEEOIC CMR address.

It has been updated in v10 to:

5. <u>How a Claimant Files an Impairment Claim</u>. After the FAB issues a Part E FD to an employee with a positive causation determination, the CE sends Form EE-10 to solicit impairment claims from employees who are potentially eligible for impairment benefits. See Section 16 of this chapter for developing a claim for increased impairment two years after the initial impairment FD.

a. Impairment Form EE-10 contains information explaining impairment benefits and that the employee may be eligible for an award based on permanent impairment.

b. Words of Claim. If the employee submits written words of claim for impairment, the CE must follow up with the employee to obtain a Form EE-10 signed by the employee, AR, or the employee's attorney-in-fact or a person with legal authority to act on the claimant's behalf.

(1) Physician Choice. Form EE-10 includes instructions that the employee may choose to have his/her own qualified physician, or a CMC perform an impairment evaluation. CMCs are DEEOIC contracted physicians qualified to perform impairment evaluations. The employee indicates this choice on Form EE-10. If the employee requests his/her own physician to perform the impairment rating, the employee must provide the physician's name, address, and phone number. Form EE-10 contains a space for this information.

(2) Timeframe. The CE allots 30 days for the employee to respond to Form EE-10, The CE does not develop the impairment issue until he or she receives a completed Form EE-10.

(a) If the employee does not respond within 30 days, the CE updates ECS to indicate the employee is not claiming impairment. If at any time, the employee informs the CE that he/she does not want to pursue a claim for impairment, the CE sends a letter to the employee advising that the DEEOIC will not undertake further development of the claim for impairment. The CE also notifies the employee of his/her right to claim impairment in the future.

(b) If the employee responds by submitting Form EE-10 claiming impairment, the CE updates ECS appropriately. The impairment claim date is the postmark date of the form, if available, or the date the DO, FAB, CMR, or RC receives the form, whichever is the earliest determinable date.

(c) The employee may only choose one physician or CMC to perform an impairment evaluation. If the employee does not indicate on the EE-10 form who he or she would like to perform the impairment evaluation, or there is some other discrepancy including conflicting requests involving multiple EE-10 forms, the CE calls the employee for clarification. The CE advises the employee to document the resolution of the matter in a signed, written statement submitted to the DEEOIC CMR address.

- Ch. 21.6b has been edited to instruct staff to follow up on the scheduling of an impairment assessment between 30-45 days after an initial letter instructing the claimant to schedule the appointment. The language in v9.0 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 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 have 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.

It has been updated in v10 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, but no longer than 45, 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 30-45 days have 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.

- Ch.21.9b-c has been edited to instruct staff they may refer a claim to a Contract Medical Consultant (CMC) when a claimant's physician offers an opinion that is contradicted by objective evidence or insufficient rationale. The language in v9.0 previously read:

  b. The AMA Guides specify the parameters for assessing ADL functionality so a physician can gauge the assignment of a percentage of impairment (Table 1-2, pg. 4). A rating physician referring to ADL functionality must relate any discussion of the severity of ADL dysfunction to the activities cited specifically in the AMA Guides. Moreover, the severity of any reported ADL dysfunction must align with other objective information in the case file that describes the employee's functional capacity. Where the CE identifies an obvious contradiction between

the ADL deficits communicated in an impairment report versus other available objective evidence, further development is appropriate. A rating physician's discussion of functional limitations or an employee's capacity to complete ADLs must also align reasonably to the assigned scale or grade that the AMA Guides explicitly requires for the impairment. However, when the AMA Guides do not communicate a clear requirement or communicate that the physician has discretion to assign a percentage of impairment within a particular range, the CE is to defer to the judgment of the physician.

For situations where a documented contradiction exists between the manner in which the physician communicates their understanding of ADL functionality and other available objective evidence contained in the case file, the CE has to assign less weight to the physician's opinion. The CE is to initiate development that seeks clarification from the physician. For example, the AMA Guides explains that for some ratings, an individual must be fully dependent on others for self-care. If a physician refers to this standard in justifying a particular percentage of impairment, and upon review of the case file there is documented evidence that the claimant has independent ADL functionality, this is a reason for the CE to assign less weight to the physician's opinion and to undertake development.

c. *Upon identification of a deficiency in the application of the AMA Guides by a CMC or an employee's physician, the CE is to initiate development. The purpose of development is to communicate to the rating physician any question(s) regarding the application of the AMA Guides or to provide the physician with an opportunity to consider new evidence. Upon receipt of any response, the CE must weigh whether any clarification overcomes the concerns with the initial impairment rating. For any CMC opinion deemed insufficient after further development, the CE refers the matter to the Policy Branch for a review by the CMC Contract Manager.*

   If the employee's chosen physician does not respond to further development requests or submits a response to which the CE cannot assign the weight of medical evidence because of an explicit defect in the application of the AMA Guides, the CE is to make a referral for a CMC file review. Upon receipt of the second opinion, the CE is to conduct a comparative analysis of the competing whole-person impairment ratings by the employee's chosen physician and the CMC. The opinion to which the CE assigns the greatest weight will be used to calculate the whole-person impairment benefits awarded. In the event the CE assigns equal weight to the opinions of the employee's physician and CMC, the CE refers the issue to a Referee Specialist for review per established procedure.

It has been updated in v10 to:

b. *The AMA's Guides specify the parameters for assigning whole-person impairment by organ system using specified measures or gauges of permanent partial impairment. For many ratings, this may also include a physician's consideration of the ability of a claimant to perform activities of daily living, given the effect of*

work-related illness(es). In assessing the accuracy and reliability of an assigned level of whole-person impairment by a CMC or a claimant's physician, the CE is to compare the physician's analysis to the narrative stipulations of the AMA's Guides for the assignment of a specified rating. As long as the rating aligns reasonably to the guidance contained in the AMA's Guides, the CE may accept the rating.

c. If the CE identifies a deficiency in a CMC's application of the AMA's Guides, the CE is to initiate follow-up. The CE is to communicate to the CMC question(s) or concerns(s) regarding the appropriate application of the AMA's Guides so that the CMC may provide clarification about the assigned rating. Upon receipt of a response, the CE must weigh whether the supplemental input overcomes the concerns with the initial impairment rating. For a CMC opinion deemed insufficient after further development, the CE refers the matter to the Technical Procedures Branch for review, and possible corrective action, by the CMC Contract Officer Representative.

For situations where the claimant's physician presents an impairment report that communicates information that is contradicted by other objective evidence in the file (e.g., the severity of activities of daily living dysfunction) or communicates information that is confusing or difficult to decipher, the CE is to make a CMC referral to assess whether the assigned rating represents a reasonable, accurate application of the AMA's Guides based on the available objective evidence and, if not, what alternative whole-person impairment rating is recommended. The CE is to permit the claimant's physician the ability to respond to a CMC assessment that concludes there is a defect in how the claimant's physician assessed impairment. Once the claimant's physician has been afforded the opportunity to respond to the CMC finding and has chosen to provide a counter argument about the assigned whole-person impairment, the CE is to weigh the competing opinions to decide which has the most probative value regarding the assignment of whole-person impairment. If the opposing opinions are of equal weight, the CE is to obtain a referee opinion, as directed by staff procedure.

- Ch. 21.10 has been edited to include guidance to staff to direct impairment claims to a referee medical specialist to resolve conflicting impairment opinions that are found to be of equal weight, but not within 10 percentage points of one another. The language in v9.0 previously read:

10. <u>Pre-RD Challenges</u>. Upon request, the CE may provide the employee with a copy of the impairment rating report. The employee may submit written challenges to the impairment rating report and/or additional medical evidence of impairment. However, any additional impairment evaluations must meet the criteria discussed above in Section 9 before the CE can consider it when making impairment determinations. The DEEOIC will only pay for one impairment evaluation unless the DEEOIC directs the employee to undergo additional evaluations. The employee is responsible for the payment of any subsequent evaluations not directed by the DEEOIC. If the additional evaluation differs from the existing rating, the CE must review and weigh (see guidance provided in Chapter 16 – Developing and Weighing Medical Evidence) the two reports to determine

which report has more probative value. If the reports appear to be of equal value and the impairment ratings are within 10% of each other, the CE accepts the higher rating impairment.

It has been updated in v10 to:

10. <u>Disagreement with a Submitted Impairment Rating Prior to RD</u>. With the filing of an impairment claim, DEEOIC will provide authorization for a single impairment evaluation by a physician of the claimant's choosing or a CMC. If the claimant elects to challenge the sufficiency of an impairment rating obtained from the authorized physician before the CE issues an RD, the claimant may elect to obtain another impairment rating by a qualified physician at their own cost. The submission of such an assessment must meet the regulatory and procedural criteria for permissible whole-person impairment.

Upon receipt of competing whole-person impairment assessments, the CE must weigh the competing opinions. If the CE deems the competing opinions to have equal weight, and the assigned percentage of whole-person impairment is within a 10% differential, the CE may accept the higher rating. If equally weighted opinions are not within a 10% differential, it will be necessary for the CE to direct the claim to a referee medical specialist to conduct a file review to resolve the conflict in medical opinions. If the CE assesses one opinion to possess significantly more weight than the other, the CE may proceed to issue a recommendation based on the opinion assigned the greatest weight. The assignment of weight to an opinion from a physician that the claimant obtained without authorization does not obligate DEEOIC to reimburse the cost of the evaluation.

- Ch.21.16 has been updated to remove reference to outdated Forms no longer used by the DEEOIC and replace them with reference to updated Form EE-10. The language in v9.0 previously read:

  16. <u>Additional Filings for Increased Impairment Benefits</u>. An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. The DEEOIC will accept the submission of the EN-10, EN-11A or words of claim to initiate a claim for increased impairment; however, the DEEOIC must receive a completed EN-11A to allow the claimant to communicate his or her choice as the physician to perform the rating for increased impairment.

  When a claim for increased impairment is developed but the medical evidence establishes lower whole person impairment than previously determined, the CE denies the claim for increased impairment. The CE takes no action to reopen a prior impairment determination in these circumstances because a claim filed for increased impairment after the two-year waiting period is a new claim.

