

# 2015 Annual Report to Congress

## OFFICE OF THE OMBUDSMAN

Energy Employees Occupational Illness Compensation Program



**OFFICE OF THE OMBUDSMAN**  
UNITED STATES DEPARTMENT OF LABOR

Photo on the cover: The Energy Research and Development Administration's Oak Ridge (Tenn.) Gaseous Diffusion Plant is the first such facility built in the world for production of enriched uranium. The original gaseous diffusion process building "K-25," which is the U-shaped building, was constructed in 1943 and began operating in 1945, producing enriched uranium for the Manhattan Project of World War II. Circa 1976. Photo courtesy of ENERGY.GOV.

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**U.S. Department of Labor**

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



December 21, 2016

The Honorable Joseph R. Biden, Jr.  
President of the United States Senate  
Washington, DC 20510

Dear Mr. President:

I am pleased to present the 2015 Annual Report of the Ombudsman for the Energy Employees  
Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,



Malcolm D. Nelson  
Ombudsman for the Energy Employees  
Occupational Illness Compensation Program

Enclosure

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Washington, D.C. 20210



December 21, 2016

The Honorable Paul Ryan  
Speaker of the U.S. House of Representatives  
Washington, DC 20515

Dear Speaker Ryan:

I am pleased to present the 2015 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

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# INTRODUCTION

Section 7385s-15(e) of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or Act), requires the Department of Labor's Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (the Office) to submit an annual report to Congress. This report is to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by the Office during the preceding year and (b) an assessment of the most common difficulties encountered by claimants and potential claimants during that year. See 42 U.S.C. §7385s-15(e). The following is the Office's annual report for calendar year 2015.

## 1. A brief history of the Energy Employees Occupational Illness Compensation Program Act

On January 19, 1942, following the attack on Pearl Harbor, President Franklin D. Roosevelt approved the production of an atomic bomb. The task of constructing an atomic weapons complex was assigned to the U.S. Army Corps of Engineers, and, on August 13, 1942, the Manhattan Engineer District (MED), later known as the Manhattan Project, was established to design and produce an atomic bomb.

The development and production of an atomic bomb was performed at production facilities, towns and research laboratories scattered across the country. See *The Manhattan Project*, Terrence R. Fehner and F.G. Gosling, U.S. Department of Energy, April 2012, pages 1 - 3. Just to name a few, following the creation of the MED, Oak Ridge, Tennessee was selected as the site to produce nuclear materials; Los Alamos, New Mexico was selected as the site for a scientific laboratory to design the bomb; and Hanford, Washington was the site for plutonium production and separation.<sup>1</sup> The production of nuclear weapons did not stop with the end of World War II. Rather, in 1947 the operations of the MED were transferred to the civilian Atomic Energy Commission (AEC), which in later years would become the Department of Energy (DOE).<sup>2</sup> The size of the atomic weapons complex is reflected in a database maintained by DOE. This database identifies over 350 facilities as covered facilities for purposes of EEOICPA.<sup>3</sup> These covered facilities are dispersed among 42 of the 50 states as well as Puerto Rico and the Republic of the Marshall Islands. Estimates suggest that at its peak, the U.S. nuclear weapons program employed more than 600,000 workers, many of whom were contracted through private and academic entities.<sup>4</sup>

## 2. EEOICPA

On October 30, 2000, Congress enacted the Energy Employees Occupational Illness Compensation Program Act at Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. In enacting EEOICPA Congress made a number of findings. Among these findings was recognition that:

<sup>1</sup> The Manhattan Project actually pursued two separate courses in developing an atomic bomb. One course involved the separation of uranium-235. The other course involved fissionable plutonium. Separate facilities were constructed to pursue each of these courses.

<sup>2</sup> The AEC was abolished in 1974 when the Energy Research & Development Administration (ERDA) was created. Thereafter, in 1977 the ERDA became the Department of Energy.

<sup>3</sup> DOE's list of facilities covered under EEOICPA can be found at: <https://ehss.energy.gov/Search/Facility/findfacility.aspx>.

<sup>4</sup> See United States Government Accountability Office, Report to Congressional Requesters: ENERGY EMPLOYEES COMPENSATION- Additional Oversight and Transparency Would Improve Program's Credibility, March 2010, GAO-10-132.

1. Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapons production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.
2. Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay.
3. Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the Department of Energy and its predecessor agencies have been, since World War II, self-regulating with respect to nuclear safety and occupational safety and health. No other hazardous Federal activity has been permitted to be carried out under such sweeping powers of self-regulation.

See 42 U.S.C. §7384(a)(1), (2) and (3). Thus, as outlined in the statute, the purpose of EEOICPA was to provide for timely, uniform, and adequate compensation for covered employees, and where applicable, survivors of such employees, for suffering from illnesses incurred by such employees in the performance of duty for the DOE and certain of its contractors and subcontractors. See 42 U.S.C. §7384d(b).

As enacted in October 2000, EEOICPA contained two parts, Part B and Part D. Part B, which is administered by the Department of Labor (DOL), provides lump-sum payment of \$150,000 to covered employees (and eligible survivors of covered employees) whose chronic beryllium disease, chronic silicosis, or cancer related to radiation exposure is due to exposures sustained in the performance of duties for DOE and certain of its vendors, contractors and subcontractors. Workers covered under Part B are also potentially eligible for medical benefits. Under Part B, covered employees with beryllium sensitivity are entitled to medical monitoring. Part B also provides compensation of \$50,000 to claimants and eligible survivors who are determined by the Department of Justice (DOJ) to be eligible for compensation under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. 2210 note.<sup>5</sup>

Part D of the Act required DOE to establish a system by which DOE contractor employees and their eligible survivors could seek assistance obtaining state workers' compensation benefits if a Physicians Panel determined that the employee sustained a covered illness as a result of work-related exposure to a toxic substance at a DOE facility. Part D was abolished on October 28, 2004, when Congress amended EEOICPA in Subtitle E of Title XXXI of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178 (October 28, 2004). In lieu of Part D, Congress created Part E, a federal compensation scheme for DOE contractors, subcontractors, as well as employees covered under section 5 of RECA, and for eligible survivors of such employees. The administration of Part E was assigned to DOL.

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<sup>5</sup> A former worker eligible for the \$50,000 under Part B would also be eligible for medical benefits.

While DOL has primary authority for administering Parts B and E, other agencies are also involved with the administration of this program. The National Institute for Occupational Safety and Health (NIOSH) conducts activities to assist claimants and supports the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: (1) developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; (2) developing methods to estimate worker exposure to radiation (dose reconstruction); (3) using the dose reconstruction regulations to develop estimates of which classes of workers can be considered for inclusion in a Special Exposure Cohort (SEC) class; and (4) providing staff support for the independent Advisory Board on Radiation and Worker Health Advisory Board on Radiation that advises HHS and NIOSH on dose reconstructions and SEC petitions. There is also an Ombudsman to NIOSH who provides direct assistance to claimants and individuals who wish to file Special Exposure Cohort petitions. The Ombudsman to NIOSH also conducts outreach to promote a better understanding of EEOICPA and the claims process.

DOE's role with the program is to ensure that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or NIOSH with information related to individual claims such as employment verification and exposure records; (2) supporting DOL, NIOSH, and the Advisory Board on Radiation in large-scale records research and retrieval efforts at various DOE sites; (3) conducting research, in coordination with DOL and NIOSH, on issues related to covered facility designations; and (4) hosting the Secure Electronic Records Transfer (SERT) system.<sup>6</sup>

As of January 3, 2016, DEEOIC had paid out a total of \$12,106,083,884 in compensation and medical benefits under Parts B and E.<sup>7</sup>

### **3. The Office of the Ombudsman**

As enacted on October 28, 2004, Public Law 108-375 also established within DOL an Office of the Ombudsman. While this Office is established within DOL, the Secretary of Labor is directed to take appropriate action to ensure the independence of the Office within DOL.<sup>8</sup>

The statute outlines three (3) specific duties for the Office:

1. Provide information to claimants and potential claimants about the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits.
2. Make recommendations to the Secretary of Labor (the Secretary) regarding the location of resource centers for the acceptance and development of EEOICPA claims.
3. Carry out such other duties as the Secretary specifies.

<sup>6</sup> The SERT is a DOE hosted environment where DOL, NIOSH, and DOE can send and receive EEOICPA records and data in a secure manner.

<sup>7</sup> Please see Appendix 2 for a summary of compensation and medical benefits paid to date.

<sup>8</sup> The Secretary of Labor is directed to take appropriate action to ensure the independence of the Office of the Ombudsman within DOL, including independence from other officers and employees of DOL engaged in activities relating to the administration of EEOICPA. See 42 U.S.C. § 7385s-15(d).

See 42 U.S.C. §7385s-15(c). The statute also requires the Office to submit an annual report to Congress. In this annual report the Office is to set forth:

1. The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year.
2. An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

See 42 U.S.C. 7385s-15(e).

As we routinely indicate, most people who contact our Office do not merely want to talk about a complaint or grievance. Rather, when they contact us, most people are seeking some level of assistance with their claim. This assistance can involve: (1) guidance on how/where to file a claim or where to obtain more information about the program; (2) assistance locating the various tools/resources that have been developed to assist claimants, and/or guidance on how to use these tools/resources; (3) clarification/ explanation of a word or document; (4) claim status inquiries; (5) assistance forwarding concerns to or obtaining information from one of the agencies involved in the administration of EEOICPA; (6) advice on where to search for relevant documents; and (7) listening to their concerns.

We make every effort to assist claimants. Nevertheless, there are some requests that we cannot satisfy. For instance, we are contacted by claimants who want us to serve as their authorized representative (AR), or who are seeking legal advice. Such assistance is beyond our statutory authority. In addition, while we can bring matters to the attention of the Division of Energy Employees Occupational Illness Compensation (DEEOIC), the division within DOL that administers EEOICPA, we do not have the authority to change a result, nor can we direct DEEOIC to change a result.

This report is a synthesis of the many e-mails, letters, telephone calls, facsimiles, and face-to-face conversations that the Office had with claimants, potential claimants, health care providers, physicians, authorized representatives, and others during calendar year 2015.

# PREFACE TO THE REPORT

**B**y the end of calendar year 2015, DEEOIC had paid over \$12 billion in compensation and benefits to EEOICPA claimants. In spite of these impressive numbers, claimants, ARs, advocates and others came to us with complaints regarding the program, or searching for assistance with their claims. The fact that this program has paid out so much money might cause one to question the basis for the complaints that we received. In particular, some might question whether the complaints that we receive merely reflect that there are some claimants who are not happy with the outcome of their claim – i.e., that claimants complain when their claims are denied. However, in our opinion the answer is not that simple. The complaints that we receive are not limited to instances where claims or benefits have been denied. We also received complaints from claimants who are still processing their claim. In addition, claimants with accepted claims sometimes share their problems with us. This especially occurs at outreach events, where in an effort to support the concerns raised by their colleagues and friends, those with accepted claims will share their personal encounters with this program. Thus, as we reflect on our experiences, we believe that the complaints that we received highlight a reality that underlines this program – namely that while some claimants are able to take advantage of (or can benefit from) the various procedures/tools/resources that have been developed, there are other claimants who, oftentimes through no fault of their own, cannot take advantage of (or cannot benefit from) these same procedures/tools/resources. Here are some examples that illustrate this reality:

- While notices announcing this program were never directly mailed to former workers, some former workers nevertheless learned of this program soon after its creation. Yet, there are other claimants who for reasons that can be as simple as he/she did not read the right newspaper or did not talk to the right colleagues, are just now learning of this program.
- To be eligible under EEOICPA employees must meet the statutory definition of a “covered employee.” See 42 U.S.C. §7384(1).<sup>9</sup> Employees who do not meet this definition are not covered even if he/she worked onsite at a covered facility.
- DEEOIC and the other agencies involved in the administration of EEOICPA have posted useful information on their websites. Some claimants make great use of this information. Other claimants, especially those without access to the internet (as well as those with limited access to the internet) sometimes find it hard, if not impossible to access this information.
- When it comes to verifying DOE contractor employment, DOE has had success locating DOE contractor employment records. On the other hand, since DOE generally did not keep DOE subcontractor employment records, verification of subcontractor employment may be difficult.
- Locating medical and scientific literature discussing the link between some toxins and some illnesses is easy. For other illnesses and toxins, there is little, if any available literature.
- If the worker passed away less than 10 years ago, there is a chance the medical records still exist. If the loved one passed away more than ten years ago, there is a good chance that the medical records have been destroyed.

<sup>9</sup> The term “covered employee” means any of the following, (a) a covered beryllium employee; (b) a covered employee with cancer; or (c) to the extent provided in 42 U.S.C. §7384r, a covered employee with chronic silicosis. See 42 U.S.C. §7384(1).

- Some claimants fully understand the scientific and medical concepts discussed in the documents they receive. Others tell us that these concepts go right over their heads.

This list could go on.

## Case Study One

This report focuses on the complaints, grievances and requests for assistance received by this Office. Nevertheless, we also hear of, and encounter, instances where DEEOIC staff members, and/or the staff of the other agencies involved in the administration of this program are helpful. In fact, there have been instances when those who came to us with a complaint also took the time to tell us of a helpful encounter with other staff members or of an instance where a tool/resource was useful. The following is an incident we observed this year.

In light of the claimant's covered condition, the claimant received approval for medically necessary modifications to his/her house. The modifications, which were performed by a provider enrolled in the program, did not meet the claimant's satisfaction. The claimant turned to us when the provider stopped answering the telephone. In contacting us, the claimant feared that because they had not paid for the work (DEEOIC directly paid the provider) their options to remedy this situation might be limited.

In response to our inquiry, a DEEOIC staff member not only acknowledged our inquiry, but also telephoned to gain a better understanding of the situation. A week later, this same staff member called to see if we had obtained additional information and to inform us that the claimant had not reported the problem to DEEOIC. In this exchange, the staff member volunteered to contact the claimant directly. We suggested that we first talk to the claimant.

A subsequent conversation with the claimant confirmed that they had not reported the problem to DEEOIC. We recommended that the claimant contact DEEOIC and we followed up by alerting the district office that this claimant might call. When the district office did not hear from the claimant, the DEEOIC staff member again contacted us. In this e-mail the staff member stated, "I am reluctant to just let [this matter] drop if there is something we can do to help."

Ultimately, this staff member and another DEEOIC staff member had a conference call with the provider and reached an understanding on an approach to address this matter.

# **The 2015 Annual Report to Congress**

**OFFICE OF THE OMBUDSMAN**

for the Energy Employees Occupational Illness Compensation Program

# TABLES

This annual report is required to set forth the numbers and types of complaints, grievances, and requests for assistance that this Office received in the preceding calendar year, and is to provide an assessment of the most common difficulties encountered by claimants and potential claimants in that year. Consistent with these requirements, we will begin this report with tables setting forth the numbers and types of complaints received in 2015. Following these tables we will provide an assessment of the most common difficulties encountered by claimants in 2015. In this assessment we will explore why in spite of this program's successes, there are claimants who continue to contact us with complaints and requests for assistance.

**Table 1 – Complaints by Nature**

	CONCERN	NUMBER OF COMPLAINTS
1	Covered Employment	52
2	Covered Facility	27
3	Covered Illness	44
4	Survivor Eligibility	17
5	Exposure to a Toxic Substance	48
6	Dose Reconstruction Process	23
7	Special Exposure Cohorts	31
8	Causation	39
9	Impairment	6
10	Wage Loss	4
11	Medical Benefits	27
12	Home Health Care	42
13	Billing Issues	34
14	Status Inquiries	23 <sup>10</sup>
15	Issues Related to Authorized Representatives	10
16	Issues Concerning RECA	4
17	Issues Involving Interactions with DEEOIC	
	Problems communicating with DEEOIC	14
	Inappropriate conduct	26
	CE not available/telephone not answered	10
	Claimant specifically reference fear of retaliation	7
18	Allegations of Delays	118
	Worker dies before payment	9

<sup>10</sup> This number reflects those instances when the claimant called specifically and solely to inquire into the status of a claim.

CONCERN		NUMBER OF COMPLAINTS
19	Wanted to File a Claim	28
20	Issues Related to Reopening/Reconsideration	7
21	Due Process	18
22	Requests for Assistance	192
23	Asked to Submit Additional Evidence, Do Not Know What to Submit	26
24	Did Not Understand Decision	28
25	Concerns Related to the Use of a DEEOIC Specialist	21
26	Cap on Benefits	8
27	Complimented DEEOIC	2
28	Issues with DEEOIC's Expert	13
<b>TOTAL</b>		<b>958</b>

## Table 2 – Complaints by Facility

Table 2 sets forth the number of complaints identified with specific covered facilities. In reviewing this table, please keep in mind:

1. In many instances the claimant did not identify the facility where they worked.
2. Similarly, we frequently find that when they call, claimants want someone to first listen to their concerns - as opposed to having someone immediately begin to ask questions. Because of this, we often find that we can address the claimant's concern without identifying the facility where the claimant was employed. This is especially true when the matter relates to the payment of bills or the receipt of medical benefits.
3. We have endeavored to count the number of complaints/issues that we received, not the number of contacts. In many instances, during the course of addressing a complaint, we will have multiple interactions with the claimant. To the extent that these interactions relate to the same complaint, we would count these multiple interactions as one complaint.