It has been updated in v10 to:

16. Additional Filings for Increased Impairment Benefits. An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. The DEEOIC will accept the submission of the Form EE-10, or words of claim, to initiate a claim for increased impairment; however, the DEEOIC must receive a completed Form EE-10 to allow the claimant to communicate his or her choice as the physician to perform the rating for increased impairment.

When a claim for increased impairment is developed but the medical evidence establishes lower whole person impairment than previously determined, the CE denies the claim for increased impairment. The CE takes no action to reopen a prior impairment determination in these circumstances because a claim filed for increased impairment after the two-year waiting period is a new claim.

- **Chapter 22 – Wage-Loss Determinations**

  - Ch. 22.6 has been edited to remove reference to outdated forms and replace them with reference to updated Form EE-10. The language in v9.0 previously read:

    6. How to File Initial Wage-Loss Claims. After a Part E FD is issued to a claimant with a positive causation determination, the CE sends Form EE-11B/EN-11B to solicit wage-loss claims from claimants who are potentially eligible for wage-loss benefits.

    a. Wage-Loss Letter and Response Form (Form EE-11B/EN-11B): Form EE-11B lists the criteria to establish wage-loss. The form includes an explanation regarding earnings records for the twelve quarters prior to the first quarter of wage-loss and contains a solicitation for earning records. Form EE-11B includes a statement that earnings records will be requested from the SSA. However, since SSA no longer requires the claimant's signature on Form SSA-581 to submit earnings records, the CE is no longer required to include Form SSA-581 (See paragraph 10a) with Form EE-11B. Form EE-11B also includes a request for additional employment evidence that supports the wage-loss, along with medical evidence supporting a causal relationship between the covered illness and the wage-loss. The form contains an instruction for the claimant to submit Form EN-11B, Wage-Loss Benefits Response Form, if he/she is claiming wage-loss, and to provide the date (trigger month and year) the employee first experienced wage-loss.

    b. Timeframe: The CE is to allot 60 days for the claimant to respond to Form EE-11B/EN-11B, with a follow up request sent to the claimant at the first 30-day interval. The CE uses Form EE-11B/EN-11B for the follow up request but marks the form "Second Request." The CE does not develop for wage-loss until a completed Form EN-11B is received.

    (1) If the claimant does not respond to Form EE-11B/EN-11B within

60 days, the CE sends a final Form EE-11B/EN-11B marked as a "Final Request" to the claimant. After the CE sends the final request Form EE-11B/EN-11B, the CE updates the ECS to indicate that the claimant is not claiming wage-loss.

If at any time the claimant informs the CE that he/she does not want to pursue a claim for wage-loss, the CE sends a letter to the claimant advising that the DEEOIC will not undertake further development of the claim for wage-loss at this time. The CE also notifies the claimant of the right to claim wage-loss in the future.

c. If the claimant submits Form EN-11B claiming wage-loss, the CE updates ECS to reflect the wage-loss claim. The wage-loss claim date is the postmark date of the form, if available, or the date the DO, FAB, CMR, or RC receives the form, whichever is the earliest determinable date.

It has been updated in v10 to:

6. <u>How to File Initial Wage-Loss Claims</u>. After a Part E FD is issued to a claimant with a positive causation determination, the CE sends Form EE-10 to solicit wage-loss claims from claimants who are potentially eligible for wage-loss benefits.

a. Wage-Loss Form: Form EE-10 contains information explaining wage-loss benefits.

b. Timeframe: The CE is to allot 30 days for the claimant to respond. The CE does not develop for wage-loss until a completed Form EE-10 is received.

(1) If the claimant does not respond within 30 days, the CE updates ECS to indicate that the claimant is not claiming wage-loss. If at any time the claimant informs the CE that he/she does not want to pursue a claim for wage-loss, the CE sends a letter to the claimant advising that the DEEOIC will not undertake further development of the claim for wage-loss at this time. The CE also notifies the claimant of the right to claim wage-loss in the future.

c. If the claimant submits Form EE-10 claiming wage-loss, the CE updates ECS to reflect the wage-loss claim. The wage-loss claim date is the postmark date of the form, if available, or the date the DO, FAB, CMR, or RC receives the form, whichever is the earliest determinable date.

- Ch. 22.17 has been updated to remove reference to outdated forms and replace them with reference to updated Form EE-10. The language in v9.0 previously read:

17. <u>RDs and FDs</u>. The CE first determines if the employee contracted a covered

illness due to exposure to a toxic substance at a DOE facility or RECA section 5 facility prior to making a determination on wage-loss. The CE can develop for the wage-loss simultaneously with the development of other aspects of the case, but this development should not delay the issuance of a RD to award medical or impairment benefits. If a Part E claimant files a Form EE-11B or Form EN-10 claiming wage-loss or subsequent wage-loss, the CE develops the wage-loss claim and the CE issues a RD for potential wage-loss benefits. If the claimant formally files a claim for wage-loss and then subsequently submits a signed written request to withdraw the wage-loss claim, a RD on wage-loss benefits is not required.

In a RD to accept wage-loss benefits, the CE is to include a narrative explanation of all the relevant findings. The RD is to include an explanation of the trigger month and how it was determined, the causal relationship between the covered illness and wage-loss and how it was established, the AAW (including all figures used), the retirement age and the calendar year in which the employee would reach that age and its significance in wage-loss calculation. Prior to the issuance of a RD to award wage-loss benefits, the calculations performed by the Wage-Loss Calculator must be bronzed in OIS. The CE is to clearly explain all the figures used in the Wage-Loss Calculator and how the wage-loss award was calculated so that a claimant may request a hearing if he/she disagrees with the figures.

In a RD denying wage-loss benefits, the CE is to explain which specific requirement(s) was not established to justify the wage-loss denial. For finalizing a wage-loss RD, the FAB Representative independently evaluates the CE findings and wage-loss calculations for accuracy. The FAB Representative ensures that a copy of the DO calculations is in OIS. Printouts of the calculation performed by the FAB Representative are also bronzed in OIS. If the FAB Representative cannot determine the basis for a wage-loss decision, the case file is remanded.

It has been updated in v10 to:

17. <u>RDs and FDs</u>. The CE first determines if the employee contracted a covered illness due to exposure to a toxic substance at a DOE facility or RECA section 5 facility prior to making a determination on wage-loss. The CE can develop for the wage-loss simultaneously with the development of other aspects of the case, but this development should not delay the issuance of a RD to award medical or impairment benefits. If a Part E claimant files a Form EE-10 claiming wage-loss or subsequent wage-loss, the CE develops the wage-loss claim and the CE issues a RD for potential wage-loss benefits. If the claimant formally files a claim for wage-loss and then subsequently submits a signed written request to withdraw the wage-loss claim, a RD on wage-loss benefits is not required.

In a RD to accept wage-loss benefits, the CE is to include a narrative explanation of all the relevant findings. The RD is to include an explanation of the trigger month and how it was determined, the causal relationship between the covered illness and wage-loss and how it was established, the AAW (including all figures used), the retirement age and the

calendar year in which the employee would reach that age and its significance in wage-loss calculation. Prior to the issuance of a RD to award wage-loss benefits, the calculations performed by the Wage-Loss Calculator must be bronzed in OIS. The CE is to clearly explain all the figures used in the Wage-Loss Calculator and how the wage-loss award was calculated so that a claimant may request a hearing if he/she disagrees with the figures.

In a RD denying wage-loss benefits, the CE is to explain which specific requirement(s) was not established to justify the wage-loss denial. For finalizing a wage-loss RD, the FAB Representative independently evaluates the CE findings and wage-loss calculations for accuracy. The FAB Representative ensures that a copy of the DO calculations is in OIS. Printouts of the calculation performed by the FAB Representative are also bronzed in OIS. If the FAB representative cannot determine the basis for a wage-loss decision, the case file is remanded.

- **Chapter 23 – Consequential Conditions**

  - Exhibit 23-2, Sample Letter Decision, and any reference to this exhibit within the text of Chapter 23, have been removed, as it is available in CCAT.

- **Chapter 24 – Recommended Decisions**

  - Ch. 24.5 has been edited to clarify when it is necessary to reopen a multi-claimant case when money has been held in abeyance. The language in v9.0 previously read:

    5. <u>Who Receives a RD</u>. Each individual who files a claim under a case, and has not had their claim administratively closed, is required to be a party to a RD that decides a benefit entitlement. Given the variant benefit filings that may exist in a single case, the CE may divide benefit entitlement claims to be addressed by separate RDs. This will occur when the CE is able to decide one or more entitlement benefits based on the evidence of record, while concurrent development occurs on outstanding claimed components. For example, the CE may issue separate decisions awarding medical benefits for a cancer under Part E, and a subsequent decision for any impairment linked to that cancer.

    a. Multiple Claimant RDs. All claimants who have filed a claim under Parts B and/or E, and have not had their claim administratively closed, are to be parties to any RD deciding a benefit entitlement. This is necessary to ensure that any decision comprehensively addresses the entitlement for all claimants with an interest in the claim. Each claimant is provided with the information necessary to understand the outcome for all claims. Moreover, it grants all claimants equal opportunity to present objections, should they disagree with any particular aspect of the decision. A CE should not issue a RD determining any single individual claimant's eligibility to receive benefits in a multiple person claim, except in the circumstance of a newly filing ineligible survivor.

Once a FD is issued, should a new individual subsequently file a claim seeking benefits, the CE will undertake normal development to determine the claimant's eligibility to benefits. Should the new claimant be deemed ineligible, a recommended denial of benefits that addresses his or her individual claim may be issued without reopening the previously decided claims. However, if the circumstances of the case develop to the point where a newly filing claimant may be eligible for benefits, or a denial would affect the benefits available to other parties to the claim, it will be necessary to reopen all claims and issue a new RD addressing the eligibility of all claimants under the case record.

b. *Discretionary Authority in the Decision Process. The CE employs appropriate discretion to decide the most effective course to bring timely resolution to all entitlement claims. The CE should pay particular attention to benefit entitlement determinations that will result in a positive outcome. In these situations, the CE is not to delay the issuance of a RD, even if other benefit entitlements may exist that require development. For example, two survivors of an employee file for lump-sum compensation under Parts B and E. Development is undertaken and both are found eligible to a Part B benefit of $150,000 because the employee had lung cancer related to covered employment. However, under Part E, only one of the survivors has submitted evidence to establish that he or she was under the age of 18 at the time of the employee's death. The other survivor indicates he or she is having problems obtaining school transcripts to show full-time student status. In this situation, the CE issues a decision on the benefit entitlement of both claimants under Part B but defers any decision on the Part E claim.*

c. *Non-Filing Survivors. The situation may arise where the CE identifies a potentially eligible survivor through development, but whose whereabouts are unknown or who does not wish to seek benefits. This includes situations where a survivor specifically notifies the CE that he or she does not wish to pursue benefits or states that he or she is clearly ineligible and will not file a claim. Under these circumstances, it is not possible for the CE to include them as party to a RD. The CE may proceed with the issuance of the RD to the remaining claimants; however, the CE's decision is to reference the fact there is a potentially eligible survivor who has not filed a claim.*

   (1) *In the situation where the non-filing survivor's eligibility to benefits cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-filing survivor is eligible. The potential survivor's share of compensation is held in abeyance until a claim is filed, evidence is received establishing the survivor's status as ineligible or notice of his or her death is received. Should the CE obtain evidence*

establishing that the non-filing survivor is clearly ineligible or deceased, any payable compensation being held in abeyance can then be allocated among the remaining survivor(s).

(2) When non-filing survivors have been advised of the requirements for establishing eligibility and have communicated to the CE that they will not file as they consider themselves ineligible, the CE attempts to obtain a signed, written statement confirming the survivors' ineligible status. Development involving a non-filing survivor should not extend past a reasonable period, as to significantly delay the issuance of a RD to other claiming survivors. The CE should make a reasonable effort to obtain either a claim form or written confirmation of the non-filing survivor's status. In most situations, the CE should allow 30 days to provide requested documentation. If written confirmation cannot be obtained, the CE must clearly document that the survivor intends not to file. Under this circumstance, unless the CE has reason to doubt the accuracy of the survivor's ineligibility, the CE may proceed with the issuance of a RD regarding the eligibility of the remaining claimants. The fact that there is a non-filing, ineligible, survivor is to be noted in the decision. However, the non-filing survivor is not a party to the decision, is not to be named, and instead addressed as a non-filing survivor. In such a situation, the CE does not hold payable lump-sum compensation in abeyance.

(3) Once a RD has been issued that involves a non-filing survivor, if the survivor later decides to file a claim form, it will be necessary to issue a new RD. Should development result in the claimant being found ineligible, a RD is permitted to be issued solely to the new claimant denying his or her claim. Under this circumstance, a reopening of any prior claims is unnecessary because the denial has no effect on the previously decided claims. Alternatively, if the claimant is found to be eligible to a benefit, a reopening of all previously decided claims is required to allow for the issuance of a new RD to all individuals who are party to the claim.

d. Non-Responsive Claimants. In situations in which a claim is filed and the claimant subsequently becomes unresponsive, reasonable steps should be taken to obtain confirmation of the non-responsive claimant's status. However, development should not extend past a reasonable period. In most situations, the CE should allow 30 days to provide the requested documentation. When there is no response within the allotted time, the CE may proceed with adjudication of the claim and issuance of a RD based on the evidence present in the case record.

In the situation where the non-responsive claimant is a party to a multiple survivor claim, and the non-responsive survivor's eligibility cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-responsive survivor is eligible; and his or her share of compensation is held in abeyance until such time evidence is received establishing the survivor's eligibility. In such cases, the non-responsive claimant is to be a party to the RD. Should the CE obtain evidence establishing that the non-responsive survivor is clearly ineligible or deceased, any payable compensation can then be allocated among the remaining survivor(s).

It has been updated in v10 to:

5. <u>Who Receives a RD</u>. Each individual who files a claim under a case, and has not had their claim administratively closed, is required to be a party to a RD that decides a benefit entitlement. Given the variant benefit filings that may exist in a single case, the CE may divide benefit entitlement claims to be addressed by separate RDs. This will occur when the CE is able to decide one or more entitlement benefits based on the evidence of record, while concurrent development occurs on outstanding claimed components. For example, the CE may issue separate decisions awarding medical benefits for a cancer under Part E, and a subsequent decision for any impairment linked to that cancer.

a. Discretionary Authority in the Decision Process. The CE employs appropriate discretion to decide the most effective course to bring timely resolution to all entitlement claims. The CE should pay particular attention to benefit entitlement determinations that will result in a positive outcome. In these situations, the CE is not to delay the issuance of a RD, even if other benefit entitlements may exist that require development. For example, two survivors of an employee file for lump-sum compensation under Parts B and E. Development is undertaken and both are found eligible to a share of the Part B benefit of $150,000 because the employee had lung cancer related to covered employment. However, under Part E, only one of the survivors has submitted evidence to establish that he or she was under the age of 18 at the time of the employee's death. Meanwhile, the other survivor indicates he or she is having problems obtaining school transcripts to show full-time student status. In such a situation, the CE issues a decision on the benefit entitlement of both claimants under Part B but defers any decision on the Part E claim.

b. Multiple-Claimant RDs. All claimants who have filed a claim under Parts B and/or E, and have not had their claim administratively closed, are to be parties to any RD deciding a benefit entitlement. This is necessary to ensure that any decision comprehensively addresses the entitlement for all claimants with an interest in the case. Each claimant is provided with the information necessary to understand the outcome for all claims.

Moreover, it grants all claimants equal opportunity to present objections, should they disagree with any particular aspect of the RD. A CE should not issue a RD determining any single individual claimant's eligibility to receive benefits in a multiple person claim, except in the circumstance of a newly filing ineligible survivor (see discussion below).

c. Non-Filing Survivors. The situation may arise where the CE identifies a potentially eligible survivor through development, but whose whereabouts are unknown or who does not wish to seek benefits. This includes situations where a survivor specifically notifies the CE that he or she does not wish to pursue benefits or states that he or she is clearly ineligible and will not file a claim. Under these circumstances, it is not possible for the CE to include them as party to a RD. The CE may proceed with the issuance of the RD to the remaining claimants; however, the CE's decision is to reference the fact there is a potentially eligible survivor who has not filed a claim.

(1) In the situation where the non-filing survivor's eligibility to benefits cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-filing survivor is eligible. The potential survivor's share of compensation is held in abeyance until a claim is filed, evidence is received establishing the survivor's status as ineligible or notice of his or her death is received. Should the CE obtain evidence establishing that the non-filing survivor is clearly ineligible or deceased, any payable compensation being held in abeyance can then be allocated among the remaining survivor(s).

(2) When non-filing survivors have been advised of the requirements for establishing eligibility and have communicated to the CE that they will not file as they consider themselves ineligible, the CE attempts to obtain a signed, written statement confirming the survivors' ineligible status. Development involving a non-filing survivor should not extend past a reasonable period, as to significantly delay the issuance of a RD to other claiming survivors. The CE should make a reasonable effort to obtain either a claim form or written confirmation of the non-filing survivor's status. In most situations, the CE should allow 30 days to provide requested documentation. If written confirmation cannot be obtained, the CE must clearly document that the survivor intends not to file. Under this circumstance, unless the CE has reason to doubt the accuracy of the survivor's ineligibility, the CE may proceed with the issuance of a RD regarding the eligibility of the remaining claimants. The fact that there is a non-filing, ineligible survivor is to be noted in the decision. However, the non-filing survivor is not a party to the decision, is not to be named, and

instead addressed as a non-filing survivor. In such a situation, the CE does not hold payable lump-sum compensation in abeyance

d. Additional Survivor(s) Subsequently File Claim Following Issuance of FD. Once a FD has been issued that involves a non-filing survivor, if the survivor later decides to file a claim form, it will be necessary to issue a new RD under one of the following scenarios. First, should development result in the new survivor being found ineligible, an RD is permitted to be issued solely to the new survivor denying his or her claim. Under this circumstance, a vacating of any prior FD is unnecessary because the denial has no effect on the previously decided claims.

Alternatively, if the new survivor is found eligible for benefits and their entitlement alters the allocation of lump-sum compensation previously awarded to other survivors, a vacating of the prior FD is necessary. The CE will then issue a new RD to all claimants who are party to the case that reallocates lump-sum compensation to eligible survivors based on the correct proportion of compensation payable. This may result in some survivors having been overpaid compensation.

However, if the compensation held in abeyance is payable to the newly filing, eligible survivor without any change in the amount of any other survivor's entitlement, the CE issues a new RD to award the new survivor their share of the deferred lump-sum compensation. The new RD describes the distribution of the balance of payable lump-sum compensation to the new claimant(s). While each survivor is party to this decision, it is not necessary to vacate the original FD to allow for the new RD in this scenario because the previous award of lump-sum compensation will not need to be reallocated in a way that results in a reduction of any previous award.

e. Non-Responsive Claimants. In situations in which a claim is filed and the claimant subsequently becomes unresponsive, reasonable steps should be taken to obtain confirmation of the non-responsive claimant's status. However, development should not extend past a reasonable period. In most situations, the CE should allow 30 days to provide the requested documentation. When there is no response within the allotted time, the CE may proceed with adjudication of the claim and issuance of a RD based on the evidence present in the case record.

In the situation where the non-responsive claimant is a party to a multiple-survivor claim, and the non-responsive survivor's eligibility cannot be ascertained, any payable lump-sum compensation will be allocated with the presumption that the non-responsive survivor is eligible and his or her share of compensation is held in abeyance until such time evidence is received establishing the survivor's eligibility. In such cases, the non-

responsive claimant is to be a party to the RD. Should the CE obtain evidence establishing that the non-responsive survivor is clearly ineligible or deceased, any payable compensation can then be allocated among the remaining survivor(s) in a new adjudication.