FACILITY	LOCATION	NUMBER OF COMPLAINTS
ALLEGHENY-LUDLUM STEEL	Watervliet, NY	1
ALLIED CHEMICAL CORPORATION PLANT	Metropolis, IL	1
AMES LABORATORY	Ames, IA	2
AREA IV OF THE SANTA SUSANA FIELD LABORATORY	Santa Susana, CA	5
BENDIX AVIATION (PIONEER DIVISION)	Davenport, IA	1
BETHLEHEM STEEL	Lackawanna, NY	8
BLOCKSON CHEMICAL COMPANY	Joliet, IL	1
BROOKHAVEN NATIONAL LABORATORY	Upton, NY	6
CLARKSVILLE MODIFICATION CENTER	Clarksville, TN	1
DOW CHEMICAL CORPORATION	Pittsburg, CA	3
DOW CHEMICAL CORPORATION (MADISON SITE)	Madison, IL	5
ELECTRO METALLURGICAL	Niagara Falls, NY	1
EXTRUSION PLANT (REACTIVE METALS, INC)	Ashtabula, OH	46
FEED MATERIAL PRODUCTION CENTER	Fernald, OH	5
GENERAL ELECTRIC COMPANY	Cincinnati/Evendale, OH	1
GENERAL STEEL INDUSTRIES	Granite City, IL	13
GRAND JUNCTION FACILITIES	Grand Junction, CO	2
HANFORD	Richland, WA	28
HOOD BUILDING	Cambridge, MA	1
IDAHO NATIONAL LAB	Scoville, ID	8
IOWA ORDNANCE PLANT	Burlington, IA	21
KANSAS CITY PLANT	Kansas City, MO	7
KETTERING LABORATORY, UNIVERSITY OF CINCINNATI	Cincinnati, OH	1
KIRKLAND OPERATIONS OFFICE	Albuquerque, NM	1
LATTY AVENUE PROPERTIES	Hazelwood, MO	1
LAWRENCE LIVERMORE NATIONAL LABORATORY	Livermore, CA	5
LOS ALAMOS NATIONAL LABORATORY	Los Alamos, NM	8
MALLINCKRODT CHEMICAL COMPANY	St. Louis, MO	20
MASSACHUSETTS INSTITUTE OF TECHNOLOGY	Cambridge, MA	1
MOUND PLANT	Miamisburg, OH	7
NATIONAL BUREAU OF STANDARDS	Washington, DC	9

<b>FACILITY</b>	<b>LOCATION</b>	<b>NUMBER OF COMPLAINTS</b>
OAK RIDGE	Oak Ridge, TN	7
OAK RIDGE GASEOUS DIFFUSION PLANT (K-25)	Oak Ridge, TN	12
OAK RIDGE NATIONAL LABORATORY (X-10)	Oak Ridge, TN	6
NEVADA TEST SITE	Mercury, NV	12
NUCLEAR FUELS SERVICES	Erwin, TN	1
NUCLEAR METALS, INC.	West Concord, MA	1
PACIFIC PROVING GROUND	Republic of Marshall Islands	2
PADUCAH GASEOUS DIFFUSION PLANT	Paducah, KY	10
PANTEX PLANT	Amarillo, TX	2
PINELLAS PLANT	Clearwater, FL	11
PORTSMOUTH GASEOUS DIFFUSION PLANT	Piketon, OH	8
PRINCETON PLASMA PHYSICS LABORATORY	Princeton, NJ	56
REDUCTION PILOT PLANT	Huntington, WV	1
ROCKY FLATS PLANT	Golden, CO	19
SANDIA NATIONAL LAB	Albuquerque, NM	6
SAVANNAH RIVER SITE	Aiken, SC	19
UNIVERSITY OF ROCHESTER ATOMIC ENERGY PROJECT	Rochester, NY	1
URANIUM MINE	Various locations	15
WELDON SPRINGS PLANT	Weldon Spring, MO	1
WEST VALLEY DEMONSTRATION PROJECT	West Valley, NY	105
Y-12 PLANT	Oak Ridge, TN	10
MISC		49

# CHAPTER 1

## Concerns Alleging that Notice of the Program was Delayed or Never Directly Provided

### *What took you so long to get here?*

(The first question asked when we opened the floor for questions at a meeting in Ashtabula, Ohio)

Since the creation of this program in 2000, DEEOIC and the other agencies involved with the administration of EEOICPA have worked to notify potential claimants about this program. Nevertheless, we routinely encounter claimants who: (1) only recently learned of this program and/or (2) believe that the delay in being notified of this program negatively impacted the processing of their claim.

When complaining that notice of this program was delayed, claimants frequently ask why the government never directly contacted them about this program.<sup>11</sup> Underlying this question is the fact that notices announcing this program were not directly sent to every potential claimant. Claimants have told us that when they ask why notices were not directly sent to potential claimants, the response often indicates that direct mailings were not used because the government did not have employee rosters for many of the facilities. Claimants often find this response unpersuasive. In light of the security that usually surrounded these facilities, claimants find it hard to believe that the government destroyed all of (or cannot find any of) the records that could identify the employees who worked at these facilities.

### **A. Sufficiency of the efforts undertaken to notify potential claimants**

Claimants also question the sufficiency of the efforts that have been taken by DEEOIC and the other agencies involved in the administration of EEOICPA to notify potential claimants about this program. In particular, claimants question the extent to which the government has tried to obtain employment records from contractors and subcontractors. Among the claimants who raise this question are some who assure us that they regularly receive a retirement check or other correspondence from their former employer. Where an employer is still in contact with former employees, claimants question why the government did not coordinate with these employers to ensure that former workers received notice of the program.

Claimants also question the sufficiency of the outreach events sponsored by DEEOIC and the other agencies involved in the administration of EEOICPA. For instance, there is a belief by some claimants that most of the town hall meetings sponsored by DEEOIC and the other agencies involved with EEOICPA are held near facilities that once employed large numbers of employees. We are frequently reminded that there are over 350 covered facilities and that all of them did not employ large numbers of employees. Claimants complain that it is not fair to focus so much of the outreach efforts on certain sites, while giving little, if any attention to other sites. Similarly, claimants complain that while DEEOIC and the other agencies have hosted multiple outreach events at some sites, other sites have not been the location for

<sup>11</sup> The effort undertaken by DEEOIC and the other agencies involved with the administration of this program to inform potential claimants of this program included hosting town hall meetings, distributing literature, and contacting labor organizations.

even one outreach event. This concern prompted the comment cited at the top of this page. At a 2015 event we sponsored in Ashtabula, Ohio, as soon as we opened the floor for questions, we were asked what took us so long to come to the area.<sup>12</sup>

Other comments noted that limiting outreach efforts to areas close to a facility (or close to where the facility once existed) overlooks the fact that in the ensuing years:

- Some former employees moved to other areas when they retired or when the facility closed.
- Some workers moved away to take new jobs.

The concern that former employees who moved away from the area may not know about the program was underscored by a conversation with a former Paducah Gaseous Diffusion Plant worker. This former worker, who no longer lived in the Paducah area, only learned of EEOICPA when in 2015 a friend called to discuss the closing of the Paducah Plant. By chance, during this conversation the friend mentioned receiving compensation. This passing remark prompted the former worker to seek more information about this compensation program. In his search for more information, this former worker eventually called our Office.

We recognize that merely hosting an outreach event does not guarantee that everyone living in that area will now be aware of this program. We routinely visit areas where outreach events were previously held and encounter individuals who only recently learned of this program. There are many reasons why an individual might not be aware of this program in spite of earlier outreach events held in the area where they lived, including:

- Press releases announcing an upcoming event are not picked up by local media.
- Individuals live outside of the area covered by the press release, radio announcement, etc.
- When the earlier outreach event was held, the claimant was not sick. Thus, the claimant did not pay attention and/or saw no need to attend an event targeting “sick workers.”<sup>13</sup>
- The mailing list utilized by DEEOIC to notify people of outreach events only contains the name of individuals who have previously filed claims. Similarly, some of the mailing lists utilized by DOE and the FWP only include individuals who have signed up for medical screenings.

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<sup>12</sup> Ashtabula, Ohio was the site of the Extrusion Plant (Reactive Metals, Inc.). We cannot find any records of any prior events sponsored by DEEOIC in this area.

<sup>13</sup> According to some claimants since they were not sick, they paid little attention when they first heard about a program for “sick workers.” It was only when they were diagnosed with an illness that they decided to obtain more information about this program.

While DOE does not have complete rosters of the employees who worked at the various facilities, DOE has utilized information, such as medical records, to compile lists of employees shown by these records to have worked at some facilities. While these lists created by DOE do not contain updated contact information, DOE, as well as the Former Worker Screening Programs, have made use of available programs or online tools to obtain updated addresses.

What remains unclear is: (1) the number of facilities for which DOE has compiled such lists and (2) the extent to which these lists can and have been used to notify potential claimants of this program.

## **B. The impact of no notice (or delayed notice)**

When they finally learn of this program, some claimants immediately contact us to complain about the lack of prompt notice. However, in other instances, complaints are only brought to our attention when the claimant subsequently feels that they have been impacted by the lack of prompt notice.

For instance, we are contacted by surviving family members who complain that the amount of compensation paid on their Part E claim was less because their loved one was never notified about this program and thus never filed a claim. Surviving family members point out that the maximum compensation under Part E for a claim filed by a worker is \$250,000, while the maximum compensation paid for an accepted Part E survivor's claim ranges between \$125,000 and \$175,000, depending on whether wage loss is awarded. Similarly, there are times when the surviving children do not meet the survivor eligibility requirements established for Part E claims.<sup>14</sup> Because of Part E's separate requirements for survivor claims, and in light of the definition of "covered child" found in Part E, survivors often argue that DEEOIC ought to do everything possible to notify workers of this program before they pass away.

We also hear from claimants who complain that their ability to locate evidence was impacted by the delay in receiving notice of this program. We are told of instances where in the time between the creation of EEOICPA and when the claimant first learned of this program, evidence was destroyed and/or colleagues who could have provided relevant testimony passed away.

In addition, some claimants have complained that the delay in receiving notice of this program impacted their ability to receive reimbursement for medical bills. In pertinent part, Section 7384t(d) provides that "[a]n individual receiving benefits...shall be furnished those benefits as of the date on which that individual submitted the claim for those benefits..." 42 U.S.C. §7384t(d). Claimants argue that it is unfair to delay notifying them of this program and to then penalize them by denying reimbursement for medical bills incurred after the program was created but before they received delayed notice of this program. Claimants find this outcome especially troubling when they believe that they filed their claim as soon as they learned of the program.

<sup>14</sup> To be an eligible surviving child under Part E, at the time of the worker's death the child had to be: (1) under the age of 18; (2) under the age of 23 and a full time continuous student; or (3) any age, but at the time of the worker's death, incapable of self-support.

Our experiences suggest that there are potential claimants who still do not know of this program. Moreover, we continue to encounter claimants who believe that a delay in receiving notice of this program impacted their chances of successfully processing their claim and/or impacted the compensation that was paid. Some claimants interpret this lack of notice (or lack of prompt notice) as an indication of the government's lack of commitment to this program. In spite of these concerns, the good news is that DEEOIC and the other agencies involved in the administration of EEOICPA continue their outreach efforts. In fact, as we write this report we are aware of plans to host outreach events, including plans to host events in areas that are not necessarily near large facilities. The challenge is to reach as many claimants as possible, including those who have moved to other areas, as well as those who missed (or were missed by) previous efforts.

Recently, we have seen an increase in the number of outreach events sponsored by non-profit organizations, advocacy groups and other entities.<sup>15</sup> Because home health care providers and/or ARs sometimes participate in these events, questions arise as to the extent to which these home health care providers or ARs financially benefit from these events. We do not dismiss the financial benefits a home health care provider or AR could derive from these events.<sup>16</sup> Nevertheless, in our opinion, the outreach events sponsored by these organizations and entities help to fill a gap that exists in the efforts to notify potential claimants of this program. For example, while DEEOIC's outreach efforts often focus on areas close to covered facilities, some of these organizations and entities have hosted outreach events in areas that were not necessarily close to covered facilities.

We have also seen that in addition to extending their outreach efforts beyond the areas close to covered facilities, some of these organizations and entities periodically return to an area to host follow-up events. This can be valuable because: (1) some claimants do not focus on this program until they become sick, and (2) some claimant only attend these events when they have a problem or a question. Hosting subsequent events in the same area increases the likelihood that when a claimant has a question, there will be an event to attend.

Moreover, we are aware of instances where health care providers, non-profits, advocacy groups and ARs are disseminating information about this program via their websites and other channels. These efforts recognize that changes to the program can sometimes be hard to locate, especially if a claimant does not routinely review DEEOIC's entire website. These organizations and entities attempt to assist claimants by highlighting the significant changes.<sup>17</sup>

<sup>15</sup> In many instances, home health providers attend and make presentations at the events sponsored by these organizations and entities.

<sup>16</sup> In some instances, even if the home health provider is not sponsoring the event, a representative from a home health provider will make a presentation at the event.

<sup>17</sup> Some claimants are much more comfortable bringing their materials to an event and talking to someone face-to-face as opposed to talking to someone over the telephone.

In evaluating the effectiveness of outreach events, consideration is often given to the number of attendees at the event, as well as the number of claimants who sign up to file claims, or sign up for medical screenings. We agree that these are relevant considerations. However, in our experience, outreach events are also beneficial because of the interest that they generate. It has been our observation that notices announcing an upcoming outreach event usually results in an increase in the number of inquiries to the Office.

Outreach events also offer an opportunity to distribute literature. Our Office is frequently contacted by claimants with little, if any, knowledge of EEOICPA. When we inquire how a claimant with little knowledge of the program came to contact us, we are often told that a friend or colleague provided the claimant with our contact information, or with a copy of one of the brochures prepared by our Office (which contains our contact information).

## Difficulties Locating Information about the Program

*This was the first meeting we have attended for EEOICPA...I'm sure I would have been in a better position to file a claim on my husband's behalf if I were more aware of what needed to be done.*

(Letter from a claimant thanking us for our meeting in West Valley, New York).

We encounter claimants who contend that when they first learned of this program, they knew so little about EEOICPA they had no idea where to look for more information. This chapter focuses on the difficulties encountered by claimants when endeavoring to obtain more information about this program.

### A. Word of mouth can result in incomplete information

As noted in the previous chapter, some claimants learn of this program via word-of-mouth. The good news is that these claimants finally know about the program. The bad news is that the information passed on by word-of-mouth can be inaccurate and/or incomplete. For example, we encounter claimants who contend that when they first heard of this program, they were simply told of a program for “sick workers.” Other claimants have told us that while they initially thought that they understood the program, they quickly discovered that this program was more complicated than they originally thought. While some claimants knew that the program was administered by the government, when they tried to find more information, they discovered that they did not know which agency administered the program. According to some claimants, it came as a shock to discover that DOL administered the program that compensated former DOE employees and contractors who built nuclear bombs. Considering that some claimants only became aware of this program years after it was created, combined with the fact that some claimants find it difficult to locate information about the program, it becomes easier to understand why some claimants are frustrated with the program before they even file a claim.

### B. Claimants are not aware of the tools/resources available online

DEEOIC's website contains information/resources that can assist with the processing of claims. The same is true of the websites of the other agencies involved in the administration of EEOICPA. However, some claimants: (1) do not have access to the internet; (2) only have limited access to the internet; and/or (3) do not appreciate the value of the resources/tools available on these websites. As a result, we are routinely contacted by claimants looking for information that is available online. The four most common requests that we receive for information found on DEEOIC's website are: (a) a listing of the toxins known to have been used at a facility; (b) the status of a claim; (c) a list of the covered facilities; and (d) a list of the physicians/providers enrolled in the program.

While claimants can contact one of the Resource Centers to obtain copies of information found on DEEOIC's website, some claimants do not contact the Resource Centers because:

- I. They do not have access to the internet and thus, have no way of knowing the information that is available online; and

2. They do not realize that they can contact the Resource Center for copies of information found on DEEOIC's website.<sup>18</sup>

In addition, merely having access to the internet does not guarantee that a claimant will be familiar with the information found on DEEOIC's website. For example, we routinely encounter claimants, including claimants with recommended or final decisions, who admit that they do not understand the Site Exposure Matrices (SEM) database or that, while processing their claim, they never attempted to access this database. It is common for these claimants to tell us that while SEM was routinely mentioned throughout the claims process, no one ever explained SEM or showed them how to use SEM. Similar complaints are made about many of the other online tools/resources.<sup>19</sup>

In this regard, claimants find it upsetting when it is not until well after the information could have been useful that someone finally informs them about a tool/resource. In response to such situations, claimants usually ask why he/she was not told of this tool/resource at an earlier time in the claims process when the information could have been helpful.

### **C. Information/resources can be hard to locate**

Some claimants are able to locate the information that is available online. However, there are other claimants who are not comfortable with computers and/or the internet. These claimants can find it difficult to locate information online, and this can be true even when they know that the information is available online.<sup>20</sup>

Some claimants attribute their difficulties locating information online to their inability to "speak" the language of EEOICPA. For instance, the online tool known as the "SEM" contains a listing of the toxins known to have been used at covered facilities. Yet, even when claimants are aware that such a listing is available online, we find that some claimants search the website for a link that specifically says "listing of toxins." These claimants often do not realize that this listing is found using the link, "Site Exposure Matrices- SEM."

In addition, while DEEOIC's website contains a search function, some claimants believe that their ability to use this search function was impacted by their inability to "speak" the language of EEOICPA. Claimants complain that when they do not know the precise phrase or terminology used by DEEOIC, their search can result in a long list of hits, many of which have no relevance to the information they are seeking.

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<sup>18</sup> In some instances, claimants do not call us specifically looking for information. Rather, in the course of our conversation, we sometimes ask if the claimant has accessed a tool/resource. For some claimants, our inquiry is the first time they were made aware of the tool/resource. We also find that some claimants believe that the role of the Resource Centers is to assist with the filing of claims. Thus, some claimants believe that once the claim is filed and information is forwarded to the District Office, the Resource Center has fulfilled its role. As a result, it does not occur to some claimants to approach the Resource Center to ask for copies of documents found online.

<sup>19</sup> Claimants frequently tell us that acronyms such as SEM are used so routinely, they are embarrassed to admit that they do not understand the term.

<sup>20</sup> In our 2014 Annual Report we discussed the difficulties encountered by some claimants attempting to access the list of health care providers enrolled in the program. At the time, DEEOIC's website did not have a direct link to this list. The website now contains a direct link.

Other claimants have noted that when they do not know the phrase or terminology used by DEEOIC, there is a greater chance that their search will result in no hits.<sup>21</sup>

A more general complaint contends that looking for information on DEEOIC's website is sometimes complicated by the inability to understand DEEOIC's logic for the placement of information. A common complaint comes from claimants who contend that they do not understand the logic for placing certain information in the EEOICP Procedure Manual, while other information is found in an EEOICP Bulletin or an EEOICP Circular. For example, claimants ask why the announcement of some Special Exposure Cohorts (SECs) is found in bulletins, while the announcement of other SECs is found in circulars. According to these claimants, the issue is not whether DEEOIC decides to place the information in a bulletin or a circular. Rather, claimants want to understand where to look for information. Claimants contend that when they do not know where to look for information, they often spend hours trying to find needed information. Moreover, because relevant information can be scattered among various documents, claimants complain that it is often hard, if not impossible, to determine when and if they located all of the pertinent information relating to a subject. Consequently, it is not unusual to be contacted by claimants who:

1. Hope that we can direct them to the information they seek, thereby avoiding the need to spend time searching multiple documents, or
2. Want confirmation that they found all of the relevant information addressing a matter.<sup>22</sup>

The criteria for hearing loss claims were once found in the PM at Chapter 2-1000.18(a). However, as a result of revisions made in September 2015, the discussion of hearing loss is now found in Exhibit 3 of PM Chapter 2-0700. Claimants have noted that when they now turn to Chapter 2-1000.18(a) for the discussion of hearing loss, there is nothing that redirects them to Exhibit 3 of PM Chapter 2-0700. In addition, the removal of the discussion of hearing loss is not mentioned in EEOICPA Transmittal NO. 15-08, the document issued by DEEOIC highlighting the changes to Chapter 2-1000. Rather, EEOICPA Transmittal NO. 16-01 which highlights changes to PM Chapter 2-0700 mentions the adding of "Exhibit 3, Establishing Causation for Asbestosis and Hearing Loss."

Since this revision, claimants have complained that they were unable to locate the discussion of hearing loss. Most of these claimants never thought to review the EEOICPA Transmittals. Moreover, even if they reviewed the transmittals, they did not think to review the transmittal discussing PM Chapter 2-0700 for the criteria previously found in Chapter 2-1000. Thus, in at least one instance a claimant contends that he/she spent hours trying to find the discussion of hearing loss, before finally contacting us. In other instances, claimants contacted us when they realized that the discussion of hearing loss was no longer found in Chapter 2-1000.18(a). In the opinion of these claimants, had they not contacted our Office they might have thought the criteria was no longer being applied or spent considerable time trying to find the new location for the discussion of hearing loss.

<sup>21</sup> Because claimants often search using broad concepts, there is often a high possibility that their search will yield unrelated "hits."

<sup>22</sup> On occasion claimants contacted us seeking information otherwise available online because the search function was not operational.

## D. Information is not sufficient

- **Website does not provide the information sought by the claimant** – While DEEOIC’s website contains a great deal of information, it does not always provide the specific information that a claimant is seeking. For example, while DEEOIC’s website contains the link, “Check the Status of My Claim,” claimants often contact us for the status of their claim hoping that we can provide a more thorough response than that provided when utilizing this tool.<sup>23</sup>
- **I was simply told to file a claim** – When potential claimants initially learn of this program, the information that they receive can sometimes be cursory. Thus, after learning of this program, some claimants want more information. Claimants tell us that it is troubling to contact DEEOIC for more information, and instead of receiving answers to their questions, they are simply told to file a claim. This response is especially troubling to those claimants who believe that they should not file a claim against the government unless they earnestly believe that the claim is valid. However, providing an immediate answer to a claimant’s question is not always possible. In some instances, the answers sought by the claimant are the precise issues that must be adjudicated in the claims process.<sup>24</sup>

When claimants come to us for answers to questions that must be resolved in the claims process, we explain why these questions cannot be immediately answered. In most instances, claimants understand when an explanation is provided for why an immediate answer cannot be provided.

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<sup>23</sup> The other reasons claimants ask us for the status of their claim is that: (1) some claimants are not aware that such a link is available on DEEOIC’s website, or (2) some claimants do not have access to the internet.

<sup>24</sup> A similar concern was raised by personnel associated with the Radiation Employees Screening and Education Program (RESEP). Among the individuals entitled to screening by RESEP are former uranium miners, millers and ore transporters, who in some instances may also be eligible for compensation and benefits under EEOICPA. RESEP personnel have noted that when they approached DEEOIC with questions, they were simply advised to have the former employee file a claim. In light of their frequent contact with these individuals, the personnel associated with RESEP wanted a response that provided them with a better understanding of the program.

## Case Study Two

In our 2014 Annual Report at pages 52 and 63 we discuss a concern raised by former security guards at the Iowa Ordnance Plant (IOP). These former security guards took issue with information found in SEM indicating that the source information used to compile SEM did not verify any toxic substance exposure for security guards. See 2014 Annual Report to Congress, Office of the Ombudsman, January 8, 2016.

In 2015, it was brought to our attention that in one case a security guard at IOP was able to obtain and submit into evidence an affidavit from an administrative worker. In this affidavit, the affiant discussed his/her knowledge of how security guards were assigned to posts. Subsequently, this particular claim was accepted by DEEOIC.

We have been contacted by claimants and ARs who are aware of this case. These claimants and ARs question why the decision accepting the security guard's claim is not included in the "Significant EEOICP Decisions" database. They also question why SEM has not been revised to show that there is at least one toxin to which security guards at IOP are known to have been exposed.

A common complaint that we hear, especially from ARs, suggests that there are times when an AR is required in one case to submit evidence to prove a fact that the AR previously established in an earlier case. This is the concern that we hear from security guards at IOP. Because SEM has not been revised to reflect that in one case a security guard was found to have been exposed to a toxic material and because that case is not included in the "Significant EEOICP Decisions," there is a fear that success in other claims filed by security guards at IOP will depend on the claimant's ability to locate this one administrative person who drafted the affidavit that was accepted by DEEOIC. Similarly, the Office has received other complaints suggesting that in subsequent cases claimants were required to submit medical literature establishing a link between an illness and a toxin, even though that link had been accepted in prior cases.

Some claimants believe that the way to resolve this problem is to post all final decisions. Other claimants contend that there needs to be better protections to guard against unnecessary duplication of efforts.

# CHAPTER 3

## Statutory Concerns

Some of the complaints we received during the year directly challenged provisions of the EEOICPA statute. While these complaints address practically every aspect of the claims process, the common factor with these complaints is that resolution of these concerns tends to require action by Congress.

### **A. Statutory limitations on who is covered, the facilities covered, and the illnesses covered**

When it comes to complaints challenging a statutory provision, a majority of the issues that we encounter involve coverage – i.e., the workers covered; the facilities covered; and/or the illnesses covered under the program. These complaints generally focus on the fact that under EEOICPA coverage can depend on the classification of the worker or the facility, as well as on the illness suffered by the worker. The charts found at Appendix 3 outline some of the key distinctions found in the statute. The most common complaints arising from these distinctions are:

- EEOICPA does not cover every employee who worked at a covered facility.
- Some employees are covered under Part B but not covered under Part E.
- The differences in coverage under Part B. In particular, employees of Atomic Weapons Employers (AWEs) ask why they are covered under Part B for cancers caused by radiation exposure, but not covered under Part B for chronic beryllium disease (CBD), beryllium sensitivity, or chronic silicosis. See Chart 3 found at Appendix 3 for all of the distinctions in Part B coverage.<sup>25</sup>

Claimants frequently assert that it is not fair that certain employees who worked at these covered sites are covered under EEOICPA, while others who worked at these same sites are not covered. This is the precise argument raised by former members of the U.S. Navy who worked at the Pacific Proving Ground (in the Republic of the Marshall Islands) between 1946 and 1962 when the U.S. conducted nuclear testing. These former members of the Navy contend that it is unfair to exclude them from coverage under EEOICPA while providing coverage to the DOE federal employees, as well as the DOE contractors and subcontractors who worked with them at this site.<sup>26</sup>

When complaints are raised concerning the distinctions in coverage, it is frequently noted by claimants that in creating the EEOICPA, Congress specifically found that state workers' compensation programs did not provide a uniform means of ensuring adequate compensation for the types of occupational illnesses and diseases that relate to the employees at [these] sites. See 42 U.S.C. §7384(a)(7). Consequently, claimants argue that it is inconsistent to find that state workers' compensation programs are not adequate

<sup>25</sup> Under Part B, DOE federal employees, as well as DOE contractors and subcontractors are covered for cancers caused by radiation exposure, CBD; beryllium sensitivity; and chronic silicosis. Employees of AWEs are only covered under Part B for cancers caused by radiation exposure. In addition, under Part B, employees of beryllium vendors are covered for CBD and beryllium sensitivity, but are not covered for cancers caused by radiation exposure or for chronic silicosis.

<sup>26</sup> DOE federal employees who worked at the Pacific Proving Ground from 1946 to 1962 are potentially covered under Part B. Employees of DOE contractors and subcontractors who worked at the Pacific Proving Ground from 1946 to 1962 are potentially covered under both Parts B and E.

and then deny coverage to certain employees who worked at these facilities, thus leaving these employees with only one option – attempting to pursue a claim under inadequate state workers’ compensation programs.

We also receive complaints from former employees of AWEs. For instance, we talked to former employees of AWEs who insisted that, in the course of their employment they were exposed to beryllium. They questioned why employees of AWEs were not covered under Part B for chronic beryllium disease (CBD) and beryllium sensitivity.<sup>27</sup> In addition, other former employees of AWEs were adamant that in addition to radiation exposure, they were exposed to a variety of other toxins. These workers questioned why employees of AWEs were not covered at all under Part E for illnesses related to the other toxins to which they were exposed.<sup>28</sup>

In many of the instances that we encountered, the disappointment of discovering that they were not covered under this program was compounded when:

- No one could provide these workers with a rationale for why some employees who worked at these facilities were covered under this program, while others were not. Claimants frequently complain that when they ask for a rationale, they are simply told that this is how Congress wrote the Act. To the dismay of claimants, no one seems to be able to explain why the Act was written in this manner.
- No one could direct them to a program that might compensate them for their illnesses related to employment at these facilities.<sup>29</sup>

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<sup>27</sup> We have encountered former employees of AWEs who assert that they were diagnosed with CBD.

<sup>28</sup> Employees of facilities classified as Beryllium Vendors are also only covered under Part B. However, in 2015 we did not receive any complaints from employees of Beryllium Vendors.

<sup>29</sup> Claimants who are not eligible under EEOICPA may be eligible to file a state workers’ compensation claim. Some claimants have questioned whether state workers’ compensation programs can adequately compensate for occupational illnesses and diseases related to toxic exposures. See generally, 42 U.S.C. §7384(a)(7). Employees of the federal government may be eligible to file a claim under the Federal Employees’ Compensation Act (FECA). Some federal employees similarly question the ability of FECA to adequately compensate for occupational illnesses and diseases related to toxic exposures.

EEOICP Bulletin 3-27 has been the subject of complaints to our Office. This bulletin states that the delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, including workers involved in the delivery and loading or unloading of goods for construction and/or maintenance activities. Since such a prohibition is not found in the statute, claimants question the basis for this bulletin. Claimants also note that while this bulletin states that for purposes of this program, the delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, in fact, this program covers ore transporters. Since those engaged in the transportation of uranium ore are covered under this program, claimants would like to see the documents relied upon by DEEOIC in concluding that Congress intended to exclude everyone engaged in the delivery and the loading or unloading of goods with the exception of ore transporters. Another complaint argued that this prohibition was too broad and that coverage ought to be determined on a case by case basis. Still other claimants asked if DEEOIC would define the term “goods.”

While coverage was a frequent issue raised in the complaints challenging a statutory provision, we also received complaints raising other issues as well.

## **B. Cap on Benefits**

Both Part B and Part E contain a cap/maximum as to the amount of compensation that can be awarded. Claims accepted under Part B are generally entitled to a lump sum payment of \$150,000.<sup>30</sup> See 42 U.S.C. §7384s(a). Pursuant to 42 U.S.C. §7385s-12, the maximum aggregate compensation under Part E is not to exceed \$250,000.<sup>31</sup> We are approached by claimants who believe that because of one or both of these caps, they were not adequately compensated. These complaints usually arise in conjunction with one of the following circumstances:

- The claimant’s covered condition continued to deteriorate even after the claimant was paid the statutory maximum(s).
- After receiving the statutory maximum(s) for one illness, the claimant subsequently developed an additional illness.

Claimants also wanted to know how Congress arrived at these specific monetary caps/maximiums.

<sup>30</sup> Under Part B, an employee with an accepted claim for beryllium sensitivity is entitled to medical monitoring (but no monetary compensation). In addition, individuals with an approved Section 5 RECA claim are entitled under Part B to an additional \$50,000 lump sum.

<sup>31</sup> The cap does not include payment for medical benefits.

### **C. Commencement date for medical benefits**

Section 7384t(d) provides that an individual receiving benefits shall be furnished with medical benefits as of the date on which the claim was submitted. See 42 U.S.C. §7384t(d). This provision continues to generate concerns.

- Claimants who first learned of this program years after it was created argue that it is unfair to have delayed notifying them of this program and to then limit them to medical benefits as of the date the claim was filed. Where notice of this program was delayed, claimants contend that they ought to be reimbursed for the medical bills related to the covered illness that they incurred following the creation of this program.
- Claimants also argue that this statutory provision ignores the realities of when and how a person often comes to know that they have a compensable claim. In particular, claimants question why medical benefits are limited as of the date of filing when in many instances the worker has to undergo medical treatment (or a medical procedure) in order to know that he/she has an illness for which a claim can be filed. This is the precise complaint that we often hear from claimants with skin cancer. Claimants have assured us that when they went to the doctor they did not know if the lesion was malignant (and/or if it had to be removed). Instead, it was only after the lesion was removed and they received the pathology report that they had a diagnosis. Complaints arise when the claim is accepted and yet the claimant is not reimbursed for the visit to the physician which led to the diagnosis (including the excision of the lesion) because these services were rendered prior to the filing of the claim.
- When presenting these complaints to us, claimants often stress that as soon as the physician determined that the lesion had to be removed the physician proceeded with the procedure. Thus, claimants have asked whether, in order to ensure payment of the procedure, they should have postponed the removal of the lesion, so they could first file a claim. Similar concerns have been raised by other claimants who needed medical treatment in order to diagnose an illness/condition. Sometimes further complicating this issue is the claimant's belief that it is not appropriate to file a claim unless and until he/she is diagnosed with a condition.
- Some claimants have noted that as a result of Section 7384t(d) the government is sometimes able to avoid payment for the most costly aspects of the worker's illness. This sentiment is often raised by workers who were treated for a covered illness prior to the creation of this program, or prior to learning of this program. In raising this concern, it is noted that in some instances, the medical expenses incurred prior to the filing of the claim (and sometimes incurred closer in time to when the condition was diagnosed) were the most costly expenses related to the condition. Claimants find it hard to accept that a claim can be accepted and yet they may not be fully reimbursed for all of the medicals expenses related to that covered condition.

## **D. Chronic Lymphocytic Leukemia (CLL)**

Section 7384I(9) provides that in order to qualify as a “covered employee with cancer,” a member of the Special Exposure Cohort (SEC) must be diagnosed with a specified cancer. 42 U.S.C. §7384I(9). However, the statute specifically excludes CLL from the list of specified cancers. See 42 U.S.C. §7384I(17). Confusion arises because in addition to this statutory provision, NIOSH at one time had a regulation that also excluded CLL from dose reconstructions. As a result of NIOSH’s regulation excluding CLL from dose reconstructions and Section 7384I(9), which specifically excluded CLL from the list of specified cancers, claims for CLL could not be accepted under Part B. This changed in 2012 when NIOSH announced a new rule designating CLL as potentially caused by radiation and therefore eligible for dose reconstruction. In light of this action by NIOSH, claims for CLL are now potentially compensable under Part B.

When claimants learned of NIOSH’s action, they assumed that for purposes of SECs CLL would now be added to the list of specified cancers outlined in Section 7384I(9). This has not occurred. Since Section 7384I(9) specifically excludes CLL from the list of specified cancers, the statute will have to be revised in order to add CLL to the list of specified cancers.

## Issues Related to Locating Evidence

As their case proceeds, claimants may be asked to submit additional evidence. Claimants complain that it can be difficult to locate the evidence necessary to support their claim.

### A. In General

- Section 7384v of the statute provides that the government “shall” provide claimants and potential claimants with assistance in connection with their EEOICPA claim. See 42 U.S.C. §7384v. A common complaint questions whether the government fully complies with this requirement. Claimants believe that when EEOICPA was created, Congress was well aware that there would be times when relevant records had been destroyed, as well as times when relevant information was not collected. Thus, claimants believe that in enacting Section 7384v Congress intended the government to do more than merely search for records.<sup>32</sup>

In response to the suggestion by claimants that Section 7384v anticipated more assistance, DEEOIC has indicated that under EEOICPA the burden of proof is on the claimant. While claimants appreciate that they bear the burden of proof, they believe that this does not diminish the fact that Congress specifically included a statutory provision requiring the government to provide assistance in connection with their claim. In the opinion of claimants, a specific provision in the statute entitled “Assistance for claimants and potential claimants” must have some significance.

- During the year we were approached by claimants who contend that they were misled as to the amount of assistance they could expect from DEEOIC. We encountered claimants who asserted that prior to filing their claim, DEEOIC emphasized that assistance would be provided in obtaining necessary evidence. These claimants contend that this approach changed after DEEOIC determined that evidence could not be located. According to these claimants, when they responded to this determination by trying to suggest other avenues for DEEOIC to explore, DEEOIC answered by emphasizing that under EEOICPA the claimant bears the burden of proof.<sup>33</sup> Claimants were taken aback by what came across as a sudden change in emphasis. It was suggested that it would have been better if DEEOIC had been more upfront in emphasizing that it provided some assistance, but that ultimately the burden was on the claimant to locate necessary evidence.<sup>34</sup>

<sup>32</sup> When a claim is filed, DEEOIC contacts DOE for employment verification. As appropriate, DEEOIC also endeavors to verify employment through the Oak Ridge Institute for Science and Education, the Center for Construction Research and Training, Social Security Administration wage data, and/or corporate verifiers.

<sup>33</sup> In response to being informed that DEEOIC’s search could not locate evidence, claimants often want additional assistance, such as help locating colleagues and former employers.

<sup>34</sup> The language found in the DEEOIC brochure “How is my EEOICPA claim processed?” is indicative of the assistance some claimants suggested they were led to expect. This brochure states, “[o]ur claims examiners (CEs) will work with you to obtain the necessary evidence and also assist in obtaining certain evidence from other sources...” This brochure does not mention that the burden of proof is on the claimant.