- Ch. 24.9b has been modified to clarify that any report justifying a claim denial is to be included in the RD packet, and only impairment reports are required to be included in the RD packet in the case of an acceptance. The language in v9.0 previously read:

b. Mailing the RD. The signed and dated RD is mailed to the claimant's established address of record, and a copy is sent to the claimant's designated representative, if any. Notification to either the claimant or the representative is considered notification to both parties.

(1) A signed and dated copy of the RD is imaged into the electronic case file. The imaged RD added to OIS must include all required attachments (HP, IH, TOX, and/or CMC reports) that provided justification or support for the claim's acceptance or denial.

It has been updated in v10 to:

b. Mailing the RD. The signed and dated RD is mailed to the claimant's established address of record, and a copy is sent to the claimant's designated representative, if any. Receipt of the RD by either the claimant or the representative is considered notification to both parties.

(1) A signed and dated copy of the RD is imaged into the electronic case file andmust include all required attachments (HP, IH, TOX, and/or CMC reports) that provided justification or support for the recommended acceptance or the recommended denial of a claim. In the case of a denial, such supporting documentation is also required to be included with the RD provided to the claimant(s).. A copy of the impairment report used as the basis of the RD, regardless of whether the claim is being recommended for acceptance or denial, is to be included in the RD packet.

- Exhibit 24-2, Sample Recommended Decision, and any reference to this exhibit within the text of Chapter 24, have been removed. As such, the remaining exhibit of Chapter 24 has been renumbered accordingly.

- Exhibit 24-2, Notice of Recommended Decision, has been updated to include information regarding the Energy Document Portal (EDP).

- **Chapter 25 – FAB Review Process**

  - Ch. 25.6 has been modified to align DEEOIC's hearing request process with C.F.R. § 30.314(a) regarding providing hearings through electronic means. The language in v9.0 previously read:

    6. Hearing Requests. An oral hearing permits the claimant, his or her AR, and any witnesses to voice objections to a HR.

    a. Initial Handling of Hearing Requests. FAB management is responsible for coordinating the assignment of a case file record to an HR once a DO has issued a RD. Upon upload into OIS of a timely written request for an oral hearing in response to the issuance of a recommendation of the DO, the assigned HR becomes responsible for coordinating the scheduling of the hearing. If for whatever reason the case file requires transfer to a different HR, or if for whatever reason the case is not assigned to an HR at the time a hearing request is received, FAB management is responsible for coordinating the assignment of the case file record to an HR, who shall then be responsible for scheduling the hearing.

    b. Acknowledgement. Once the timely written request is uploaded into OIS, the HR assigned to the case telephones the claimant, or AR, to acknowledge receipt of the hearing request. The HR is to engage with the claimant, or AR, to settle on a mutually acceptable date and time for the hearing. As part of the communication with the claimant, the HR is to reach agreement on the hearing format (telephone, video, or in-person). If the claimant chooses to pursue an in-person hearing, the HR will discuss options available for locations for such a hearing. The HR is to record any arraignments in an ECS telephone call note. If the HR is unable to contact the claimant, or the claimant's AR, the HR is to record at least two attempted calls in the ECS telephone log. The attempted calls should occur on two different days, at different times of day. In the event that the HR is unable to make verbal arrangements for the hearing, the HR proceeds with scheduling the hearing absent input of the claimant or their AR. In the event that multiple claimants in a case request a hearing, the HR contacts the claimant who made the request first, and coordinates the date, time, and location with that claimant.

    c. Hearing Notification. Once the HR has arranged a hearing, the HR completes an internal referral document and forwards it to a Hearing Scheduler. Once the Hearing Scheduler receives the referral document from the HR, the Hearing Scheduler undertakes actions necessary to facilitate the hearing, arranging for a court reporter to record the proceedings, reserving physical space for the hearing if in-person or via video conferencing, or, for telephonic hearings, obtaining a single-use conference calling number. The Hearing Scheduler then prepares and

mails a Notice of Hearing to the claimant and AR, updating ECS with the pertinent information relating to the scheduled hearing. The Hearing Scheduler then completes the referral document(s) received from the HR and emails a copy to the assigned HR. The Hearing Scheduler also attaches a copy of the finalized Notice of Hearing to the email. The Hearing Scheduler is to upload all finalized documents, including the completed referral document from the HR, into the OIS.

If the Hearing Scheduler cannot accommodate the requested hearing date for whatever reason, the Hearing Scheduler is to contact the HR and explain the need for a new date for the hearing. Under this circumstance, it may be necessary for the HR to contact the claimant to ascertain a new hearing date. Once the new hearing date is determined, the HR will contact the Hearing Scheduler to notify the HR of the new hearing date. The HR will then complete an updated referral document.

(1) Within the hearing notice, FAB will provide each claimant written notice of the scheduled hearing including instructions for the hearing logistics (in-person, video, or telephone). The notice provides other important information about the hearing including the claimant's rights to have other participants present. See Exhibit 25-1 and Exhibit 25-2 for sample Hearing Notice letters.

d. Changes to the Scheduled Hearing. The assigned HR may consider a reasonable request to postpone a scheduled time and place of a hearing. The assigned HR may accommodate a scheduled hearing change; however, the claimant must document a convincing or compelling basis for any hearing postponement including the death of a close family member, documented illness, or some other justifiable explanation. The HR must receive clearance from a FAB management official to postpone a hearing.

(1) Failure to Attend. If a claimant does not attend the hearing at the designated time and place and makes no effort to contact the HR to request a rescheduling based on one of the reasons outlined in paragraph d(4) above, the claimant will not be allowed to reschedule his or her hearing. In such instances, the claimant will be considered to have withdrawn the hearing request, and a review of the written record will be undertaken. If new evidence or argument accompanied the objection, it will be reviewed in the review of the written record.

(2) Cancellation of Hearing. If upon review, the HR determines that an error or other deficiency in the RD or in the initial case adjudication precludes the need for a hearing, and the FAB supervisor agrees, the HR will notify the claimant that the hearing

will not be scheduled, and a Remand Order will be prepared. When a hearing is canceled for any reason, the FAB acknowledges the cancellation in writing and gives the claimant 10 days from the date of the acknowledgement to submit additional evidence. The FAB representative then conducts a review of the written record.

(3) Resumption of FAB review after claim withdrawal. A claimant may choose to withdraw a claim prior to the issuance of a FD. If FAB had scheduled a hearing, a withdrawal of the claim will also constitute a withdrawal of the request for a hearing. Under this circumstance, should the claimant seek to resume adjudication of the claim, a hearing will not occur and instead the FAB will undertake a review of the written record at the conclusion of any balance of the 60-day period remaining for the claimant to submit evidence for consideration. If the claimant did not file an objection prior to a withdrawal of a claim, and the claimant later seeks to resume adjudication of the claim, the claimant retains their right to object and/or request a hearing for any remaining balance of the 60-day period for filing objections that existed prior to the claim withdrawal.

e. Review of Case File. Prior to the hearing, the HR reviews the evidence of record, as well as any additional evidence or materials submitted by the claimant and conducts whatever additional investigation is deemed necessary to prepare for the proceedings. If the additional evidence received establishes compensability or the need for further development and the FAB supervisor agrees, the HR will notify the claimant and/or AR that the claim will be remanded, and the hearing will be canceled. If the evidence is sufficient to warrant reversal in favor of the claimant, FAB may issue a reversal.

f. Multiple RDs. Since more than one RD can be issued prior to a hearing and additional objections and hearing requests may result, measures are needed to streamline the hearing process. If more than one RD is pending a FD, the HR contacts each objecting claimant and advises that all objections, not just those pertaining to the RD that is the subject of the hearing request, may be discussed during the hearing. The claimant(s) will be encouraged to bring relevant evidence, even if it concerns a RD for which a timely objection was not filed. All telephonic contact prior to the hearing is documented in ECS.

(1) Hearing Requests on Multiple RDs Pending a FD. When additional timely hearing requests are submitted based on other recommended denials prior to the date of the previously scheduled hearing, the HR contacts the requesting party to advise that all objections will be considered so that one hearing may serve to

accept evidence and testimony on several different RDs. This process is designed to avoid multiple hearings.

The HR notes the conversation with the claimant in ECS, confirming that the claimant was advised that all outstanding objections will be considered at the hearing. The HR updates ECS for each RD and each claimant requesting the hearing.

Separate hearing request acknowledgments and hearing notices are not required. The HR must be prepared to entertain objections about all RDs issued up to the date of the hearing and will take testimony and evidence on all outstanding objections. Each RD in question is considered in a single FAB decision once the FAB hearing process is concluded.

(2) Hearing Request on One RD, Request for Review of the Written Record on Another. If a claimant has requested a hearing on one outstanding RD and a review of the written record on another, the HR allows the claimant to present evidence about the objections which are not the subject of the hearing, so long as FAB has not issued a FD on the review of the written record request. (If FAB has issued a FD on the request for review of the written record, see sub-subsection (4) below.)

(a) The objections and evidence are considered at the hearing and addressed in the post-hearing FAB decision. No review of the written record decision is issued. ECS must be updated to reflect a Request for a Hearing, rather than a Request for a Review of the Written Record.

(b) In cases with multiple claimants when one claimant requests a review of the written record and another requests a hearing, no decision is issued to either claimant until the hearing process is complete. FAB may contact the claimant who requested a review of the written record and ask if he or she would like to address objections to the RD for which a review of the written record was requested at the time of the hearing on the other RD. If he or she agrees, the Review of the Written Record is changed to a hearing in ECS. If he or she declines, his or her objections will be reviewed as part of the hearing decision. Coding in ECS must be updated to reflect a Request for a Hearing rather than a Request for a Review of the Written Record and a note should be added to ECS explaining this action. All claimants, whether they request a hearing or not, are served with notice of the hearing and are afforded the

opportunity to be present at the hearing and participate. The request for Review of the Written Record objections and the objections discussed at the hearing will be addressed in one FD.