## **B. Locating Employment Evidence**

In 2015, as in previous years, most of the complaints that we received concerning the difficulties encountered locating employment evidence involved subcontractor employment. The reason for this is that while the program has enjoyed success locating employment records relating to DOE contractors, it has not enjoyed the same success locating employment records for DOE subcontractors.<sup>35</sup> The difficulties that arise trying to locate subcontractor employment records are acknowledged by DEEOIC in its Procedure Manual:

*Subcontractor employment at DOE facilities. Because the DOE generally did not keep records of employees of subcontractors, the CE is faced with particular evidentiary challenges in establishing subcontractor employment. To establish each of the elements needed, it is generally necessary to gather and evaluate documentation from multiple sources including the DOE, the SSA and the CWPR.*

See EEOICP Procedure Manual, Chapter 2-500.13(d). Since the government acknowledges that it did not keep records of subcontractor employees and, in many instances, other records that could have verified this employment, such as gate records, were destroyed by the government, many claimants are taken aback when informed that they must locate evidence verifying their subcontractor employment. In the opinion of many claimants, situations where the government concedes that records do not exist are the exact situations that Congress had in mind when it mandated the government provide assistance to claimants and potential claimants in connection with their EEOICPA claim. See generally, 42 U.S.C. §7384v.

### **1. Employment at a covered facility**

In light of the difficulties DOE has encountered locating subcontractor employment records we encountered situations where subcontractor employees were asked to submit evidence verifying that they worked onsite at the covered facility. When they are unable to locate records, claimants often try to obtain affidavits. However, obtaining affidavits can be complicated by the fact that colleagues (or the claimant) have moved away from the area where they worked. Moreover, these affidavits cannot come from just any former colleague. Rather, the person preparing the affidavit must have personal knowledge of the former worker's employment, and must be able to testify as to the time frame when this employment occurred.<sup>36</sup> Some claimants find it extremely difficult to locate former colleagues who can prepare such affidavits, especially when the employment occurred 20 or more years ago.

Some claimants believe that it would be easier to search for colleagues if DEEOIC provided them with the names and/or addresses of other employees who worked at the facility. In response to this suggestion, DEEOIC has indicated that due to privacy concerns, it cannot provide one claimant with the name and address of another claimant. While claimants understand the need to protect privacy, they question if more could be done to assist them in locating colleagues.

<sup>35</sup> In response to being told that DOE did not keep DOE subcontractor employee records, some have asked about medical records. DOE has indicated that if the employee received medical services onsite or if the employee was badged for dosimetry, these records would be available.

<sup>36</sup> Complaints arising from attempts to use affidavits prepared by the claimant are discussed in Chapter 5, section C.

We are aware of claimants who were able to locate and obtain information from former employers. In our experience this is the exception to the rule. More frequently we encounter instances where former employers are out of business and the claimant has no idea of how to contact this former employer. In addition, in those few instances where the former employer was still in business, we found that claimants were often reluctant to reach out to these former employers. Claimants often: (1) did not feel comfortable contacting an employer with whom he/she was last employed many years ago, and/or (2) felt that he/she did not know what to ask. As a result some claimants asked if DEEOIC could contact these former employers. Claimants believe that: (1) employers are more likely to respond to inquiries from the government, as opposed to an inquiry from someone who last worked for the company many years ago, and (2) DEEOIC is in a better position to identify the information that is needed and if necessary, to explain why this information is needed.

## **2. Evidence of a DOE Contract**

Some subcontractor employees have also complained about the need to establish that the employer had a contractual relationship with DOE (or a DOE contractor). Claimants faced with this challenge routinely remind us that these facilities usually operated on a need-to know basis, and we are assured that most workers did not engage in jobs where he/she had a need to know about the contract between the employer and DOE (or the DOE contractor). Consequently, claimants are often at a loss as to how to prove the existence of a contract to which they were not a party.

Claimants find it especially troubling when the evidence establishes that they worked onsite at the covered facility and yet they are asked to establish that the employer had a contractual relationship with DOE (or a DOE contractor). Because of the security that generally surrounded these facilities claimants believe that if the evidence shows that a company performed work onsite at a covered facility, then one should be able to assume that there had to be some type of agreement or contract. Claimants believe that drawing such a conclusion is reasonable, especially since the government is in the better position to resolve the matter by producing the contract (or the agreement) under which the employer performed work onsite. They also argue that asking them to produce the actual contract requires them to establish employment with 100% certainty.

## **3. Difficulties encountered by survivors locating employment records**

Survivors of former workers sometimes find their search for employment records hampered by the fact that their loved one did not discuss his/her employment. We are frequently reminded that workers were instructed not to discuss their employment and, true to their word, many workers did not share a lot of details about their employment with their families. Therefore, it is common to encounter survivors who know very little about their loved one's employment. In a number of instances, further hampering a survivor's search for employment information was the fact that during his/her lifetime their loved one worked for a number of different employers. When this occurs, it can be difficult to determine which,

if any, employment was covered employment.<sup>37</sup> Survivors have suggested that it would help if DEEOIC could provide a listing of the known contractors and subcontractors associated with particular facilities. It is our understanding that DEEOIC has such listings for some facilities. However, these listings are not available to the public.<sup>38</sup> DEEOIC explained that national security concerns keep them from sharing this information.<sup>39</sup>

#### **4. The status of certain facilities**

Attempts by claimants to establish that a facility meets the statutory definition of a covered facility have also prompted questions concerning the efforts undertaken by the government to find relevant records. In particular, claimants question the extent to which relevant evidence was reviewed in determining whether certain facilities were covered facilities. This concern was raised in conjunction with the determination that the National Bureau of Standards (NBS) is not a covered facility. NBS was initially included on the list of covered AWE facilities. However, on November 30, 2005, DOE de-listed this location as an AWE facility because it had been part of the Department of Commerce and the statute precludes worksites that are owned by the federal government from being AWE facilities, which was the former designation of the NBS worksite.<sup>40</sup> We continue to hear from claimants who question whether there are documents that have not been made public that could shed light on the degree of control the government had over this facility.

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<sup>37</sup> This is another reason some potential claimants overlook notices about this program. We have talked to survivors who noted that when they first heard about a program for employees of DOE contractors and subcontractors, they had no idea that their loved one engaged in such employment. Rather, it was not until they learned more about these facilities that they realized they might be eligible for this program.

<sup>38</sup> DOE's listing of covered facilities identifies the main contractors at various facilities, but does not identify subcontractors.

<sup>39</sup> In the opinion of many claimants, that the government has records that it cannot share is all the more reason the government ought to aggressively assist claimants in locating information.

<sup>40</sup> DOE is the agency with exclusive authority to designate and "de-list" Atomic Weapons Employers

## Case Study Three

The Office was approached by an AR who wanted to know if X-rays taken at the Kadlec Hospital (Kadlec) in Richland, Washington should be included in dose reconstructions performed by NIOSH. Initial guidance from NIOSH indicated that x-rays taken at Kadlec were not included in dose reconstruction since these x-rays were not performed onsite at the covered facility. In discussing this response with the AR, the AR questioned whether Kadlec might be a covered facility. An internet search using the terms “Kadlec Hospital” and “AEC” led to the hospital’s website where in its history the hospital stated that in 1956 Kadlec became the first hospital to be removed from the control of the AEC. Another result led to a 1950 decision by the National Labor Relations Board. This decision specifically discussed the terms of the contract between Kadlec and the AEC. This evidence was forwarded to DOE, who subsequently located a deed dated September 10, 1956, in which the AEC conveyed Kadlec to the Kadlec Methodist Hospital. In light of these findings, NIOSH has indicated that it will revise its guidance on x-rays taken at Kadlec up until 1956. At the time of this report, DOE and DEEOIC were still reviewing the status of the hospital. The AR was pleased to hear this result. However, instances such as this feed into a fear that there are instances where the government’s search for relevant evidence was not as thorough as it could be. Because of this fear, some claimants believe that there are instances when claims are denied (and/or decision are made) without the benefit of relevant evidence that has not been located. This fear also helps to explain why some claimants continue to make requests for documents even after being told that the documents do not exist. These claimants hope that the next request prompts a more thorough search that results in locating additional relevant evidence.

### **5. Social Security Earning Records**

Our 2014 Annual Report discussed complaints asserting that the processing of some claims had been delayed while DEEOIC awaited receipt of Social Security Administration (SSA) earnings records. In this discussion we also recognized that on October 15, 2014, DEEOIC issued EEOICP Bulletin No. 15-01 announcing that SSA and DEEOIC had agreed to new procedures to expedite the process for requesting earnings data to assist in verifying covered employment and/or to establish wage loss. In 2015 we did not receive any complaints alleging a delay in the processing of a claim related to the receipt of SSA earnings records.

## C. Exposure Records

Claimants also complain that it can be difficult to locate exposure records. While SEM contains exposure information, many claimants question the accuracy of the information found in SEM. Thus, in the opinion of some claimants, finding accurate information is crucial. The concerns that we have heard regarding the difficulties finding such information are discussed below.

### **1. EEOICPA Circular NO. 15-06**

In December 2014, DEEOIC issued Circular 15-06, Post-1995 Occupational Toxic Exposure Guidance. We have received complaints suggesting that this circular will have a significant impact on the evidence that must be located and submitted to establish sufficient work-related exposure. These concerns are addressed in Chapter VI, Notice and Due Process.

### **2. The use of Industrial Hygienists (IHs)**

During the year, we were initially approached by ARs who questioned if DEEOIC had changed its policy that governed when cases were forwarded to an IH for review of the nature and extent of a claimant's exposure to toxic substances. These questions were prompted by what these ARs perceived as an increase in the number of cases being forwarded to IHs for review. At about the same time, we began to notice an increase in the number of claimants contacting us to inquire into the status of their claims. What caught our attention was that these claimants often told us that it had been months since anyone associated with DEEOIC had talked to them about their case. Our inquiries to DEEOIC revealed a number of instances where cases were waiting for a report from an IH, including at least one response in which DEEOIC acknowledged "a significant increase in IH referrals."<sup>41</sup> This increase in referrals to IHs has, in turn, generated more questions and concerns. In particular, claimants question what would happen if they passed away while the case was waiting for review by the IH.<sup>42</sup> In addition, claimants want to know if this increase in referrals to IHs reflects a new policy (or a new approach) in determining exposure.

### **3. Level of exposure**

PM Chapter 2-0700.2 currently provides that,

*To establish that an employee was exposed to a toxic substance, the evidence of file must show evidence of potential or plausible exposure to a toxic substance and evidence of covered DOE contractor/subcontractor or uranium employment at a covered DOE/RECA facility during a covered time period.*

As previously discussed, claimants approached the Office about what they feel is an increase in the number of cases referred to IHs. Claimants question if this increase in referrals to IHs is part of an effort to increase the burden they must meet to establish exposure to a toxic substance. In particular, claimants

<sup>41</sup> We encounter claimants who contend that their cases sat for months while waiting for a report from an IH. In one instance a claimant contacted us in May 2015 asserting that the National Office sent his case for specialist review on 12/10/2014. The response from DEEOIC simply noted that the case was currently with the IH. In another instance, in November 2015, DEEOIC informed a claimant that the request to the IH had been made on 04/09/2015. Often complicating these delays is the fact that the death of the claimant during this delay could significantly impact the payment of compensation.

<sup>42</sup> While DEEOIC has procedures to expedite cases if the claimant is terminal, we find that many claimants are not aware of this procedure.

suggested that they were required to show more than a potential or plausible exposure to a toxic substance. Some claimants argue that the CE's focus on the level of exposure essentially required them to establish exposure to a toxic substance with almost absolute certainty.

There is also a concern that when asked to address the level of exposure, IHs often rely on generalized information that address labor categories in general. There is a concern that an IH does not always have access to and thus may not review information specifically related to the work performed by that specific worker. Some claimants believe that the only site specific information relied on by some IHs is the information found in SEM. In addition, claimants argue that in arriving at their conclusions, IHs often rely upon information prepared by the employer – information that many claimants believe is inaccurate and possibly misleading.

Another concern comes from claimants who fear that when focusing on levels of exposure there is a tendency to overlook (or minimize) the fact that under Part E, the exposure does not have to cause the illness. Rather, under Part E it is sufficient if the exposure is a significant factor in contributing to, or aggravating the illness. In response to a CE's or CMC's determination that a worker did not have sufficient exposure, some claimants have noted that it is impossible to determine if the CE or CMC simply focused on whether there was sufficient exposure to cause the illness, or whether they also considered whether the level of exposure could have been a significant factor in aggravating or contributing to the illness.

#### **4. Accuracy of the information on SEM**

While it is the position of DEEOIC that no claim is to be denied solely due to a lack of information contained in SEM, many claimants believe that SEM is often a critical factor in determining if a claim is accepted or denied. See EEOICP PM Chapter 2-0700.9(a). For instance, we frequently talk to claimants who believe that the only site specific information given to an IH is from the SEM database. Therefore, concerns with the accuracy of the information found in SEM leads some claimants to try to find other records.

We have received complaints suggesting that SEM failed to acknowledge any use of a particular toxin at a facility. More frequently, claimants question the accuracy of those aspects of SEM that list the toxins used at specific areas, work processes, or labor categories, as well as the accuracy of the listing of toxins associated with particular accidents or incidents. We are routinely approached by claimants who assure us that in performing their jobs, they did not limit themselves to certain defined work areas; that the actual duties they performed did not match their job description; or that in performing their job they did not strictly adhere to the outlined procedures. Consequently, claimants are troubled when they are informed that, according to SEM, their jobs did not bring them into contact with a particular toxin. A frequent question asked by claimants is whether in creating SEM, DEEOIC simply relied on documents prepared by the facilities and did not take into account (and/or did not realize) the extent to which day-to-day activities did not always follow established procedures. In furtherance of this concern claimants emphasize that they often worked in an environment in which quickly completing the project was the number one priority, and in this environment, adherence to written procedures was not strictly enforced.

One complaint involving the accuracy of SEM came from a former employee who maintained that the listing of known incidents at the Hanford facility in Richland, Washington, did not include an accident that occurred on August 30, 1976. As this employee notes, if you search the internet for "McCluskey" and

the word “Hanford,” you will find multiple links, including a link to DOE’s website, where this incident is discussed.<sup>43</sup> Since DOE’s webpage discusses this incident, this employee cannot understand why this incident is not listed in SEM.<sup>44</sup>

There is a belief that the failure to recognize incidents can have a direct impact on the adjudication of a claim. Claimants are concerned that if an incident is not listed in SEM, the CE will not be aware of the incident (or may overlook the incident when processing a claim). Claimants also fear that when an incident is not listed in SEM, it can be difficult and time consuming to convince a CE or HR that the incident occurred and to what they were exposed.

Complaints challenging the accuracy of exposure records also question the extent to which DEEOIC has been able to retrieve all of the relevant records. For instance, an AR working on claims arising out of employment at the Santa Susana Field Laboratory noted that when he/she initially asked the employer for records, he/she was told that no radiation records could be located. When he/she expanded the request to include “all other records,” he/she was informed that “[a]ll the employee’s records have been destroyed in accordance with...Master records Retention Guidelines.” In the opinion of this AR, this response not only raises questions as to the appropriateness of destroying exposure records but also raises a question as to the sufficiency of the records provided to DEEOIC regarding employment at Santa Susana Field Laboratory.

In the next chapter (Issues Related to the Weighing of Evidence), we will talk in more detail about the complaints raised by claimants questioning whether exposure records were deliberately altered. At this point, it is sufficient to say that claimants frequently note that in creating this program Congress found that,

*...a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demand for hazardous duty pay.*

See 42 U.S.C. §7384(a)(2). Many claimants believe that the same fears that caused employers not to inform the employees about the risks at these worksites also led some employers to alter records and to fail to record certain incidents and accidents.

<sup>43</sup> Harold McCluskey was injured in 1976 when a vessel inside a glove box burst and exposed him to radioactive material.

<sup>44</sup> There is also a concern that if an incident as well known as the McCluskey Incident is not in SEM, how many lesser known incidents may be missing from SEM.

## **D. Locating Part B Evidence**

Practically all of the complaints that we received concerning the difficulties encountered when trying to locate Part B exposure evidence involve radiation exposure.<sup>45</sup> Claimants question the accuracy of the information relied upon by NIOSH in performing the dose reconstruction and in particular, they question the determination as to the areas, work processes, labor categories, and the incidents where an employee could have sustained radiation exposures.

An issue that we continued to encounter in 2015 questions the levels of radioactive exposure at the Kansas City Plant (KC) in Kansas City, Missouri. Former employees indicate that in the years immediately following the creation of this program, the KC Plant was described as a facility that produced non-nuclear components for nuclear weapons. Recently, however, additional evidence has come to light that suggest greater levels of radiation than originally thought. When this additional evidence came to light, some former KC Plant employees assumed that this would lead to the establishment of a SEC for the KC Plant. Instead, these former employees cannot understand how a few years ago no one seemed to fully appreciate the levels of radiation at the KC Plant, and now NIOSH maintains that it possesses sufficient information to perform dose reconstructions on former KC Plant employees.<sup>46</sup>

## **E. Locating Evidence Addressing Causation**

Under Part E, there must be evidence linking the illness to the toxic exposures that occurred at the covered facility. Claimants often contact us when they receive a letter from DEEOIC directing them to submit evidence establishing this link. As with other evidence that claimants are asked to submit, claimants complain that locating such evidence can be difficult.

A common complaint notes that physicians are reluctant to address issues that were not addressed at the time of treatment. Where the worker died before the creation of this program (or died before knowing of this program), existing medical reports often do not address the link between the death and work related exposures. Claimants contend that in such situations it can be nearly impossible to find a physician willing to address this link. Similar complaints are raised when the worker was diagnosed and treated for the condition years before the claim was filed.

Claimants also contact the Office to share that it can be difficult to find medical literature addressing the possible link between certain illnesses and particular toxins. Claimants frequently question whether it was Congress' intent to deny claims when no one had engaged in the research necessary to confirm or deny the possibility of a link between a particular illness and a certain toxin. Many claimants believe that where medical literature cannot confirm or deny a link, a reasonable and rationale medical opinion ought to suffice. Other claimants have suggested that the government ought to take a more active role researching possible links.

<sup>45</sup> Employees of AVEs have sometimes questioned whether their exposure to beryllium was properly noted. However, employees of AVEs are not covered under this program for exposure to beryllium.