(3) Hearing Request on One RD, No Objection Filed on Another. While awaiting a hearing on one RD, the FAB may issue a FD on another RD if the 60-day period for objecting has passed without objection from the claimant. However, if at the time of a hearing, there is one or more pending RDs, the claimant may offer testimony or evidence in response to any of the pending decisions, even if outside of the 60-day period in which to object. The FAB HR must subsequently address such testimony or evidence to determine whether a FD or Remand Order is appropriate.

(4) Hearing Request on One RD, FD Issued on Another. A claimant may request a hearing on one RD and a reconsideration of a previously issued FD within 30 days of its issuance.

(a) If a FD has been issued and a hearing is held regarding an outstanding RD within the 30-day post-decision reconsideration period, the HR reviews any new evidence related to the previously issued FD as a request for reconsideration. Reconsideration requests cannot be assigned to a FAB representative who has had prior involvement with the claim. If the FD was issued by the HR present at the hearing, the reconsideration request should be assigned to another FAB representative. A decision on the reconsideration should be issued separately from the hearing decision.

(b) If the claimant presents evidence or argument pertaining to a FD at the hearing and the hearing date is outside of the 30-day post-decision reconsideration period, the evidence is referred to the DD with jurisdiction over the case file for reopening consideration.

It has been updated in v10 to:

6. <u>Hearing Requests</u>. An oral hearing permits the claimant, his or her AR, and any witnesses to voice objections to a HR.

a. Initial Handling of Hearing Requests. Case files are automatically assigned to HRs when an RD is issued. Upon upload into OIS of a timely written request for a hearing in response to the RD, the assigned HR becomes responsible for scheduling the hearing. However, FAB

management may assign or reassign cases as needed, and the new HR is responsible for the case, including any remaining actions regarding a hearing.

b. Acknowledgement. Once the timely written request is uploaded into OIS, the HR assigned to the case telephones the claimant, or AR, to acknowledge receipt of the hearing request. The HR is to engage with the claimant, or AR, to settle on a mutually acceptable date and time for the hearing. As part of the communication with the claimant, the HR is to reach agreement on the hearing format (telephone or video). The HR is to record any arrangements in an ECS telephone call note. If the HR is unable to contact the claimant, or the claimant's AR, the HR is to record at least two attempted calls in the ECS telephone log. The attempted calls should occur on two different days, at different times of day. In the event that the HR is unable to make verbal arrangements for the hearing, the HR proceeds with scheduling the hearing absent input of the claimant or their AR. If multiple claimants in a case request a hearing, the HR contacts the claimant who made the first request, and coordinates the date and time with that claimant.

c. Hearing Notification. Once the HR has arranged a hearing, the HR completes an internal referral document and forwards it to a Hearing Scheduler. Once the Hearing Scheduler receives the referral document from the HR, the Hearing Scheduler undertakes actions necessary to facilitate the hearing, arranging for a court reporter to record the proceedings, and for telephonic hearings, obtaining a single-use conference calling number. The Hearing Scheduler then prepares and mails a Notice of Hearing to the claimant and AR, updating ECS with the pertinent information relating to the scheduled hearing. The Hearing Scheduler then completes the referral document(s) received from the HR and emails a copy to the assigned HR. The Hearing Scheduler also attaches a copy of the finalized Notice of Hearing to the email. The Hearing Scheduler is to upload all finalized documents, including the completed referral document from the HR, into the OIS.

If the Hearing Scheduler cannot accommodate the requested hearing date for whatever reason, the Hearing Scheduler is to contact the HR and explain the need for a new date for the hearing. Under this circumstance, it may be necessary for the HR to contact the claimant to ascertain a new hearing date. Once the new hearing date is determined, the HR will contact the Hearing Scheduler to notify the HR of the new hearing date. The HR will then complete an updated referral document.

(1) Within the hearing notice, FAB will provide each claimant written notice of the scheduled hearing including instructions for the hearing logistics (video or telephone). The notice provides other

important information about the hearing, including the claimant's rights to have other participants present.

d. Changes to the Scheduled Hearing. The assigned HR may consider a reasonable request to postpone a hearing. The assigned HR may accommodate a scheduled hearing change; however, the claimant must document a convincing or compelling basis for any hearing postponement; including the death of a close family member, documented illness, or some other justifiable explanation. The HR must receive clearance from a FAB management official to postpone a hearing.

(1) Failure to Attend. If a claimant does not attend the scheduled hearing and makes no effort to contact the HR to request a rescheduling based on one of the reasons outlined in paragraph d(4) above, the claimant will not be allowed to reschedule his or her hearing. In such instances, the claimant will be considered to have withdrawn the hearing request, and a review of the written record will be undertaken. If new evidence or argument accompanied the objection, it will be reviewed in the review of the written record.

(2) Cancellation of Hearing. If upon review, the HR determines that an error or other deficiency in the RD or initial case adjudication precludes the need for a hearing, and the FAB supervisor agrees, the HR will notify the claimant that the hearing will not be scheduled, and a Remand Order will be prepared.

When a hearing is canceled for any other reason, the FAB acknowledges the cancellation in writing and gives the claimant 10 days from the date of the acknowledgement to submit additional evidence. The FAB representative then conducts a review of the written record.

(3) Resumption of FAB review after claim withdrawal. A claimant may choose to withdraw a claim prior to the issuance of a FD. If FAB had scheduled a hearing, a withdrawal of the claim will also constitute a withdrawal of the request for a hearing. Under this circumstance, should the claimant seek to resume adjudication of the claim, a hearing will not occur and instead the FAB will undertake a review of the written record at the conclusion of any balance of the 60-day period remaining for the claimant to submit evidence for consideration. If the claimant did not file an objection prior to a withdrawal of a claim, and the claimant later seeks to resume adjudication of the claim, the claimant retains their right to object and/or request a hearing for any remaining

balance of the 60-day period for filing objections that existed prior to the claim withdrawal.

e. Review of Case File. Prior to the hearing, the HR reviews the evidence of record, as well as any additional evidence or materials submitted by the claimant and conducts whatever additional investigation is deemed necessary to prepare for the proceedings. If the additional evidence received establishes compensability or the need for further development and the FAB supervisor agrees, the HR will notify the claimant and/or AR that the claim will be remanded, and the hearing will be canceled. If the evidence is sufficient to warrant reversal in favor of the claimant, FAB may issue a reversal.

f. Multiple RDs. Since more than one RD can be issued prior to a hearing and additional objections and hearing requests may result, measures are needed to streamline the hearing process. If more than one RD is pending a FD, the HR contacts each objecting claimant and advises that all objections, not just those pertaining to the RD that is the subject of the hearing request, may be discussed during the hearing. The claimant(s) will be encouraged to present relevant evidence, even if it concerns a RD for which a timely objection was not filed. All telephonic contact prior to the hearing is documented in ECS.

(1) Hearing Requests on Multiple RDs Pending a FD. When additional timely hearing requests are submitted based on other recommended denials prior to the date of the previously scheduled hearing, the HR contacts the requesting party to advise that all objections will be considered so that one hearing may serve to accept evidence and testimony on several different RDs. This process is designed to avoid multiple hearings.

The HR notes the conversation with the claimant in ECS, confirming that the claimant was advised that all outstanding objections will be considered at the hearing. The HR updates ECS for each RD and each claimant requesting the hearing.

Separate hearing request acknowledgments and hearing notices are not required. The HR must be prepared to entertain objections about all RDs issued up to the date of the hearing and will take testimony and evidence on all outstanding objections. Each RD in question is considered in a single FAB decision once the FAB hearing process is concluded.

(2) Hearing Request on One RD, Request for Review of the Written Record on Another. If a claimant has requested a hearing on one outstanding RD and a review of the written record on another, the

HR allows the claimant to present evidence about the objections which are not the subject of the hearing, so long as FAB has not issued a FD on the review of the written record request. (If FAB has issued a FD on the request for review of the written record, see sub-subsection (4) below.)

(a) The objections and evidence are considered at the hearing and addressed in the post-hearing FAB decision. No review of the written record decision is issued. ECS must be updated to reflect a Request for a Hearing, rather than a Request for a Review of the Written Record.

(b) In cases with multiple claimants when one claimant requests a review of the written record and another requests a hearing, no decision is issued to either claimant until the hearing process is complete. FAB may contact the claimant who requested a review of the written record and ask if he or she would like to address objections to the RD for which a review of the written record was requested at the time of the hearing on the other RD. If he or she agrees, the Review of the Written Record is changed to a hearing in ECS. If he or she declines, his or her objections will be reviewed as part of the hearing decision. Coding in ECS must be updated to reflect a Request for a Hearing rather than a Request for a Review of the Written Record and a note should be added to ECS explaining this action. All claimants, whether they request a hearing or not, are served with notice of the hearing and are afforded the opportunity to be present at the hearing and participate. The request for Review of the Written Record objections and the objections discussed at the hearing will be addressed in one FD.

(3) Hearing Request on One RD, No Objection Filed on Another. While awaiting a hearing on one RD, the FAB may issue a FD on another RD if the 60-day period for objecting has passed without objection from the claimant. However, if at the time of a hearing, there is one or more pending RDs, the claimant may offer testimony or evidence in response to any of the pending decisions, even if outside of the 60-day period in which to object. The FAB HR must subsequently address such testimony or evidence to determine whether a FD or Remand Order is appropriate.

(4) Hearing Request on One RD, FD Issued on Another. A claimant may request a hearing on one RD and a reconsideration of a previously issued FD within 30 days of its issuance.

(a) If a FD has been issued and a hearing is held regarding an outstanding RD within the 30-day post-decision reconsideration period, the HR reviews any new evidence related to the previously issued FD as a request for reconsideration. Reconsideration requests cannot be assigned to a FAB representative who has had prior involvement with the claim. If the FD was issued by the HR who conducted the hearing, the reconsideration request should be assigned to another FAB representative. A decision on the reconsideration should be issued separately from the hearing decision.

(b) If the claimant presents evidence or argument pertaining to a FD at the hearing and the hearing date is outside of the 30-day post-decision reconsideration period, the evidence is referred to the DD with jurisdiction over the case file for reopening consideration.