<sup>46</sup> In the event NIOSH has sufficient information to complete dose reconstructions for claimants at a covered facility, no SEC class will be implemented.

## Issues Related to the Weighing of Evidence

Issues surrounding the weighing of evidence are the subject of a large percentage of the complaints that the Office received. The concerns raised in these complaints often address issues that go beyond the mere disagreement with the outcome. Rather, many of the complaints question the rationale for crediting certain evidence, or question whether rules and procedures were properly followed in weighing evidence. Here are the most common complaints that we received this year addressing the weighing of evidence.

### A. What is the burden of proof

There continues to be considerable confusion regarding the burden of proof that a claimant must satisfy in an EEOICPA claim. A number of comments noted that the discussion of the burden of proof found in decisions often repeats the same message. This message, which is discussed in many of the cases found on DEEOIC's website under "Significant EEOICP Cases" - "Burden of Proof," states that,

It is the claimant's responsibility to establish entitlement to benefits under the EEOICPA. The EEOICPA regulation at § 30.111(a) states, "the claimant bears the burden of proving by a preponderance of the evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category set forth in § 30.110. Proof by a preponderance of the evidence means that it is more likely than not that the proposition to be proved is true. Subject to the exceptions expressly provided in the Act and these regulations, the claimant also bears the burden of providing to OWCP all written medical documentation, contemporaneous records, or other records and documents necessary to establish any and all criteria for benefits set forth in these regulations." 20 C.F.R. §§ 30.110, 30.111(a).

Claimants find it confusing that while 20 C.F.R. §30.111(a) states that "[e]xcept where otherwise provided in the Act and these regulations..." the claimant bears the burden of proving each necessary criterion by a preponderance of the evidence, Part E of the Act specifically provides that a contractor employee shall be determined to have contracted a covered illness through exposure at a DOE facility if:

- (A) it is at least as likely as not that exposure to a toxic substance at a Department of Energy facility was a significant factor in aggravating, contributing to, or causing the illness; and
- (B) it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility.

See 42 U.S.C. §7384s-4(c). Claimants do not understand when the preponderance of the evidence (more likely than not) standard applies and when the "at least as likely as not" standard applies.<sup>47</sup> In this regard, claimants contend that some decisions do not articulate the standard of proof used to weigh the evidence.

<sup>47</sup> The preponderance of the evidence standard requires a finding of greater than 50%. The at least as likely as not standard requires a finding of 50% or greater.

## **B. Is the burden of proof properly applied**

Even though they are sometimes uncertain as to the specific standard of proof used to adjudicate aspects of their claim, some claimants feel certain that the burden imposed on them was greater than either the preponderance of the evidence or the “at least as likely as not” standard. In particular, we are approached by claimants who believe that they were required to prove certain criterion to near certainty. This concern is often raised by subcontractor employees who are required to prove the existence of a contractual relationship between their employer and DOE (or a DOE contractor). Some subcontractor employees have argued that there was more than enough circumstantial evidence in the record to draw the conclusion that it was more likely than not that a contract existed. However, according to these claimants, instead of accepting the circumstantial evidence, DEEOIC demanded the production of documents or direct testimony confirming the existence of the contract. In the opinion of these claimants, the evidence sought by DEEOIC, in essence, required the claimant to prove the existence of a contractual relationship with near certainty, and thus required them to meet a higher burden of proof than required by EEOICPA.

A similar argument has been raised by claimants concerning the evidence needed to establish a link between the claimed illness and a toxic exposure. A common scenario that we encounter involves situations where SEM establishes that a worker was exposed to a particular toxin and further establishes that this toxin is linked to the illness claimed by the worker. Since the standard outlined under Part E is “at least as likely as not a significant factor in causing, contributing to, or aggravating the illness”, claimants question how much additional evidence is necessary to link their toxic exposure to the illness, and to link their exposure to employment at a DOE facility.<sup>48</sup> In many of the instances brought to our attention, while the physician stated his/her opinion citing to the “at least as likely as not” standard, claimants (and sometimes the physician) complained that the follow-up questions posed by DEEOIC appeared to require the physician to state his/her opinion with near certainty.

Claimants also remind us that under Part E the issue is whether the exposure to a toxic substance was a significant factor in aggravating, contributing to, or causing the illness. There are instances when claimants believe that DEEOIC only focused on whether the exposure caused the illness, and did not consider whether the exposure was a significant factor in aggravating or contributing to the illness.

In this regard, a common scenario that we encounter involves decisions where the discussion of causation is vaguely worded. For example, we received complaints concerning decisions where the discussion of Part E simply addressed whether the illness was “related” to toxic exposure. According to claimants, the use of the word “related” makes it hard to determine if the decision simply focused on causation, or whether the decision also considered whether the exposure was a significant factor in contributing to, or aggravating the illness.

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<sup>48</sup> Under Part E a contractor employee shall be determined to have contracted a covered illness through exposure at a DOE facility if –

A. It is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness; and

B. It is at least as likely as not that exposure to such toxic substance was related to employment at a DOE facility.

42 U.S.C. §7385s-4(c).

Another concern brought to our attention this year involved situations where SEM showed a relationship between the worker's illness and multiple toxins, and according to SEM, the worker was exposed to all of these toxins. Since the standard is "at least as likely as not" and because it is sufficient under Part E if the exposure is a significant factor in causing, aggravating or contributing to the illness, ARs and physicians question the need to specifically identify which of these toxins were a significant factor in causing, contributing to, or aggravating the illness - especially where all of the toxins have an established, known link in the SEM. In some instances, it has been suggested that it is medically impossible to narrow the opinion down to one or two toxins.

In one case, claimant's medical report identified the two jobs the employee had held; identified the areas where the employee engaged in this work; identified multiple known respiratory toxins to which the employee was exposed (along with scientific references); and concluded that these exposures more likely than not caused, aggravated, and or contributed to the employee's lung condition. In response to this submission, DEEOIC acknowledged that the physician had linked multiple toxic substances to the claimant's lung condition, but asked for an addendum to clarify which toxic substance(s) were linked to the lung condition and whether/how the physician knew that these toxic substances were present in the employee's labor categories at the facility. In contacting our Office, claimant's physician was not only adamant that he had already provided this information, he also wondered why his existing report was not sufficient to establish that it was at least as likely as not that exposure to a toxic substance was a significant factor in aggravating, contributing to, or causing claimant's illness.

### **C. The weight given to affidavits prepared by claimants and family members**

Section 30.112(b)(3) of the regulations provides that,

If the only evidence of covered employment is a self-serving affidavit and DOE or another entity either disagrees with the assertion of covered employment or cannot concur or disagree with the assertion of covered employment, then OWCP may reject the claim based upon a lack of evidence of covered employment.

See 20 C.F.R. §30.112(b)(3). In our experience, the affidavits most likely to be deemed "self-serving" are those prepared by the worker or a close family member.<sup>49</sup> First and foremost, claimants are bothered by the use of the term "self-serving." Claimants are also troubled by what they feel to be an underlying assumption that anything said or produced by the worker in support of his/her claim is automatically suspect. When former workers contact us to complain about this provision, they are sure to remind us that they voluntarily agreed to work in these facilities. They also stress the extent to which they honored their commitment not to talk about the work performed at these sites. Thus, former workers find it troubling when the affidavits that they prepare on their own behalf are considered self-serving simply because they prepared it.<sup>50</sup>

<sup>49</sup> Proposed revisions to EEOICP's regulations would delete the reference to "self-serving."

<sup>50</sup> Claimants frequently argue that it is unfair that documents that they prepare on their own behalf are deemed "self-serving" and thus must be supported by other evidence in the record, while documents prepared by employers are readily accepted in spite of the evidence suggesting that employers often had many reasons to conceal accidents and/or under-report the use of toxic substances.

In complaining about this provision, claimants also take issue with Chapter 2-500.12(d) of the EEOICP PM which provides that, "...Statements provided by way of an affidavit are considered in conjunction with other evidence submitted in support of a claim." Claimants complain that in practice this means that affidavits prepared by a worker are only accepted when the affidavit is supported by other evidence in the record. Claimants argue that this is unreasonable. Claimants note that it is often because other relevant supporting evidence cannot be located that DOL informs them they can submit affidavits. This has certainly been our experience. Consequently, Chapter 2-500.12(d) makes it hard, if not impossible for claimants to use affidavits in the very cases where affidavits are most critical - i.e., cases where records were destroyed and colleagues cannot be located.

Claimants often tell us that when they prepare an affidavit, they make sure to include specific information about their employment - information that they believe would confirm their employment, especially if these affidavits were reviewed by someone who is familiar with the facility. Thus, claimants are disappointed when their affidavits are summarily rejected. Moreover, because they include information that is specific to the facility where they worked, claimants are often leery when the affidavits and the other documents they prepare are reviewed by individuals with limited knowledge of these facilities.

Some claimants have characterized DEEOIC's approach to affidavits prepared by the worker as a "catch-22." On the one hand, the government destroyed or did not collect the records that could have verified employment. Yet, on the other hand, when the worker prepares an affidavit to verify his/her employment, the affidavit is rejected because it is not supported by other evidence in the file.

Some claimants believe that DEEOIC's approach to affidavits is based on an unrealistic assumption regarding the ability to locate colleagues. A number of claimants noted that when employment records could not be located and they asked DEEOIC for other suggestions on how to verify employment, DEEOIC's only suggestion was for the claimant to submit affidavits prepared by colleagues. Claimants question if DEEOIC appreciates how difficult it can be to locate people they last worked with 20 or more years ago. Claimants also question if DEEOIC appreciates that former colleagues are not always in a position to provide the level of detailed information sought by DEEOIC about events that occurred years ago.

Claimants also argue that DEEOIC's approach to affidavits prepared by the worker places an increased evidentiary burden on claimants. This argument notes that DEEOIC has supported its approach to affidavits prepared by workers by stating that "evidence" is needed to prove employment. Several ARs and claimants have noted that in their experience with other courts, oral testimony, affidavits, and circumstantial evidence are all accepted as evidence. Thus, claimants question DEEOIC's basis for concluding that affidavits prepared by the worker must be supported by other evidence in the file. Claimants argue that such an approach places a higher evidentiary burden on EEOICPA claimants than found in criminal cases where the government must prove its case beyond a reasonable doubt.

## **D. The qualifications of the person evaluating the evidence**

There are instances when the issues that must be adjudicated in a claim involve complicated medical and/or scientific concepts. Some claimants question whether the person deciding these issues has the qualifications and knowledge to make these medical and/or scientific determinations. A common scenario involves situations where the CE or HR makes a medical/scientific determination without any references to support the conclusion that is being drawn, and without any indication as to who actually made the determination. Take for example the case where a claimant was informed that,

*Under current policy a diagnosis of myeloproliferative disorder is not the same as a myeloproliferative neoplasm. There are several types of myeloproliferative disease...*

The claimant had two concerns with this discussion: (1) the discussion failed to identify the “current policy” and (2) the discussion did not identify who made this policy. These concerns became even greater when in response to an inquiry the National Cancer Institute responded by indicating that “... both terms (myeloproliferative disorder and myeloproliferative neoplasm) have essentially the same meaning.”

Questions concerning the qualifications of the person evaluating evidence are not limited to CEs and HRs. In 2015, claimants also questioned the qualifications of the experts (the CMCs, toxicologists and the IHS) utilized by DEEOIC to provide expert opinions. In one instance, an expert opinion obtained by DEEOIC stated that, “Trichloroethylene is known to cause peripheral neuropathy from occupational exposure. The organic solvent neuropathy (trichloroethylene is an organic solvent) occurs in the peripheral nervous system...” This opinion was challenged by claimant’s physician who cited medical literature detailing central neurotoxic effects of solvents. In another instance, claimant’s expert responded to the report prepared by DEEOIC’s expert by opining that DEEOIC’s expert had not relied upon recent literature. Claimant’s expert supported his opinion by providing DEEOIC with citations to more recent literature.

We also received complaints questioning if proper consideration was given to the qualifications of all of the physicians and experts. There is a belief that there are times when CEs and HRs give more weight to DEEOIC’s experts simply because they were retained by DEEOIC. This raises fears that CEs and HRs do not consider (or give little consideration to) the qualifications of the experts obtained by claimants.

## **E. The weight given to the Procedure Manual (PM), bulletins, circulars, etc.**

Another issue that continues to generate concerns is the weight accorded by CEs and HRs to provisions of the PM, bulletins, circulars, and policy teleconference notes. In particular, claimants complain that there are instances when DEEOIC appears to accord certain PM provisions, bulletins, circulars, and policy teleconference notes the weight of law. This issue is discussed in the next chapter, Notice and Due Process. Nevertheless, the Office frequently encountered claimants who expressed concerns when a PM provision, bulletin, circular, or policy teleconference note was cited as the sole authority (or basis) for a decision.

## Case Study Four

This case study involves three separate occasions when the same claimant contacted us for assistance. All three occasions involved issues related to massage therapy prescribed by the treating physician. Among the issues highlighted by this case study is DEEOIC's use of programs policies and PM provisions.

The claimant initially contacted us in May 2012 when he/she encountered problems with the payment of bills for massage therapy visits. In response to an inquiry, DEEOIC explained that there had been a delay in sorting out a new review process. The Office was also told that the therapy had been authorized. DEEOIC indicated that it would notify the bill processor of the authorization for treatment.

In December 2012, claimant again contacted the Office when the bills still had not been paid. The problem now appeared to be that instead of allowing for 18 one-hour visits, the claimant was only being allowed 18 units of massage therapy (18 visits of 15 minutes). Following an inquiry to DEEOIC, this matter was resolved.

In 2013, the claimant's physician recommended increasing claimant's massage therapy visits to 3 one-hour visits per week. The claimant contacted us when he/she received a letter decision from DEEOIC denying the request for 3 one hour visits per week. This letter decision informed the claimant that,

[e]ffective 01/24/2013, new program policy establishes that massage therapy may be authorized for a maximum of 2 visits per week, up to 1.5 hours per visit, and may not exceed 60 massage therapy visits per calendar year.

The letter decision referred to a "new program policy." It did not identify the new program policy nor did it mention that DEEOIC had recently issued Bulletin No. 13-01, which specifically stated that "[t]he CE may not authorize more than 60 massage therapy visits per calendar year." See, EEOICP Bulletin No. 13-01 (January 2, 2013). This letter decision also informed the claimant that if he/she disagreed with the decision, he/she could request a formal decision by advising DEEOIC in writing of his/her desire to have a Recommended Decision.<sup>51</sup>

Claimant contacted us when he/she did not receive a response to his/her May 10, 2013 request for a recommended decision. In response to our inquiry, DEEOIC initially stated that the claimant was entitled to a recommended decision and that it anticipated a decision would be rendered in the "immediate future." Nine days later DEEOIC informed the

<sup>51</sup> The letter from DEEOIC further stated that, *"If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with the rights of actions."*

Office that the district office had advised that since they would approve an extension of massage therapy for up to 60 visits, a recommended decision was not warranted at that time. Claimant felt that this response was not only contrary to the letter decision which had stated that the claimant could ask for a recommended decision, but was also contrary to Bulletin 13-01 which provides that, “[s]hould the claimant request a recommended decision (RD), regarding denial of either the initial authorization or recertification of massage therapy, the CE completes the RD process in accordance with existing DEEOIC procedure.” See EEOICPA Bulletin NO. 13-01, January 2, 2013.

This claimant further felt that DEEOIC’s action left him/her in a state of limbo - he/she disagreed with DEEOIC’s determination not to approve more than 60 massage therapy visits in the calendar year, but could not object since a recommended decision had not issued. Moreover, while this claimant did not agree with DEEOIC’s approach, he/she assumed that a recommended decision would be issued once he/she exceeded 60 massage therapy visits in the calendar year. However, that did not occur. Claimant did not receive a recommended decision even after he/she was denied approval for additional visits beyond 60.

Thus, claimant retained the services of an AR.<sup>52</sup> In 2014 the claimant received a recommended decision denying the request for massage therapy visits in excess of the limits outlined in EEOICPA Bulletin No. 13-01. Claimant objected to this recommended decision. In response, the case was sent to OWCP’s Medical Director who ultimately opined that the prescribed massage therapy for 3 days per week was medically necessary. A final decision approving massage therapy sessions 3 times a week was issued in 2015.

In support of his/her contention that DEEOIC initially accorded this program policy/PM provision the force and effect of law, the claimant noted that this program policy and later Bulletin No. 13-01 were the only reasons cited by DEEOIC for denying the request for more than 60 massage therapy visits in a calendar year. Claimant also noted that Bulletin 13-01 states that, “[t]he CE may not authorize more than 60 massage therapy visits per calendar year” and that “[a]ny request for massage therapy beyond 60 visits in one calendar year should be denied without development, citing this Bulletin.”

This claim demonstrates the situation where information was provided to a claimant in a piece-meal fashion. Claimant noted that it was not until almost a year after receipt of the letter decision denying the request, and only during an e-mail exchange with DEEOIC that

<sup>52</sup> The AR requested a copy of a policy call note that had been referenced in an e-mail. In response, DEEOIC suggested that the AR could request a copy of the case file. Based on this AR’s experience, he/she doubted whether the case file would contain a copy of a policy call note. In fact, in making this suggestion, the NO noted that they were not sure that a copy of the case file was what the AR wanted. This encounter is consistent with other encounters brought to our attention where claimants believe that their ability to challenge a determinat

he/she was told that he/she could submit evidence to support that he/she needed more treatment than that allowed by the program.<sup>53</sup>

Following the issuance of the final decision approving more than 60 massage therapy visits in the calendar year, the claimant requested reimbursement for the massage therapy visits he/she had paid out-of-pocket. The claimant's third contact with this Office occurred when he/she was informed that DEEOIC would not reimburse him/her for all of his/her out-of-pocket expenses. The claimant contacted us when his/her inquiry to DEEOIC regarding the decision not to fully reimburse him/her had been pending for close to six weeks. In response to our inquiry, DEEOIC explained that while each massage therapy session had lasted one hour, for each session the claimant had only billed for 1 unit of the massage therapy billing code (1 unit is 15 minutes). DEEOIC assured us that a claims manager would contact claimant to explain the situation. Still this claimant questions why it took so long to respond to his inquiry.

In a subsequent conversation, the claimant explained his/her confusion with the billing process. The claimant noted that Bulletin No. 13-01.6 states that each massage therapy visit is equal to a maximum of 1.5 hours. This is what the claimant relied on in preparing the request for reimbursement. According to this claimant it never occurred to him/her that for purposes of seeking a reimbursement the term "visit" would have a different meaning from that used when referring to treatment units. Moreover, the claimant questioned why, in denying the request for reimbursement, no one took the time to explain the problem – rather he/she had to ask why the request had been denied.

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<sup>53</sup> As soon as his/her request was denied, this claimant decided to search for additional medical evidence that supported his/her request for more treatment than allowed by DEEOIC's policy. Nevertheless, the email exchange with DEEOIC was the first time DEEOIC ever specifically stated that the claimant could present additional evidence.

## **F. Decision not well explained**

As we indicated in our prior reports, DEEOIC has made significant improvements ensuring that decisions contain adequate reasoning and documentation. See e.g., 2013 Annual Report to Congress, Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program; August 12, 2014. However, concerns with the adequacy of the reasoning and documentation of decisions are still brought to our attention. Based on their advantage of having reviewed multiple decisions, some ARs have suggested that improvements are dependent upon the CE or HR.

In one instance, a claimant complained when the letter decision indicated that his/her request for home health care was denied because he/she was still able to work.<sup>54</sup> This confused the claimant since he/she was not aware of, and the decision did not cite to, a rule barring home health care when the employee was still working. When our Office inquired into this denial, DEEOIC's response indicated that while the decision had not clearly stated it, there was a concern with the level and amount of care.

In another instance, a claimant contacted the Office when his/her claim for CBD under Part B and Part E was denied. As frequently occurs, this claimant did not contact us to register a complaint. Instead, this claimant contacted us because he/she sought guidance on how to proceed. However, due to the lack of a clear explanation in the decision, we found it difficult to provide guidance. In this case, the recommended decision outlined the criteria for CBD under Part B and then proceeded to explain why the claimant did not meet either the pre-1993 or post-1993 criteria for CBD under Part B. With respect to the claim for CBD under Part E, the decision simply stated,

*Finally, with regard to your claim for CBD under Part E, the records you submitted do not include a diagnosis of that condition from one of your treating physicians.*

This discussion of Part E confused both the claimant and our Office. In prior cases, DEEOIC had indicated that an abnormal BeLPT result was required in order to accept a claim for CBD under Part E. Yet, this recommended decision did not state that an abnormal BeLPT result was required in order to accept a claim for CBD under Part E, nor did it mention that the record did not contain an abnormal BeLPT. Thus, it was not clear if this decision reflected a change in DEEOIC's policy, or if this was an instance where the CE had focused on the need for a diagnosis and did not address the need for an abnormal BeLPT.

Another example of an instance where problems arose because of an inadequate discussion of the evidence involved a claimant who filed a claim for wage loss benefits based upon the accepted covered illnesses of beryllium sensitivity and CBD. The claimant received letters from DEEOIC seeking medical evidence that established a causal relationship between the accepted covered illness and the wage loss. The letters from DEEOIC provided examples of such evidence, including return to work slips signed by a doctor. The claimant submitted work restriction forms signed by a physician indicating he could not work in any position where beryllium exposure was possible. In spite of claimant's submission of additional evidence, the claimant received a subsequent letter from DEEOIC seeking the same information. This subsequent letter from DEEOIC did not acknowledge the evidence previously submitted by claimant.

The claimant contacted the Office when he/she received a recommended decision to deny the claim for wage loss. This recommended decision did not acknowledge or discuss any of the evidence submitted by claimant. In contacting us, the claimant also complained of being unable, prior to the issuance of the recommended decision, to speak to the CE to confirm receipt of the evidence, and ultimately, of not understanding why the claim was recommended for denial. According to the claimant, he/she was

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<sup>54</sup> Some claimants who received letter decisions questioned the value of these decisions, especially when the decision was to deny the claim. These claimants complained that the letter decision was so cursory they were compelled to ask for a recommended decision in order to gain a better insight into the reasoning of the decision. In the opinion of these claimants, letter decisions simply added an extra step to what can already be a long, drawn out process.

confused since the decision simply stated the claimant had not provided the requested information and therefore, the claim must be denied.

Claimant objected to the recommended decision and requested a hearing. It was not until the claimant attended an oral hearing that the claimant was able to confirm that the evidence he/she submitted was in the claim file. As outlined in this example, it is not uncommon for the Office to hear from claimants who complain that they did not know what to bring to a hearing or to present on appeal because they did not fully understand the nature and scope of the evidence considered by the examiner below.

When claimants' evidence submitted to DEEOIC is not acknowledged, they do not know how to correct the short-comings in their claim. Similarly, when the basis for denying a claim is not clear, it is hard for a claimant to determine if he/she agrees with the decision. Claimants also contend that it is hard to develop a successful challenge to a decision when they do not fully understand the basis for the decision, and when the documents relied upon in making that decision are not identified.

In addition, claimants find it frustrating when they rely on the decision to develop additional evidence and DEEOIC subsequently provides additional reasons for the denial that claimant had not been made aware of in the original decision. This is precisely what occurred in the three examples discussed above. In the example of the home health care, the claimant contacted the Office when he/she could not find a rule stating that a request for home health care could be denied if the worker was still employed. It was only then that he/she discovered that the level of care was the reason for the denial. Similarly, in the case of CBD under Part E, the claimant was about to schedule an appointment with a physician to obtain a diagnosis of CBD when he/she contacted the Office. We advised the claimant of our previous conversations with DEEOIC in which we were told that an abnormal BeLPT was required in Part E CBD claims. In the example involving the wage loss claim, the claimant wanted to know if the evidence that he/she had submitted had been received. The claimant only learned that this evidence had been received when he/she attended the oral hearing.

Claimants are acutely aware of the limited time they have to prepare their objections to recommended decisions (or to submit additional evidence). Because of these limitations they feel that it is important to quickly know whether the evidence they submitted was considered, and if it was, where the deficiencies in their case remained. Most individuals do not use the word "prejudice", but express themselves in ways that make it fairly clear that they believe their ability to pursue evidence in support of their claim was delayed and sometimes harmed by the lack of discussion of the evidence in letters and decisions they received from DEEOIC.

## **G. Inadequate/lack of opportunity to respond**

Many of the claimants the Office encountered have a general familiarity with court proceedings. As such, they are aware that in court proceedings evidence is exchanged, and that before a decision is issued, each side has the opportunity to respond to the evidence submitted by the other side. We received complaints questioning the adequacy of the opportunities presented to claimants to respond to DEEOIC acquired evidence and policies.

As previously discussed, claimants find it troubling when decisions rely on program policies, PM provisions, bulletins, or circulars issued by DEEOIC and they were not afforded an opportunity to comment. In addition, even when given an opportunity to challenge a provision, claimants argue that they are additionally hampered by the inability to obtain the documents used by DEEOIC to establish these policies and provisions.

Claimants also find it troubling when decisions rely on evidence that they have never seen, and thus to which they never had an opportunity to respond. This concern is most often raised in conjunction with recommended decisions and usually involves reports sought by DEEOIC from CMCs, IHs, toxicologists, and other experts. The Office frequently hears from claimants who state that they only became aware that an expert had reviewed their case when they read about it in the recommended decision. Claimants take issue with DEEOIC's practice of issuing recommended decisions that rely on the report of DEEOIC's expert without giving the claimant an opportunity to review that report. In particular, claimants argue that it is unfair, prior to issuance of the recommended decision, to provide DEEOIC's expert with the opportunity to comment on the report submitted by the claimant's physician and not to provide the claimant with an opportunity to comment on the report prepared by DEEOIC's expert. Claimants believe that proceeding in this way increases the possibility that the report submitted by DEEOIC's expert will be credited over their evidence.

In response, DEEOIC notes that if the claimant disagrees with the recommended decision, or with parts of that decision, he/she can file objections and can submit evidence and arguments in support of these objections. See 20 C.F.R. §30.313(b). Claimants often contend that this is not adequate. Many claimants strongly believe that once a recommended decision issues, especially a recommended decision denying a claim, they face an increased burden when trying to overcome this denial. Consequently, claimants view it as a serious disadvantage when, without being afforded an opportunity to comment on the report prepared by DEEOIC's expert, this report is relied upon by the CE.

Claimants also believe that it is oftentimes inefficient to deny a claim based on an issue (or concern) that was never brought to their attention. In support of this argument it is noted that once a decision issues, correcting obvious mistakes can be time-consuming. The following example highlights this concern.

A letter from DEEOIC granted authorization for a service to be performed by a provider.<sup>55</sup> After the service was performed, payment to the provider was denied on the ground that the provider was not licensed. The claimant argued that had anyone brought this concern to his/her attention before denying

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<sup>55</sup> This letter made no mention of a need for a provider to be licensed, nor did it instruct claimant to submit evidence of a license, or to establish that a license was not required.

the payment, he/she could have provided information showing that this particular state did not require providers to be licensed in order to perform the services in question. When the claimant brought this information to the CE's attention, he/she was told that the process to appeal this decision was to provide his/her arguments and any supporting evidence to ACS, the bill processing office for DEEOIC. This claimant views it as inefficient to have to use the appeals process with ACS to correct an error that could have been avoided if, prior to denying the bill, the CE or ACS had simply notified the claimant of the concern regarding the provider's license.

## Notice and Due Process

In our 2014 Annual Report to Congress, the Office discussed complaints from claimants alleging that decisions by DEEOIC were based on evidence that was not in the record, and/or that claimants were not provided an opportunity to adequately respond to the denials of their claim. Some of the complaints discussed in prior reports also involved “policy teleconference notes.” In particular, we talked about claimants who firmly believed that the adjudication of their claim was significantly impacted by a discussion contained in a policy teleconference note. See 2013 Annual Report to Congress, August 12, 2014, pages 52 and 53; and 2014 Annual Report to Congress, January 8, 2016, page 51. In prior years, claimants generally did not receive and/or could not obtain a copy of the policy teleconference note, and thus, in all but a very few cases, claimants could not document their concerns by providing a copy of these notes. Rather, claimants usually approached the Office with an allegation suggesting that a CE (or HR) had originally indicated that the claim was moving in one direction, and then subsequent to communication with the National Office (via a policy teleconference call), the case went in an entirely different direction.<sup>56</sup>

A common complaint concerns the lack of an opportunity to challenge provisions of the DEEOIC policy, such as the PM, bulletins, circulars, and policy teleconference notes. Claimants find it especially troubling where a PM provision, bulletin, circular, or policy teleconference note is cited as the legal authority (or cited as the basis) for the denial of a claim. In addition to the lack of an opportunity to provide input prior to the passage of the provision, claimants also feel that they are often limited in their ability to challenge the PM provision, bulletin, circular, or policy note cited and/or relied upon in the decision. Claimants believe that when it comes to the work performed at these facilities, they have relevant insights and information that are not taken into consideration when documents are given the force and effect of law without an opportunity for input or to respond. Consequently, when their input is not sought prior to the issuance of PM provisions, bulletins, circulars, or policy note, and these documents are later given the weight of law, or cited as authority for conclusions of law, claimants often take exception to the substance of these policy provisions.

Complaints alleging that a document was given the force and effect of law were raised by claimants with hearing loss claims who expressed frustration when told they could not challenge program policy regarding the labor category criteria or duration of employment criteria that DEEOIC requires be met in order for a claim to be accepted. The Office also received complaints from claimants who objected to a “letter decision” denying claimed benefits but were not provided notice of when they could expect a recommended decision.

### A. DOL’s use of Policy Teleconference Notes

In decisions issued by DEEOIC, it is not unusual for claimants to see references to the statute, regulations and DEEOIC policy. References to the statute, regulations and many of DEEOIC policies can be accessed online at the DEEOIC homepage. However, when a decision references a DEEOIC policy teleconference note (policy note), claimants generally do not understand what the reference means or where it came

<sup>56</sup> In some instances, a reference in the decision alerted the claimant to the existence of a policy teleconference note. In other instances, claimants indicate that they learned of the existence of a policy teleconference note when they specifically asked.

from, and are frustrated by their inability to obtain access to this information. Occasionally, as in 2015, a claimant who is unable to obtain a copy of a policy note will turn to our Office for assistance.

In this instance, the claim filed by a survivor was initially recommended for acceptance based upon the pre-1993 CBD statutory criteria.<sup>57</sup> The worker had been exposed to beryllium while employed as a machinist at the Y-12 Plant. In pursuing the claim for survivor benefits, the only medical records available were those maintained by the Y-12 Plant, including DOE records which noted, “no safety equipment worn”.

The Recommended Decision discussed the pre-1993 CBD criteria and found that the medical evidence satisfied three of the five criteria for acceptance, as outlined in the statute. In particular, the decision found the medical evidence satisfied the criteria for characteristic chest radiographic abnormalities; restrictive or obstructive lung physiology testing or diffusing lung capacity defect; and clinical course consistent with chronic respiratory disorder. The decision concluded, in part:

*Although the employee was diagnosed with emphysema prior to his date of hire at the Y-12 Plant, the preponderance of the evidence of records supports his continued daily/nightly exposures in buildings 9204-2 Beta, 9204-4 Beta without respiratory protection contributed to and aggravated his lung disease.*

The subsequent Remand Order from the Final Adjudication Branch concluded that a pre-employment diagnosis of a chronic respiratory disorder should not be used as the basis to determine whether the pre-1993 CBD criteria could be considered, and referenced a November 14, 2012 EEOICPA Policy Teleconference Note. Subsequently, the claimant received a Recommended Decision and later a Final Decision to deny the claim based upon the conclusion that the medical evidence did not satisfy the criteria for “clinical course consistent with chronic respiratory disorder”, and thus that three of the five pre-1993 CBD criteria had not been met.

When the claimant requested and received a copy of the claim file, a copy the policy note was not provided. At the claimant’s request, the Office requested and received a copy of the policy note. Upon review of this policy note, the claimant complained that the policy note was used to determine the outcome of his/her claim with no notice or opportunity to review it during the claims adjudication process. To the extent this document was intended as policy, this claimant questioned why DEEOIC had not published this policy in any of its policy guidance materials.<sup>58</sup> The claimant also questioned whether the statute placed a time limit on the earliest development of a chronic respiratory disorder, and why the medical evidence was not reviewed by a qualified physician to determine whether the exposure to beryllium during eighteen years of covered employment had contributed to or aggravated the worker’s chronic respiratory disorder.

<sup>57</sup> See 42 U.S.C. § 7384l(13)(B).

<sup>58</sup> Chapter 2-1000 of the EEOICPA Procedure Manual contains the eligibility criteria for non-cancerous conditions, including CBD. This chapter was updated in September 2015, and does not include the pre-1993 CBD policy found in the November 14, 2012 Policy Teleconference Note.

## **B. Notice**

### **1. Expert review of evidence by DEEOIC**

A number of individuals contacted the Office this year seeking assistance in determining the status of their case. In a majority of the cases, upon contacting DEEOIC we learned that the claim was at the National Office pending review by an IH. In other cases, the claim was at the National Office for review by a different type of expert or for policy/legal guidance. In either event, claimants questioned why they were not notified when their cases were transferred for such review. They also questioned why, prior to these cases being forwarded to the expert, they were not given an opportunity to review the evidence and the questions posed to the expert (and/or the National Office).

We also talked to claimants who expressed frustration that no one explained to them that they could seek a copy of the report generated by the expert. In a number of circumstances, it was only when informed by the Office that some claimants became aware that they could obtain a copy of the report generated by the expert. EEOICP PM Chapter 2-1600.7(a) provides that if a recommended decision is issued using the opinion of a CMC, the cover letter must advise the claimant that the CMC report is available for review upon request. Based on our observations, while some DEEOIC offices inform claimants that they can seek a copy of CMC reports, this practice is not consistent.<sup>59</sup>

### **2. Appeal rights**

Claimants complained that they were prejudiced by the fact that they were not informed of their right to appeal to U.S. District Court. In support of this concern, claimants provided us with copies of final decisions and reconsideration denials that did not inform them of their right to appeal the denial of their claim to U.S. District Court, and did not inform them of the statute of limitations for the timely filing of such appeals. It concerned claimants when months, if not years after a denial, someone finally suggested that they may have been able to appeal their claim to district court.

Claimants found it troubling that while the right to file for administrative review (reconsideration and/or reopening) was discussed in detail in the PM, the PM did not address a claimant's appeal rights to district court or address the process for filing an appeal to the U.S. District Court. Claimants note that while Chapter 2-1800 of the PM is devoted to FAB decisions, this chapter does not mention that claimants are entitled to file an appeal in U.S. District Court; does not outline the process for filing such an appeal; and does not alert claimants that there is a deadline by which an appeal can be timely filed with U.S. District Court. The only mention of "District Court" in this chapter is found in the reference in Subsection 6(a)(8) where it states, "A reconsideration request does not come with further reconsideration rights but only

<sup>59</sup> According to DEEOIC, in FY2015 it began including with recommended decisions copies of the reports prepared by specialists (e.g., IHS, toxicologists, and CMCs). In spite of this assertion, in 2015 we talked to claimants who had not received a copy of the report prepared by the specialist. It may be that the claimants we talked to received their recommended decision before the initiation of this new approach.

reopening rights or right to file suit in District Court.” In the opinion of some claimants this is another example where they only learn of a right well after the time has expired for them to take advantage of the right.<sup>60</sup>

### **C. Are policies consistent with the statute and/or regulations?**

The Office continued to receive complaints questioning whether certain PM provisions, bulletins and circulars were consistent with the statute and/or implementing regulations. In addition, some claimants complained that in the decisions they received, PM provisions, bulletins, circulars, or policy teleconference notes were given the force and effect of law. Claimants and ARs argue that before such documents can be applied as law, they first need to undergo a period of public notice and an opportunity to comment. In response, DEEOIC often contends that these materials are interpretive and therefore not subject to notice and comment rulemaking under established law. See e.g., Perez v. Mortgage Bankers Association, 135 S. Ct. 1199 (2015).