- Ch. 25.7 has been edited to provide clarity regrading the length of a hearing. The language in v.9.0 read:

7. <u>Conduct of the Hearing</u>. The hearing is an informal proceeding, and the HR is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. Generally, the hearing is scheduled to last one hour, but the HR should not specifically limit the hearing to one hour and should never tell a claimant that he or she is limited to one hour. Also, the HR must bring a tape recorder to the hearing in case a court reporter is not present. The HR must ensure that the court reporter is using required back-up recorders.

It has been updated in v10 to:

7. <u>Conduct of the Hearing</u>. The hearing is an informal proceeding, and the HR is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. FAB will schedule the hearing for a duration of one hour during which the claimant/AR may present their oral testimony. At the expiration of the allotted hour, the assigned HR is to conclude the hearing and advise the claimant/AR that if they have additional argument or evidence for consideration, it must be submitted in writing. The HR is permitted to extend the duration of a hearing if the HR deems it necessary and appropriate. If transcription of the hearing is not possible, the FAB should reschedule the hearing to a later date, if possible, or provide a review of the written record.

- Exhibit 25-1: Sample Hearing Notice, Objection Filed, and any reference to this exhibit within the text of Chapter 25, have been removed, as it is available in CCAT.

- Exhibit 25-2: Sample Hearing Notice, No Objection Filed, and any reference to this exhibit within the text of Chapter 25, have been removed, as it is available in CCAT.

- Based on the removal of the exhibits listed above, the remaining exhibits of Chapter 25 have been renumbered accordingly.

- **Chapter 26 – FAB Decisions**

  - Ch. 26.3b(2)(a) has been added to incorporate guidance regarding a Hearing Representative's (HRs) processing of simple acceptances to allow for the HR to reference the case history as outlined in the RD under consideration in place of a detailed Statement of the Case. Ch. 26.3b(2)(a) has been added in v10 to read:

    (a) In the case of a simple acceptance, in which all claimed conditions included in the decision are being accepted and the HR agrees with the essential facts, relevant case history, and the outcome stated in the RD, the HR may simply state that FAB has reviewed the evidence and concurs with the case history described in the RD under consideration.

  - Ch. 26.4 has been edited to grant HRs discretion with respect to how objections are addressed within a Remand Order. The language in v.9.0 read:

    4. Remand Orders. If the FAB determines that the claim(s) addressed in the RD are not in posture for FD, 20 C.F.R. § 30.317 gives FAB the authority to return cases to the DO without issuing a FD. A Remand Order is a written directive to the DO issued in lieu of a FD.

    A Remand Order is written in narrative format to the claimant(s) but does not contain the normal sections of a FD (Statement of Case, Findings of Fact, and Conclusions of Law). However, where objections have been filed or a hearing has been held, the remand order should discuss and respond to the objections raised. It may instruct the DO to perform further development, address an error or other deficiency contained in a RD, address new evidence or a new claim received prior to the issuance of the FD, or address a change in the law, regulations, policies, or procedures. A Remand Order can be warranted at any point during a review of the written record, before or after a hearing, or during the review of a RD.

    FAB is to use reasonable discretion when assessing a case for remand. If the RD provides sound reasoning and thorough discussion of how it reached its conclusions and does not include material factual errors or erroneous application of law, the FAB must respect the DOs adjudicatory function. If FAB can make a reasonable determination that the outcome of the case would not be materially affected regardless of further development, FAB should exercise its discretion and not issue a Remand Order. Should the FAB find a technical, procedural, or some other error requiring a remand order, the FAB returns the case file to the DO with specific instructions in the remand order as to how to proceed further. Remand orders are largely issued in instances where

further development is required at the DO level. FAB does not issue a remand order where FAB personnel can conduct minor development to resolve the issue at hand.

It has been updated in v10 to:

4. Remand Orders. If the FAB determines that the claim(s) addressed in the RD are not in posture for FD, 20 C.F.R. § 30.317 gives FAB the authority to return cases to the DO without issuing a FD. A Remand Order is a written directive to the DO issued in lieu of a FD.

A Remand Order is written in narrative format to the claimant(s) but does not contain the normal sections of a FD (Statement of Case, Findings of Fact, and Conclusions of Law). The Remand Order is a narrative explanation of the FAB's justification for not accepting the recommendation of a district office to accept or deny a claim. In responding to objection(s) to a recommendation from the claimant or their AR, FAB must respond to those objections that are pertinent to, or contribute to, the justification for the remand. Within the narrative content of the remand, the FAB may provide guidance to the district office about the needed consideration of newly received evidence; pathways of suggested development including those relating to a change in the law, regulations, policies or procedures; or the need to overcome a particular error or deficiency. A Remand Order can be warranted at any point during a review of the written record, before or after a hearing, or during the review of a RD.

FAB is to use reasonable discretion when assessing a case for remand. If the RD provides sound reasoning and thorough discussion of how it reached its conclusions, and it does not include material factual errors or erroneous application of law, FAB must respect the DOs adjudicatory function. If FAB can make a reasonable determination that the outcome of the case would not be materially affected regardless of further development, FAB should exercise its discretion and not issue a Remand Order.

Should the FAB find a technical, procedural or some other error requiring a Remand Order, the FAB returns the case file to the DO with guidance about suggested courses of corrective action. In those instances where FAB can overcome a deficiency through timely development including clarification of an issue from the claimant or a provider, or a follow-up referral to DEEOIC medical health science specialists, FAB has the authority to undertake such development to avoid the necessity of a remand.

- Ch. 26.4h has been edited to remove reference to jurisdictional offices. The language in v9.0 previously read:

h. Format of Remand Order. A Remand Order (Exhibit 26-5) follows a narrative format and is directed to the DO which issued the RD. It includes a brief discussion of the claim's adjudicatory history when pertinent to the matter at hand, the basis for the remand, any explanation and supplemental documentation required and an explanation of the actions to be undertaken by the DO.

It has been updated in v10 to:

h. Format of Remand Order. A Remand Order (Exhibit 26-2) follows a narrative format and is directed to the DO. It includes a brief discussion of the claim's adjudicatory history when pertinent to the matter at hand, the basis for the remand, any explanation and supplemental documentation required and an explanation of the actions to be undertaken by the DO.

- Ch. 26.4i(1) has been modified to remove the requirement that the cover letter of a Remand Order include the address and telephone number of the district office to which the case is being returned. The language in v9.0 previously read:

(1) The cover letter explains the Remand Order and the DOs responsibility for preparing a new RD after further development. Additionally, the cover letter advises the claimant to which office the case file is being forwarded and provides the address and telephone number of that office (see Exhibit 26-5).

It has been updated in v10 to:

(1) The cover letter explains the Remand Order and the DOs responsibility for preparing a new RD after further development.

- Exhibit 26-1, Sample Final Decision Cover Letter, and any reference to this exhibit within the text of Chapter 26, have been removed.

- Exhibit 26-2, Sample Final Decision, and any reference to this exhibit within the text of Chapter 26, have been removed.

- Exhibit 26-3, Sample Certificate of Service, and any reference to this exhibit within the text of Chapter 26, have been removed.

- Exhibit 26-8, Sample Cover Letter, Alternative Filing – Denial, and any reference to this exhibit within the text of Chapter 26, have been removed.

- Based on the removal of the exhibits listed above, the remaining exhibits of Chapter 26 have been renumbered accordingly.

- **Chapter 29 – Ancillary Medical Benefits**

  - Ch. 29.4a-d has been modified to allow 30 calendar days for a response to Medical Benefit Examiner (MBE) development letters to treating physicians. The language in v9.0 previously read:

a. Communication with the Treating Physician. The MBE should consider the claimant's treating physician as the primary source of medical information supporting the need for medical benefits. As such, the MBE should permit the

treating physician the opportunity to address any questions or other deficiencies the MBE identifies during an examination of the medical evidence. The simplest course of action may be for the MBE to contact the physician's office by telephone. If a telephone call results in a clarifying response, and appropriate information is forthcoming, no further action may be necessary. However, if a telephone call is not productive, a letter to the physician is necessary. Any such letter to the physician who signed the LMN should be clear and concise. The MBE should identify the specific issue requiring clarification and should describe the evidence or information the MBE needs to proceed with adjudication of the claimant's request for reimbursement of services or expenses.

The MBE's development letter to the physician should request a response within 15 calendar days. If the requested evidence is not received within the 15-day period, the MBE sends a second development letter, providing an additional 15 days for submission of the requested evidence. The MBE should provide a copy of the development letters to the claimant and AR. The development letter should clearly state that a lack of response, or submission of insufficient evidence, will result in a denial of the request. Exhibit 29-1 provides a sample development letter for AMB requests. Upon sending any development letter, the MBE updates the ECS Correspondence section.

b. Nurse Consultant Referrals. DEEOIC Nurse Consultants assess medical evidence to ensure it reasonably supports the services or expenses prescribed by the treating physician. At any point in the development process, the MBE can request a Nurse Consultant review of the evidence. Upon receipt of a referral from a MBE, a Nurse Consultant does not offer a recommendation regarding what is appropriate for the claimant but assists by providing advice allowing the MBE to make an informed decision whether to authorize the AMB prescribed or undertake further development.

a. 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.

It has been updated in v10 to:

a. Communication with the Treating Physician. The MBE should consider the claimant's treating physician as the primary source of medical information supporting the need for medical benefits. As such, the MBE should permit the treating physician the opportunity to address any questions or other deficiencies

the MBE identifies during an examination of the medical evidence. The simplest course of action may be for the MBE to contact the physician's office by telephone. If a telephone call results in a clarifying response, and appropriate information is forthcoming, no further action may be necessary. However, if a telephone call is not productive, a letter to the physician is necessary. Any such letter to the physician who signed the LMN should be clear and concise. The MBE should identify the specific issue requiring clarification and should describe the evidence or information the MBE needs to proceed with adjudication of the claimant's request for reimbursement of services or expenses.

The MBE's development letter to the physician should request a response within 30 calendar days. The MBE should provide a copy of the development letters to the claimant and AR. The development letter should clearly state that a lack of response, or submission of insufficient evidence, will result in a denial of the request. Exhibit 29-1 provides a sample development letter for AMB requests. Upon sending any development letter, the MBE updates the ECS Correspondence section.

b. Nurse Consultant Referrals. DEEOIC Nurse Consultants assess medical evidence to ensure it reasonably supports the services or expenses prescribed by the treating physician. At any point in the development process, the MBE can request a Nurse Consultant review of the evidence. Upon receipt of a referral from a MBE, a Nurse Consultant does not offer a recommendation regarding what is appropriate for the claimant but assists by providing advice allowing the MBE to make an informed decision whether to authorize the AMB prescribed or undertake further development.

c. Medical Officer Referrals. Medical Officers are an OWCP qualified physician or pharmacist who may conduct a review of the case file records in situations involving complex medical issues, deviations from accepted medical standards, or the need to ensure any recommended treatment is in alignment with program regulations and guidelines. The Medical Officer may also conduct a review of cases designated as terminal, where timely analysis is critical. Upon receipt of a referral from a MBE, a Medical Officer or pharmacist may provide advice to allow the MBE to make an informed decision whether to authorize the request or undertake further development.

d. 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.

- Ch. 29.5a(3) has been edited to clarify that oxygen related equipment and supplies may be approved for up to 12 months. The language in v9.0 previously read:

  (3) Oxygen Therapy DME and Oxygen Medical Accessories. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Accessories to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Accessories include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery systems, cannulas, tubing, regulators, etc. (Exhibit 29-2 provides definitions and describes the functions of some of the more commonly prescribed oxygen DME).

It has been updated in v10 to:

  (3) Oxygen Therapy DME and Oxygen Medical Accessories. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Accessories to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Accessories include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery systems, cannulas, tubing, regulators, etc. (Exhibit 29-2 provides definitions and describes the functions of some of the more commonly prescribed oxygen DME). Oxygen related equipment and supplies may be approved for up to 12 months.

- Ch. 29.6 has been updated to clarify that a claimant must submit letter of medical necessity(LMN), or sufficient medical documentation that provide a convincing and compelling medical rationale explaining why the billed service, prescription drug, or other medical benefit, is medically necessary to address the effect(s) of an accepted medical condition, and any claim unaccompanied by a LMN or medical report with sufficient rationale will require development. The language in v9.0 previously read:

  6. <u>Exception Processing for Denied Medical Benefit Charges Under the OWCP Treatment Suites</u>. At the core of the medical bill reimbursement process is the use of treatment suites. Treatment suites categorize those medical services that a physician or provider routinely and customarily uses to treat the effect of an accepted medical condition. Using that categorization, DEEOIC automates the payment of billed charges that align with services permitted under a treatment suite. DEEOIC reimburses service charges under the treatment suite at a set rate of reimbursement in accordance with a standardized fee schedule.
  Upon denial of a billed service charge, the BPA issues an Explanation of Benefit (EOB), to the billing provider, communicating the reason(s) for the bill rejection. Reasons for rejection of a bill can include incomplete documents, inaccurate or improper coding, duplicate billing, etc. Under these circumstances, it is necessary for the provider to correct and resubmit the bill for processing.

  In other instances, the EOB might communicate that the billed treatment, service, or prescription drug, is not included in one of the OWCP treatment suites, for any of the claimant's accepted conditions. When this occurs, a claimant may choose to submit a claim requesting to have the rejected charge evaluated for exception approval by

DEEOIC. This exception process is a mechanism for manual review, by an MBE, to determine if the rejected service, prescription medication, or other medical benefit, is medically necessary for the care of an accepted illness, thus eligible for reimbursement authorization, by DEEOIC, on an exception basis.

Upon notification of the rejection of a service charge or prescription drug as unrelated to the care of an accepted medical condition, a claimant must submit a written claim to DEEOIC, asking for a review of the denied charge. In the request, the claimant must communicate disagreement with denial of the service charge. Any such claim must include information identifying the nature of the disputed charge (i.e., medical service, prescription drug charge, or other medical benefit rejected), dates of service (if applicable), and the billed amount in dispute. The claimant must also submit a LMN providing a convincing and compelling medical rationale explaining why the billed service, prescription drug, or other medical benefit, is medically necessary to address the effect(s) of an accepted medical condition. Any such claim, unaccompanied by a LMN, will require development by the MBE before proceeding with adjudication.

It has been updated in v10 to:

6. <u>Exception Processing for Denied Medical Benefit Charges Under the OWCP Treatment Suites</u>. At the core of the medical bill reimbursement process is the use of treatment suites. Treatment suites categorize those medical services that a physician or provider routinely and customarily uses to treat the effect of an accepted medical condition. Using that categorization, DEEOIC automates the payment of billed charges that align with services permitted under a treatment suite. DEEOIC reimburses service charges under the treatment suite at a set rate of reimbursement in accordance with a standardized fee schedule.

Upon denial of a billed service charge, the BPA issues an Explanation of Benefit (EOB), to the billing provider, communicating the reason(s) for the bill rejection. Reasons for rejection of a bill can include incomplete documents, inaccurate or improper coding, duplicate billing, etc. Under these circumstances, it is necessary for the provider to correct and resubmit the bill for processing.

In other instances, the EOB might communicate that the billed treatment, service, or prescription drug, is not included in one of the OWCP treatment suites, for any of the claimant's accepted conditions. When this occurs, a claimant may choose to submit a claim requesting to have the rejected charge evaluated for exception approval by DEEOIC. This exception process is a mechanism for manual review, by an MBE, to determine if the rejected service, prescription medication, or other medical benefit, is medically necessary for the care of an accepted illness, thus eligible for reimbursement authorization, by DEEOIC, on an exception basis.

Upon notification of the rejection of a service charge or prescription drug as unrelated to the care of an accepted medical condition, a claimant must submit a written claim to DEEOIC, asking for a review of the denied charge. In the request, the claimant must

communicate disagreement with denial of the service charge. Any such claim must include information identifying the nature of the disputed charge (i.e., medical service, prescription drug charge, or other medical benefit rejected), dates of service (if applicable), and the billed amount in dispute. The claimant must also submit a LMN or sufficient medical documentation that provides a convincing and compelling medical rationale explaining why the billed service, prescription drug, or other medical benefit, is medically necessary to address the effect(s) of an accepted medical condition. Any such claim, unaccompanied by a LMN or medical report with sufficient rationale will require development by the MBE before proceeding with adjudication.

- Ch. 29.7 has been updated to include guidance that was previously the subject of EEOICPA Bulletin No. 25-01. The language in v9.0 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 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.

It has been updated in v10 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. Authorization for AMB, including use of recurring durable medical equipment; rehabilitative therapies, treatments, and services; and medical supplies are authorized in 6-month increments, unless another duration of authorization is explicitly stipulated or required by procedure. 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.*

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

  - Ch. 30.2h has been updated to clarify the definition of "homebound." The language in v9.0 previously read:

    h. Homebound. Generally, homebound refers to the inability of a claimant to leave their place of residence, due to illness or injury. Claimants do not need to be totally immobilized or bedridden to be homebound but should only be able to leave their residence infrequently and for short durations. Any departure of the claimant from his/her residence must incur considerable and taxing effort.

  It has been updated in v10 to:

    h. Homebound. Generally, homebound refers to the inability of a claimant to leave their place of residence, due to illness or injury. A claimant's homebound status may be permanent, transient, or temporary (e.g., short recovery period after hospital discharge) due to the nature of the employee's accepted condition.

Claimants do not need to be totally immobilized or bedridden to be homebound but should only be able to leave their residence infrequently and for short durations. Any departure of the claimant from his/her residence must incur considerable and taxing effort.

- Ch. 30.2q has been added to include the definition of "Medical Officers." Based on the insertion of this definition, the remaining subsections of Ch. 30.2 have been renumbered accordingly. Ch. 30.2q has been added in v10 to read:

  q. Medical Officers. A Medical Officer is an OWCP qualified physician or pharmacist who may conduct a review of the case file records where a case involves complex medical issues, deviations from accepted medical standards, or the need to ensure any recommended treatment is in alignment with program regulations and guidelines. The Medical Officer may also conduct a review of cases designated as terminal, where timely analysis is critical.

- Ch. 30.5a(6) has been modified to include additional information on what is required in a physician's narrative and supporting documentation to demonstrate a claimant is primarily homebound. The language in v9.0 previously read:

  (6) Conditions Requiring Care. A LMN for a DEEOIC HRHC authorization must provide a clear explanation of the medical evidence supporting the justification for HRHC services related to the claimant's accepted conditions. The physician should also describe any effect that non-covered illnesses have on the claimant's need for particular HRHC services; and the treating physician must make an effort to differentiate those services from services required because of the accepted conditions.

It has been updated in v10 to:

  (6) Conditions Requiring Care. A LMN for a DEEOIC HRHC authorization must provide a clear explanation of the medical evidence supporting the justification for HRHC services related to the claimant's accepted condition(s). The physician should also describe any effect that non-covered illnesses have on the claimant's need for particular HRHC services; and the treating physician must make an effort to differentiate those services from services required because of the accepted conditions. The physician's narrative and supporting documentation must demonstrate the claimant is primarily confined to the home and any departure of the claimant from the residence must incur considerable and taxing effort.

- Ch. 30.6c has been added to include additional guidance regarding Medical Officer referrals. Based on the insertion of this new language, the remaining subsections of Ch. 30.6 have been renumbered accordingly. Ch. 30.6c has been added in v10 to read:

  c. Medical Officer referrals. Upon receipt of a referral from a MBE, a Medical

Officer or pharmacist may provide advice to allow the MBE to make an informed decision whether to authorize the request or undertake further development.