Claimants do not question DEEOIC’s authority to establish interpretive materials. Rather, they note that in Perez, the Court further observed that,

*The absence of a notice-and-comment obligation makes the process of issuing interpretive rules comparatively easier for agencies than issuing legislative rules. But that convenience comes at a price; Interpretive rules “do not have the force and effect of law and are not accorded that weight in the adjudicatory process.(Emphasis added).*

Perez v. Mortgage Bankers Association, 135 S. Ct. 1199 (2015). Claimants maintain that there are instances when, contrary to Perez, DEEOIC gives a PM provision, a bulletin, circular, or policy teleconference note the force and effect of law, and accords these materials that weight in the adjudicatory process.

**Hearing Loss** – In 2015, claims for hearing loss continued to generate complaints raising due process concerns, as well as questions regarding whether the hearing loss criteria in the PM creates an additional burden of proof under Part E of EEOICPA.<sup>61</sup>

In prior annual reports, the Office discussed claimants’ difficulties trying to understand whether the hearing loss criteria found in the PM was a policy or a rule of law. Claimants continued to grapple with this issue in 2015. In the opinion of claimants, if the PM criteria are a rule of law, then the evidence in their case must meet the criteria in order for their claim to be accepted. On the other hand, if the criteria are policy, then claimants expect that if their evidence does not meet the criteria outlined in the PM, their case would still be evaluated under the Part E causation standard.

<sup>60</sup> On November 18, 2015, DEEOIC published proposed federal regulations which include the language “Claimants may request judicial review of a final decision of FAB by filing an action in federal district court.” See Proposed §30.300 of OWCP Federal Regulations.

<sup>61</sup> As discussed previously, in November 2015 the hearing loss criteria that was originally found in PM Chapter 2-1000.18 was moved to Exhibit 3 of PM Chapter 2-0700.

One case that highlights this concern involved a claimant who had worked at the Rocky Flats Plant. The final decision stated,

*You filed a claim for benefits for hearing loss. In addition to the statutory criteria for all claim conditions, the DEEOIC in an effort to accept additional claims where the consensus of scientific experts agree even in limited circumstances, has set out specific criteria that if met can qualify an employee for acceptance based upon a presumption of causation. The Federal (EEOICPA) Procedure Manual provides policy guidance to claims examiners developing and adjudicating claims for benefits under the EEOICPA. The procedure manual indicates that a claim for hearing loss may be compensable if all of the following conditions are satisfied...* [Emphasis added].

The next sentence of the Final Decision listed the hearing loss criteria as found in the Procedure Manual and goes on to say,

*The procedure manual notes that if the employee was exposed to one of the listed chemical solvents, and worked in one or more of the listed labor categories for the required concurrent and unbroken 10-year period, and subsequently diagnosed with sensorineural hearing loss in both ears, then there is a presumption of causation and the claim may be accepted for hearing loss. See Federal (EEOICPA) Procedure Manual Chapter 2-1000.18 (issued April 2013).* [Emphasis added].

Despite submitting medical evidence, toxic exposure evidence, and co-worker affidavits to support his claim that his exposure to organic solvents throughout his career at the Rocky Flats Plant was a significant factor in aggravating, contributing to, or causing his hearing loss, the claim was denied based upon the following rationale:

*Once evidence begins to demonstrate a fact pattern in a claim that does not meet the scientifically enumerated criteria in the procedure manual, it reduces or eliminates the programmatic confidence establishing a causal relationship between the illness and toxic substance exposure. As such, any claim presented for hearing loss must fit within those scientific parameters for the DEEOIC to deem it compensable. A claim that does not contain sufficiently convincing evidence to meet each of the hearing loss criteria falls outside of the known scientific boundary for establishing a causative association between occupational toxic substance exposures and hearing loss and must be denied.* [Emphasis added].

Thus, claimant expressed confusion regarding whether the PM criterion for hearing loss is a presumption, or whether it is the law.

The Office was also contacted by claimants who had significant years of covered employment at DOE facilities, and who alleged they were exposed to organic solvents with a known link to hearing loss during the course of their job duties, but did not have the exact job title found in the PM criteria. Their claims were denied because they did not have verified covered employment within at least one of the specific job categories outlined in the PM for a period of 10 consecutive years, completed prior to 1990.

Each of these claimants wanted to challenge the “labor category” criteria based upon the fact that they performed similar, if not identical, work at their particular job site, oftentimes just under a different title. Some of these workers submitted co-workers affidavits to support their claims of similar job duties and of exposure to the organic solvents listed in the hearing loss criteria as having a known link to the disease. To our knowledge, none of these workers were permitted to challenge the list of job titles in the hearing loss PM criteria.

In one instance the decision denying the claimant’s reopening request stated that,

*Furthermore, performing essentially the same tasks as one of the labor categories listed under PM 2-1000.18(2) is not sufficient to meet the requirement under the program. The employment records must indicate that you worked in one of the labor categories. Your file does not contain such records.*

In another instance, a decision recommending denial of a claim informed the claimant,

*You were employed at XXX for ten consecutive years prior to 1990 and based on your employment records, job title and duties, you were exposed to toluene and trichloroethylene, organic solvents linked to hearing loss, for over ten consecutive years. However, the DOE identified your job title as an XXX, which is not one of the specified labor categories eligible for compensation for hearing loss per EEOICPA PM 2-1000.18. Similarly, the labor categories you claimed in your employment history and occupational history questionnaire are likewise not among the specified labor categories. Therefore, you are not eligible under Part E.*

This recommended decision also indicated that, “... [the district office] informed [the claimant] that there was evidence of exposure for ten consecutive years to toluene and trichloroethylene, two of the identified organic solvents linked to hearing loss.” Since the evidence established that he had ten consecutive years of exposure to toxins related to hearing loss, this claimant could not understand why his claim was denied solely on the ground that he did not work in a specific job category. Rather, this claimant argued that these findings should have been sufficient to establish entitlement to benefits or at the least warranted forwarding the case to a specialist for further review.<sup>62</sup>

When they feel that a PM provision, bulletin, circular or policy note is given the force and effect of law, claimants also argue that:

- It is impossible to determine which PM provisions, bulletins, circulars, and policy notes are intended as interpretive guidance and which will be accorded the force and effect of law.
- They find it troubling when PM provisions, bulletins, circulars, and policy notes do not discuss (or explain) and sometimes do not even identify the factual, medical or scientific basis that support

<sup>62</sup> In September 2015, the discussion of hearing loss was deleted from Chapter 2-1000.18 and added as Exhibit 3 of Chapter 2-0700. The current version of Exhibit 3 of Chapter 2-0700 states that Part E causation for hearing loss can be presumed without referral to National Office specialists if all three of the outlined conditions are satisfied. This provision further states that, “[h]earing loss claims supported by rationalized medical evidence asserting a causative link between covered employment and exposure to OTHER solvents not listed in this Exhibit should be forwarded to the NO for specialist review.” While it is not entirely clear how this revised provision will be interpreted, we are aware of at least one decision issued subsequent to these revisions where, according to DEEOIC, the claim for hearing loss was denied because the claimant did not meet “the specific criteria for acceptance of hearing loss.”

the provision. According to claimants, when no explanation is provided, it is hard to determine if they agree or disagree with the provision. They also contend that it is difficult to develop a challenge to a provision when the factual, scientific and/or medical basis for that provision is not identified.

It is often a surprise to a claimant to see a reference to a policy teleconference note for the first time in the decision recommending denial of their case and even more frustrating when a copy of that policy note is not provided upon request. Similarly, concerns arise when PM provisions, bulletins and circulars are the sole reason cited for the denial of a claim, and claimants feel that they never had an opportunity to comment on these documents (or comment on the conclusions drawn by these documents). Claimants complain that DEEOIC could do more to provide them with information regarding the adjudication of their case in a timely and meaningful fashion. In the opinion of many of the claimants we talk to, receipt of this information only after the administrative review process had concluded only serves to aggravate them and gives rise to questions of whether they (the claimant) were prejudiced by their inability to timely review relevant evidence.

**Circular 15-06, Post-1995 Occupational Toxic Exposure Guidance.** Circular 15-06 was issued on December 17, 2014, and states, in part:

*After 1995, significant improvements in occupational safety and health programs, engineering controls, and regulatory enforcement existed throughout Department of Energy (DOE) facilities. These measures would have served to limit employees' exposures to toxic materials. Therefore, in the absence of compelling data to the contrary, it is unlikely that covered Part E employees working after 1995 would have been significantly exposed to any toxic agents at a covered DOE facility. As a result, the claims examiner (CE) can accept the following:*

*For employees diagnosed with an illness with a known health effect associated with any toxic substance present at a DOE facility after 1995, it is accepted that any potential exposures that they might have received would have been maintained within existing regulatory standards and/or guidelines.*

*If there is compelling, probative evidence that documents exposures at any level above this threshold or measureable exposures in an unprotected environment, the CE is to contact the DEEOIC Lead Industrial Hygienist (IH) for guidance on whether a formal IH referral is required...*

Thereafter, in February 2015, DEEOIC issued a Program Memorandum discussing Circular 15-06.<sup>63</sup> The memorandum explains that DOE issued Order 440.1, "Worker Protection Management for DOE Federal and Contractor Employees" in 1995, and that this Order established a standardized Occupational Safety and Health protocol for all DOE federal and contractor employees. According to the memorandum, DOE's Order included several goals and guidelines to enhance and strengthen the requirements for protecting worker safety and health; and a series of enforcement actions known as "Tiger Teams" visited DOE sites performing health and safety audits.

<sup>63</sup> Circular 15-06 was not updated to cross-reference the February 20, 2015 EEOICPA Program Memorandum. However, the memorandum is posted online at the DEEOIC homepage as the only link under the EEOICP Program Memorandum link.

- In response to Circular 15-06 claimants have expressed doubts as to whether safety controls were in place and categorically enforced at all 350+ covered DOE facilities across the country after 1995.
- We also heard from individuals who questioned what documentation DOE would supply to CEs when determining the safe exposure threshold for a particular toxic substance that a worker was exposed to at a particular facility. Claimants asked: (1) if CEs had been provided specific DOE guidelines regarding safe exposure levels for individual toxic substances at each facility; (2) if the CE would provide claimants with information regarding the safe threshold level of exposure prior to seeking exposure information from the claimant; and (3) whether the claimant had to submit compelling, probative evidence that the exposure to a toxic substance exceeded the safe level of exposure before the case was referred for review by an IH.
- We talked to individuals who maintain that these Tiger teams did not perform audits at all DOE facilities, and contend that implementation of DOE orders was not strictly followed at all sites. Thus, claimants, such as employees from the Hanford site, suggested that DOE safety and health guidelines have not been followed since 1995, and that issues of worker safety and health continue to impact workers today. In light of these concerns, claimants find it daunting to be told they must now generate “compelling, probative” evidence to prove their exposures exceeded DOE prescribed safety levels. Claimants believe that the concerns that caused workers to be put at risk without their knowledge (the fear of adverse publicity, liability and employee demand for hazardous duty pay) still exist. Thus, claimants question the extent to which former and current DOE contractors (and subcontractors) would provide information confirming that exposure at these facilities exceeded DOE prescribed safety levels. Rather, some claimants believe that this circular is an effort to stem the flow of benefits to those who have worked at DOE facilities during the past 20 years.
- In the Program Memorandum, DEEOIC recognizes that, “...implementation of industrial hygiene standards by DOE and its predecessors was, at times, lacking...” and that “with each more rigorous standard, there would have been a time lag between issuance and implementation...” Claimants question the reasonableness of basing this circular on the issuance of an order without first determining whether the order was ever successfully implemented and without determining whether there was a time lag, and if so, the extent of the time lag between issuance and implementation at each facility.
- In challenging Circular 15-06, claimants have identified documented incidents after 1995 where the lack of adherence to safety practices and/or a lack of robust monitoring resulted in an unsafe work environment. DEEOIC’s response has been to assure claimants that each circumstance will be taken into account on a case-by-case basis. Claimant’s raise two concerns with this response:
  - a. Citing to the language of the Program Memorandum, claimants note that Circular 15-06 was not premised on the notion that DEEOIC would take into account each subsequent incident that arose. Rather, Circular 15-06 was premised on the notion that regulations and other actions had the intended effect of improving safety. Claimants cannot understand why

the documented safety violations after 1995 are not sufficient to rebut the notion that the regulations and other actions had their intended effect.

- b. Claimants also ask how many safety violations must there be before these violations are no longer viewed as isolated incidents, but rather as a pattern/trend that demonstrates the order did not have its intended effect.
- Claimants also believe that Circular 15-06 increases the burden that they must meet. Circular 15-06 requires the CE to contact DEEOIC's Lead IH (industrial hygienist) if there is "compelling, probative evidence that documents exposures at any level above this threshold or measurable exposures in an unprotected environment". Claimants question how the burden of proof to establish toxic substance exposure could be raised from "preponderance of the evidence" to "compelling, probative evidence" for all covered workers after 1995, without the EEOICPA statute or regulations being amended.<sup>64</sup>

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<sup>64</sup> It has also been noted that DOL implemented Part E of the EEOICPA in 2004, nine years after DOE indicated that improved safety controls were ordered at all DOE facilities, and five years after the EEOICPA statute was passed into law. If such safety measures were in place as of 1995, it is curious to some claimants that Congress seemingly did not take such measures into account when creating this remedial program.

## Issues Related to Medical Benefits

### A. New Medical Benefits Cards

On October 1, 2015, DEEOIC adopted the use of the International Classification of Diseases, 10th Edition diagnosis and procedure codes (ICD-10). Consequently, for services provided on, or after October 1, 2015, DEEOIC requires providers to only use the ICD-10 code sets.<sup>65</sup> In order to institute this change, DEEOIC issued new medical benefits cards to every claimant with an accepted medical condition. The implementation of this change has raised concerns.

One AR was concerned that some claimants may have inadvertently thrown away their new card. According to this AR, when he/she checked to see if clients had received their new card, some said no. When this AR explored this matter further, this AR came to realize that the new cards were mailed in envelopes that did not identify the letter as coming from DOL. This AR fears that some claimants may have assumed that the letters were junk mail and thus, without opening the letters, tossed them in the trash.

### B. The New Cards Do Not Contain The ICD-10 Codes

Prior to 2015, medical benefits cards listed the ICD-9 codes for each accepted illness on the back of the card.<sup>66</sup> When it became known that the new cards would not contain the ICD-10 codes for the accepted conditions, the Office began to receive complaints that the omission of the ICD-10 code would create hardships. Most of the concerns suggested that the omission of the ICD-10 codes would confuse claimants and further complicate the receipt of medical care. These concerns were premised on the belief that some claimants would not be able to remember the specific conditions for which they were approved, especially when they were approved for multiple conditions. As a result, it was feared that some claimants would have a hard time remembering all of their covered conditions.<sup>67</sup>

In response, DEEOIC indicated that claimants and providers could review the ICD-10 codes and accepted medical conditions by accessing the website, [owcp.dol.acs-inc.com](http://owcp.dol.acs-inc.com).<sup>68</sup> Claimants and providers contend that DEEOIC's response is not always realistic. For instance, some claimants do not have access to the internet, while others are not computer savvy. In fact, some claimants view this as another instance where those who do not have access to the internet (or with limited access to the internet) will find themselves at a disadvantage when it comes to locating crucial information.

<sup>65</sup> For services provided prior to October 1, 2015, only ICD-9 codes will be accepted.

<sup>66</sup> The exception was if the claimant had more than 10 accepted covered illnesses. For claimants with more than 10 accepted covered illnesses, the additional ICD-9 codes would not fit on the card, and were provided to claimant by letter.

<sup>67</sup> Claimants also told us that with the old card it was easy to match up the codes listed on the card with the Final Decision issued by DEEOIC in order to confirm that their accepted illness(es) were correctly listed on their medical benefits card.

<sup>68</sup> In order to access the website a provider must be an enrolled provider.

Comments that the Office received also noted that some providers do not have large administrative staff. Rather, we were reminded that some providers are small companies or sole practitioners, with limited resources. We were assured that while it was easy to suggest that providers could access the website if they needed to obtain diagnosis information, in reality, this added another step that providers who were already overburdened would have to overcome.

The Office also heard from providers who argued that omitting the ICD-10 codes would cause administrative problems. It was stressed that in order to access the DEEOIC website (to see the ICD-10 codes), the provider needed the claimant's 10-digit card ID number, as well as the claimant's social security number. In the opinion of one provider, even if they were willing to ask claimants to provide his/her 10-digit ID number over the telephone, it was not their practice (and they did not think it appropriate) to ask claimants to provide their social security number over the telephone.

Another provider explained how knowing the accepted illness helped to determine the type of care the patient received. This provider feared that when claimants telephoned to schedule appointments, if at that point the provider was unable to identify and confirm the accepted diagnosis, there could be subsequent delays in the delivery of care.

It was also noted that only enrolled providers can access the ACS website. Comments that we received reminded us that claimants do not always use enrolled providers. For example, some claimants cannot find an enrolled provider who is accessible to them.

In addition, claimants note that even before this change with the cards, some providers were already complaining about the paperwork and other administrative tasks associated with EEOICPA. There is a concern that adopting a system that places an additional burden on providers will simply raise the level of frustration and could cause some providers to stop treating EEOICPA patients.<sup>69</sup>

### **C. Lack of providers**

Some claimants complain that they are unable to locate a physician willing to accept the medical benefits card. When such matters are brought to our attention we often refer the claimant to one of the Resource Centers or to DEEOIC's webpage where they can find a link to a list of enrolled providers. However, in some instances the Office was specifically contacted because the Resource Center and/or DEEOIC's webpage did not identify any enrolled providers who were accessible to the claimant. To some extent the lack of physicians is a nationwide problem that extends well beyond EEOICPA. Still, some claimants believe that there is a component to this problem that is directly related to EEOICPA. There is a belief that some physicians refuse to treat EEOICPA claimants because of a general desire to avoid workers compensation claims and/or a specific desire to avoid EEOICPA claims. In particular, claimants believe that the medical fee schedule and the paperwork are factors that cause some providers to decline enrolling with EEOICPA.

In response to concerns regarding the fee schedule, DEEOIC notes that its fee schedule is on par, if not better than other federal programs. Some claimants and providers question whether this is always true.

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<sup>69</sup> We frequently talk to claimants who tell us that their provider is adamant that he/she does not want to enroll in this program.