- Ch. 30.7 has been modified to eliminate the requirement that MBEs send two 15-day development letters within the 30 days provided for a response. The language in v9.0 previously read:

7. <u>Developing Evidence to Support HRHC Requests</u>. The goal of MBE development is to obtain medical evidence substantiating that the need for HRHC is medically appropriate to address the effects of an accepted illness. To attain this goal, the MBE should focus development specifically on the topic or issue that is preventing an authorization at the type/level/frequency/duration/period of care prescribed in the physician's LMN.

a. Initial Review. Upon receipt of a request for HRHC, the MBE reviews the case to determine if the basic requirements necessary to substantiate an HRHC request are present.

(1) Evidence that the physician conducted a face-to-face examination of the claimant within 60 days of the date of the LMN.

(2) Evidence supports that the requested HRHC is related to one or more accepted conditions.

(3) The type/level/frequency/duration/period of prescribed care is described clearly, including any need to move to an ALF or nursing home.

b. Incomplete or defective evidence. If, upon review of the case evidence, the MBE finds that any of the basic criteria, above, are missing, or there is a documented defect in the medical evidence that conflicts with the care prescribed in the LMN the MBE is to initiate development. The duration allocated by the MBE for the submission of necessary evidence to support a HRHC claim is 30 days. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period provided, the MBE sends a second development letter, providing an additional 15 days to submit the requested documentation.

(1) For issues requiring development, the MBE is to prepare a letter to the treating physician briefly summarizing any deficiencies in the LMN and requesting a response from the physician addressing those deficiencies. The MBE is to request a response, along with an amended LMN, if appropriate. The MBE is to send a copy of the development letter to the claimant and any designated AR.

(a) Upon receipt of a response, the MBE is to evaluate information supplied by the treating physician to determine if the information adequately addresses the concern(s) identified for evaluation. Should the MBE determine that the physician's response is adequate, the MBE authorizes reimbursement of care as prescribed.

(b) Upon receipt of a response from the treating physician, that is not fully responsive, or in those situations where the MBE has not received a response to an inquiry after the allotted 15 days, the MBE is to make a determination based on the available medical evidence. Options available to the MBE at this point include a partial authorization, a denial of the request, or a decision to undertake additional development.

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.

d. Where the claimant is seeking an adjustment to a previously authorized level of HRHC to a higher level, the MBE is to undertake development to determine if the need for an adjustment to the level/frequency/duration of HRHC is medically appropriate.

e. Development involving renewal of a prior HRHC authorization may require the MBE to issue periodic extensions of an existing authorization (increments not to exceed 30 days), until the MBE reaches a resolution of the medical appropriateness of renewal.

f. 60 days prior to the expiration of an existing HRHC authorization, the MBE is to notify the claimant of the need for a renewal request and updated LMN, based upon a current (within 60 days) face-to-face examination with his or her selected physician.

It has been updated in v10 to:

7. <u>Developing Evidence to Support HRHC Requests</u>. The goal of MBE development is to obtain medical evidence substantiating the need for HRHC is medically appropriate to address the effects of an accepted illness. To attain this goal, the MBE should focus development specifically on the topic or issue that is preventing an authorization at the type/level/frequency/duration/period of care prescribed in the physician's LMN.

a. Initial Review. Upon receipt of a request for HRHC, the MBE reviews the case to determine if the basic requirements necessary to substantiate an HRHC request are present.

(1) Evidence that the physician conducted a face-to-face examination of the claimant within 60 days of the date of the LMN.

(2) Evidence supports that the requested HRHC is related to one or more accepted conditions.

(3) The type/level/frequency/duration/period of prescribed care is described clearly, including any need to move to an ALF or nursing home.

b. Incomplete or defective evidence. If, upon review of the case evidence, the MBE finds that any of the basic criteria, above, are missing, or there is a documented defect in the medical evidence that conflicts with the care prescribed in the LMN the MBE is to initiate development. The duration allocated by the MBE for the submission of necessary evidence to support a HRHC claim is 30 days.

(1) For issues requiring development, the MBE is to prepare a letter to the treating physician briefly summarizing any deficiencies in the LMN and requesting a response from the physician addressing those deficiencies. The MBE is to request a response, along with an amended LMN, if appropriate. The MBE will advise the claimant that the MBE cannot process the claimant's HRHC claim without the additional information. The MBE is to send a copy of the development letter to the claimant, treating physician, and any designated AR. The MBE will also fax a copy of the letter to the claimant's treating physician.

(a) Upon receipt of a response, the MBE is to evaluate information supplied by the treating physician to determine if the information adequately addresses the concern(s) identified for evaluation. Should the MBE determine that the physician's response is adequate, the MBE authorizes reimbursement of care as prescribed.

(b) Upon receipt of a response from the treating physician, that is not fully responsive, after the allotted 30 days, the MBE is to make a

determination based on the available medical evidence. Options available to the MBE at this point include a partial authorization, a denial of the request, or a decision to undertake additional development.

c. CMC File Review, SECOP examinations, and referee medical opinion. Upon completion of development to the claimant's treating physician and receipt of a narrative that is not fully responsive, the MBE may 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, and receipt of a well-rationalized CMC medical opinion, 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 the MBE may make a determination based on the weight of the medical evidence or may 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, or the CMC file review suggests a reduction in the services previously authorized, 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.

d. Where the claimant is seeking an adjustment to a previously authorized level of HRHC to a higher level, the MBE is to undertake development to determine if the need for an adjustment to the level/frequency/duration of HRHC is medically appropriate. The MBE may review the written summary of nursing care encounters (nursing notes) to assess the current needs of the claimant and support evidence of a decline in the claimant's accepted medical conditions. Documentation such as checklists without narrative descriptions of activities and claimant responses do not provide a sufficient level of detail to affirm or support the authorization for an increase in care.

e. Development involving renewal of a prior HRHC authorization may require the MBE to issue periodic extensions of an existing authorization (increments not to exceed 30 days), until the MBE reaches a resolution of the medical appropriateness of renewal.

- Exhibit 30-1, Sample Letter to Physician, and any reference to this exhibit within the text of Chapter 30, have been removed, as it is now available in CCAT. As such, the remaining exhibit of Chapter 30 has been renumbered accordingly.

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

  - Ch. 31.6 has been edited to clarify that tort offset is based on exposure, regardless of the claimed condition. The language in v9.0 previously read:

6. <u>Tort Offset, Parts B and/or E</u>. If the lawsuit has not adversely affected the claimant's eligibility under Part B due to election of remedies, an offset of the potential Part B and/or E award may still be needed. EEOICPA benefits are only offset if the basis for the lawsuit and the payable EEOICPA claim are due to injuries from exposure to the same toxic substance. For example, if the claimant filed a lawsuit for lung cancer based on exposure to asbestos and the Part E claim that is payable is also based on lung cancer due to exposure to asbestos, offset is required. As long as there is one exposure that

would be compensable, offset is required even if the lawsuit or EEOICPA claim is based on several other different exposures.

It has been updated in v10 to:

6. <u>Tort Offset, Parts B and/or E</u>. If the lawsuit has not adversely affected the claimant's eligibility under Part B due to election of remedies, an offset of the potential Part B and/or E award may still be needed. EEOICPA benefits are only offset if the basis for the lawsuit and the payable EEOICPA claim are due to exposure to the same toxic substance. For example, if the claimant filed a lawsuit for lung cancer based on exposure to asbestos that resulted in lung cancer, and the Part E claim that is payable is also based on lung cancer due to exposure to asbestos, offset is required. As long as there is one exposure that would be compensable, offset is required, even if the lawsuit or EEOICPA claim is based on several other different exposures. Also, offset is required when the exposure forming the basis of a tort lawsuit is the same exposure for which benefits are payable under EEOICPA, regardless of the resulting medical condition. For example, if a tort settlement is obtained for asbestos exposure, an EEOICPA claim payable for asbestos exposure must be offset, even if the conditions referred to in the tort settlement and the EEOICPA claim are different.

- Ch. 31.7a has been edited to remove outdated reference to RD cover letters. The language in v9.0 previously read:

  a. Tort Payment Pending at the DO. If the tort payment is pending at the time of the RD, the CE issues the RD without an offset. However, the CE states in the RD's cover letter that if the claimant receives tort payment after the issuance of the RD, but before issuance of the FD, the claim will be remanded by the FAB for offset and a new RD.

  It has been updated in v10 to:

  a. Tort Payment Pending at the DO. If the tort payment is pending at the time of the RD, the CE issues the RD without an offset. However, the CE states in the RD's Explanation of Findings section that if the claimant receives tort payment after the issuance of the RD, but before issuance of the FD, the claim will be remanded by FAB for offset and a new RD.

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

  - Ch. 32.7a has been updated to remove outdated reference to cover letters. The language in v9.0 previously read:

    a. SWC Payment Pending, Prior to RD. If the claimant filed a SWC claim for the same covered illness, but SWC payment is pending at the time of the RD, the CE issues the RD without any coordination. However, the CE states in the RD's cover letter that if the claimant receives SWC payment after the issuance of the

RD, but before issuance of the FD, the claim will be remanded by the FAB for coordination of benefits and a new RD.

It has been updated in v10 to:

a. SWC Payment Pending, Prior to RD. If the claimant filed a SWC claim for the same covered illness, but SWC payment is pending at the time of the RD, the CE issues the RD without any coordination. However, the CE states in the RD's Explanation of Findings section that if the claimant receives SWC payment after the issuance of the RD, but before issuance of the FD, the claim will be remanded by FAB for coordination of benefits and a new RD.

- **Chapter 33 – Compensation Payments**

  - Exhibit 33-1, Payment Transaction Form for Expedited Processing, as well as any reference to this exhibit within the text of Chapter 33, have been removed as it is available in SharePoint.

  - Exhibit 33-2, Payment Transaction Form for 3rd Party Expedited Processing, as well as all references to this exhibit within the text of Chapter 33, have been removed as it is available in SharePoint.

  - Exhibit 33-3, Payment Transaction Form for Exception Processing; and Exhibit 33-4, ECS Payment Cancellation Form, as well as all references to these exhibits within the text of Chapter 33, have been removed, as it is available in SharePoint.

Rachel D. Pond

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