In addition, DEEOIC responded to concerns regarding the paperwork by noting that physicians can bill for the time utilized completing some of the paperwork associated with claims. However, we talked to physicians who indicated that money was not the only issue. Some physicians stressed that when it came to completing paperwork, they are equally, if not more concerned about the amount of time that completing this paperwork took away from other work.

Claimants are not the only ones who encounter problems with some online tools. Providers also complain that some online tools are not easy to use. In one instance, a provider complained that it took almost four (4) months to enroll as a provider. According to this provider, “...it has been like pulling teeth in trying to enroll...” This provider further noted,

*...I resubmitted the missing information only to be told there is additional information still missing that is [clearly] seen on the application. I have spoken with several of your customer service representative[s] and each time I am told something different. Some of your representative[s] could not explain why it was rejected as they could clearly see the correct information in the correct boxes as well...*

#### **D. Requests for additional information**

There are instances when in response to receiving a request for authorization for home health care, DEEOIC needs more information. While claimants understand the need to support their request with medical documentation, there are times when they question whether additional information is really needed.

- They never asked for this information before – When it comes to home health care a common complaint concerns instances where after being approved for the same level of home healthcare on numerous occasions, the claimant seeks reauthorization for the identical level of care, and DEEOIC responds by asking for additional information. What often troubles claimants is that in making this request, DEEOIC does not explain why additional information is now needed when previous requests for the same level of care were routinely approved. In our experience, when no explanation is provided, some claimants come up with their own explanations for this change in approach. For instance, if the person asking for the additional information is a newly assigned CE, we often find that claimants will blame the request for additional information on the change in CEs. Similarly, when they cannot see any other reason for this request for additional information, some claimants conclude that the new approach is part of an effort to curtail home health care services.
- The information requested was already submitted – Claimants and providers contend that there are times when CEs make repeated requests for information they already submitted. Some claimants suggest that repeated requests for information are an indication that the CE does not fully understand the medical reports that have been submitted. Other claimants and providers strongly believe that CEs make repeated requests for the same information as a way to signal to the physician (and the claimant) that the CE is not happy with the level of care being requested.

An example that highlights this concern involves a claimant who after repeated approvals for home health care that included skilled nursing care 24 hours per day, 7 days a week, was asked by a CE to provide additional information to support the nursing care. According to this claimant, the initial letter prepared by the treating physician discussed the services that the skilled nurse would focus on during each “shift” and indicated that the skilled nurse would administer medication around the clock. In spite of this letter, the CE asked the physician to identify the conditions that warranted this level of care, to identify the services the skilled nurse would perform while the patient slept, and inquired whether the requested services were related to the claimant’s numerous other problems.

The treating physician responded to the CE’s request by submitting a letter that confirmed that the home health care was related to the patient’s covered conditions. This letter outlined the tasks the skilled nurse would perform each shift and explained that a skilled nurse was necessary since licensed personnel were required by law for medication and oxygen administration. The claimant contacted our Office when he received yet another letter from the CE essentially asking for the same information that the CE had earlier requested. In bringing this matter to our attention:

1. The claimant noted that in the most recent request for additional information the CE did not explain why the treating physician’s most recent submission was not sufficient. In fact, according to the claimant the CE did not even acknowledge receipt of the treating physician’s most recent submission.<sup>70</sup>
2. Since the CE found the treating physician’s response to the first request to be insufficient, claimant questioned why the CE decided to send virtually the same request the next time. Claimant questioned why the CE did not try to clarify his/her request.

## **E. A lapse in services**

Approvals for home health care services are granted for up to six-month periods and must be renewed with the submission of updated medical information from the treating physician and a new face-to-face evaluation by the physician within 60 days of reauthorization. There are also instances where authorization for health care services expires before authorization is renewed. The Office is approached by claimants who contend that they experienced a lapse in needed services as they awaited reauthorization.

In one situation, a claimant was authorized to receive massage therapy. According to this claimant at one point during the year there was a two month delay in receiving reauthorization. After this delay, claimant asserts that he/she stayed on top of matters and as a result, the next two authorizations were received without delay.<sup>71</sup> The claimant contacted us when his/her most recent authorization for massage therapy expired while he/she awaited a response from the CE.<sup>72</sup>

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<sup>70</sup> The claimant maintains that he/she has facsimile confirmation that DEEOIC received the letter in question from the treating physician.

<sup>71</sup> According to this claimant, he/she had to recertify for massage therapy every 8 weeks.

<sup>72</sup> After experiencing a two month delay, the claimant began to telephone the CE when he/she submitted a reauthorization for the massage therapy. The claimant questions if the most recent delay can be attributed to the fact that instead of calling the CE, he/she faxed the CE.

There are instances where claimants receive temporary approval while DEEOIC reviews the authorization request, thus ensuring continuation of services. While it is not entirely clear why some claimants experience a lapse in services, based on our experiences it appears that when faced with a possible lapse in home health care services, some claimants do not contact their CE. Rather, because they do not want to “bother” the CE and/or because they do not want come off as “pushy,” some claimants decide to await a decision from DEEOIC on the reauthorization.

## Case Study Five

When discussing the problems with home health care, we frequently hear references to providers who have or have tried to take advantage of the system. Many of the providers we encounter concede that there are some in the industry who try to take advantage of the system. Thus, most providers understand the need for procedures to prevent abuse. However, there is a feeling by some providers that because of the actions of a few, there is a tendency by DEEOIC to approach all providers as if they were potential abusers. Similarly, there is a belief that because a few providers abused certain services/treatments, DEEOIC approaches every request for this service/treatment as suspect. This was the concern raised by a claimant who complained that it took over four (4) months to get a response to a request for an increase in home health care necessitated by an emergency. When his/her spouse was hospitalized, this claimant, who was already approved for home health care, requested an increase in care. In the letter of medical necessity, the treating physician explained that because the spouse was in the hospital, the claimant was not receiving necessary medical care and as a result, had an increased risk of injury.<sup>73</sup> This claimant could not understand why it took more than four months to respond to this request. The claimant questions whether this delay was the result of a general suspicion by DEEOIC regarding requests for increased care due to an emergency. While this claimant understands the need for procedures, he/she questions the appropriateness of delaying necessary treatment, especially in emergency situations.<sup>74</sup>

<sup>73</sup> While the spouse was not a home health aide, the treating physician explained that the wife provided necessary medical care during those hours when there was no home health aide in the house.

<sup>74</sup> On two occasions while awaiting a response, DEEOIC was contacted. On both occasions, DEEOIC indicated that more information was needed from the treating physician. On both occasions, when the claimant followed up, the treating physician indicated that he/she had not been contacted by DEEOIC.

## **F. Some providers are not sure when they can or should contact DEEOIC**

Some providers have indicated that they do not fully understand the rules as to when personnel associated with a home health care provider can contact DEEOIC on behalf of a claimant. These providers note that EEOICP PM Chapter 3-0300.2(f) provides that requests for in-home health care do not have to be initiated by a claimant. Rather, requests for in-home assessment of a patient's needs and/or requests for in-home care can be initiated by an AR, or any licensed doctor or medical provider. In spite of this provision, providers have told us that when they contacted DEEOIC to initiate a request for in-home health care, they were made to feel as if they were doing something wrong. Providers have talked of insinuations suggesting that their efforts to request in-home health care for a claimant were solely motivated by the financial benefits the company hoped to gain. To avoid these insinuations, some providers have indicated that they usually try to encourage claimants to initiate their own requests for in-home health care.

We often become involved in these matters when the claimant is unable to articulate his/her concerns to DEEOIC, or when the claimant cannot understand DEEOIC's instructions. In addition, when a provider is unsure if he/she can directly contact DEEOIC, or is hesitant to contact DEEOIC, the provider will sometimes ask our Office to contact the claimant (or will have the claimant contact us).<sup>75</sup>

Some providers noted that when they contacted DEEOIC, it was suggested that if the claimant had an AR, the AR should be the one who contacted DEEOIC to discuss matters related to in-home health care. In the opinion of some providers, this suggestion is not always realistic. As discussed earlier, some ARs do not assist claimants with matters related to in-home health care. In addition, especially where the person serving as the AR is a family member, some ARs do not have experience with issues related to in-home health care, and thus, may not be in the best position to provide the claimant with the necessary guidance.

## **G. Ethical and moral concerns**

Providers complain that they are sometimes faced with the choice of strictly adhering to the terms of the authorization for in-home health care or following the professional ethical standards placed on them (as well as their own moral standards). A frequent scenario brought to the attention of the Office involves claimants with a covered condition who also suffer from dementia or Alzheimer's disease – and the dementia or the Alzheimer's disease is not a covered condition. Thus, we have been told of instances where because of a non-covered condition (dementia) the claimant was not taking the medicine prescribed for the covered condition. Where the authorization for care did not include assistance taking medicine, providers believe that they are not authorized to assist these claimants in taking their medicine (even though the medicine is for a covered condition). Providers fully understand that DEEOIC only authorizes care for covered conditions. Nevertheless, they feel that it is unethical and immoral to

<sup>75</sup> Where in-home health care has been authorized by DEEOIC, providers routinely contact DEEOIC to discuss the authorized services. The concern brought to our attention arises when new services need to be initiated

walk out of a house knowing that there is a great likelihood that the claimant will not take the medicine prescribed for the covered condition. Over the years, we have heard similar complaints relating to other services as well. In response to these concerns by providers, it has been noted that claimants who find themselves in situations such as this can explore other avenues for assistance. Providers contend that this response does little to resolve the immediate situation.<sup>76</sup>

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<sup>76</sup> Providers note that in some instances there are no easy and/or viable options for obtaining needed in-home care for non-covered conditions at the same time as in-home care for conditions covered under EEOICPA

## Issues Related to Medical Bills

When it comes to issues related to medical bills, the most common complaints center on two (2) issues:

1. Denials are not well-explained
2. Assistance addressing medical billing issues can be difficult to locate

### 1. Denials are not well-explained

A frequent complaint comes from claimants who approach us when they are unable to understand the reasons for the denial of the payment of a medical bill. Claimants often come to the Office when they receive a letter or recommended decision denying their request for medical bill payment that do not explain in any detail why the bill was denied.

Not receiving a full explanation for the denial of a bill is especially difficult when the claimant, as opposed to a provider, submitted the bill (or is seeking reimbursement). Many of the complaints concerning the payment of medical bills involve instances where a claimant is seeking reimbursement for a medical bill. These instances usually involve a claimant who paid one or two bills out-of-pocket and is now seeking reimbursement for those bills. Because these claimants do not routinely submit bills for payment they often have little, if any, experience with the bill paying process. As a result, some claimants have suggested that it would help if there were a special process for reviewing bills submitted by claimants. This alternate process would ensure that when bills submitted by claimants are denied, attention is given to provide claimants with an easy to understand explanation for why the bill was denied, as well as guidance on what needs to be done to correct any deficiencies.

However, claimants are not the only ones to encounter problems with the payment of bills. We also encounter providers, including providers who routinely do business with DEEOIC, who have problems with the payment of bills. As with claimants, some providers complain that there are instances when the denial of a bill is not well explained. In addition, providers have complained of situations where even after it was apparent that they did not understand why the bill was rejected, there was no effort by DEEOIC to clarify the situation. Thus, providers have complained of submitting documents only to thereafter receive the same boiler-plate request for more information instead of an explanation.

### 2. Assistance addressing medical billing issues can be difficult to locate

The frustration felt when a bill is denied and the denial is not well explained is compounded when the claimant is unable to locate someone who can help resolve the problem.

- Who do you call – Providers, especially those who routinely submit bills for payment, know they can contact ACS, DEEOIC's medical bill payment agent, if they have a billing problem. However, claimants, especially those who do not routinely submit bills for payment, are often unaware of where to turn when they encounter a billing problem.

DEEOIC has a brochure that explains the bill payment process. However, this brochure is another example where: (1) a tool is found online, and (2) the existence of this brochure is not

readily apparent when you access DEEOIC's homepage. To access this brochure from DEEOIC's homepage, one has to click on the link to "Brochures" instead of the link listed below it to "Get Help With My Medical Bills." This is confusing for some claimants because only then can the user see that there is a brochure entitled, "How Will My EEOICP Medical Benefits Be Paid."

Those who have reviewed this brochure tell us that it contains a lot of useful information. Still, it has been pointed out that this brochure does not clearly outline who a claimant should contact if a problem arises with a bill. At one point the brochure states that,

*For further information about special circumstances or individual cases, please contact one of our Resource Centers or your claims examiner at the Energy Employees Occupational Illness Compensation Program (EEOICP) District Office...*

According to some claimants, when a billing issue arose and they called the CE, they were told that they should call ACS. In at least a few instances claimants contend that when they subsequently contacted ACS, they were told that the CE was the only person with the authority to address the matter.

In many instances, a claimant's effort to resolve a billing issue is compounded by other factors. For example:

- Because enrolled providers can directly bill DEEOIC, many claimants only encounter billing issues when he/she utilizes a provider who is not enrolled in the program, or otherwise seeks reimbursement for services. Thus, many claimants are not familiar with the bill paying process.
- Issues with the payment of medical bills sometimes arise while the claimant is addressing other life issues. A frequent scenario involves situations where a claimant encounters billing issues following a hospitalization. Thus, we talk to claimants who are trying to resolve a billing issue while recuperating from an illness.
- Often adding to the concerns with payment of a bill is the fear that a delay in payment will negatively impact the claimant's credit rating.
- Citing to their current financial situation, some claimants are adamant that they are not in a position to endure a long wait for reimbursement of money that they paid out-of-pocket.

## Issues Involving DEEOIC's Administration of the Program

This Office routinely works with the staff of DEEOIC, as well as the staffs of DOE and NIOSH to assist claimants. This assistance is critical in carrying out our efforts to assist claimants. In addition, as noted earlier, many of the claimants who come to the Office with complaints often take the time to also recognize other instances where a staff member was helpful.

*We want to let you know about several Cleveland office CEs who have been very helpful recently initiating communications between stakeholders and facilitating the claims process for some complicated claims.*

(An e-mail forwarded to DEEOIC that was shared with our Office).

Moreover, those who can access the tools and resources available online have often told us that they find these tools and resources to be very useful. For instance, an AR who tested DEEOIC's new process for submitting documents told us how easy he/she found this process.

Still, we are approached by other claimants who have concerns with some of their interactions with DEEOIC staff members and/or the staff of the other agencies involved in the administration of this program. Most of these complaints involve interactions with DEEOIC. The most common concerns are:

### **A. Cannot get through on the telephone and/or calls are not returned**

Over the years claimants have complained that when they telephone DEEOIC, their calls are not answered and/or that their messages are not returned. In response to these complaints, DEEOIC indicated that it implemented technological improvements to ensure that telephone calls were promptly answered and that when staff was not available, telephone calls were returned within a reasonable amount of time. In spite of these assurances, we continue to receive complaints.

Recent complaints allege that when claimants telephoned DEEOIC, they were put on hold for a long period of time. Because claimants do not always distinguish between ACS and DEEOIC, it is not always clear if the complaints are directed at DEEOIC or ACS. Similarly, because claimants do not always distinguish between the Resource Center and the District Office, it is not always clear who the claimant telephoned. However, some claimants have made it clear that it was the district office that did not answer the telephone.<sup>77</sup>

There have been other instances when claimants were certain that their complaints were directed at ACS. In particular, claimants allege that when they telephoned ACS, they had to listen to a long introduction. Some claimants and ARs have complained of being forced to listen to this same long introduction every time they called ACS. We talked to claimants who noted that they had mobile telephone service plans where they are charged by the minute. These claimants argued that it was a waste of time and money to be forced to listen to this same long introduction every time they called ACS. Claimants suggested that ACS ought to modify this introduction so that callers had the option of skipping this introduction.

<sup>77</sup> Where claimants are certain of who they called, most complaints involve calls to one of the District Offices or to ACS.

The Office also continues to receive complaints alleging that there are instances when messages were not returned. It is not always clear if claimants are suggesting that their messages were not returned at all or if they are alleging that their messages were not returned in a timely manner. What we frequently find is that when a claimant telephones DEEOIC there is a sense of urgency. The urgency often arises when claimants are calling DEEOIC in response to correspondence in which DEEOIC provided the claimant with a limited amount of time to submit additional evidence (or to respond). When they only have 30 days or less to respond, claimants view any delay as critical.<sup>78</sup>

*...the AR for X contacted our office and described his unsuccessful efforts to contact the claims examiner for his father's case. He indicated that he believes that his father's [home health care] expires in [three weeks], and he is anxious to confirm that DEEOIC has everything needed to reauthorize [home health care]...*

(Email sent by our Office to DEEOIC in June 2015).

*Our office was contacted today by X. X indicated that he has been unable to reach his claims examiner when he calls the district office. He reports that he was told by the receptionist today that he must stay by his phone waiting for the CE to call him. He alleges that he has called 5 times in the past 2 days, and that he missed [one] return call from the CE who advised him that when he called back a message would be waiting for him. When he called back he claims there was no message for him, nor was he able to speak with his CE.*

(E-mail sent by our Office to DEEOIC in February 2015).

*...I have called several times and left messages. Every time I call there is no examiner available to speak with me...*

(E-mail from a claimant).

## **B. Multiple CEs handling the claim**

It is rare for a claimant to contact us to specifically complain about a change in the CE handling his/her case. Rather, we usually find that while discussing other concerns, a claimant will mention how he/she found it troubling to have had multiple CEs working on his/her case. Or a claimant will tell us how he/she believes that his/her case was negatively impacted by having had multiple CEs. In a frequent scenario that we encounter, claimants report that they initially became concerned about their claim when an extended period of time elapsed during which they did not hear from DEEOIC. It is only when these claimants finally tried to contact the CE that they learned that their case was assigned to a new CE.

- Claimants contend that after working with, and sometimes establishing a relationship with one CE, it can come as a shock to suddenly discover that their case had been assigned to a new CE. To avoid this shock, claimants believe that they ought to be informed when their case is assigned to a new CE.
- Claimants believe that a change in CEs sometimes cause delays in the processing of the claim.

<sup>78</sup> A frequent complaint contends that because notices are sent by mail, in reality the response time can sometimes be even less than what is outlined in the notice. For example, while the notice gives the claimant 30 days to respond, because the notice was sent by mail, by the time the claimant receives the notice, he/she has less than 30 days to respond.

In this regard, we are told of instances where new CEs indicated that he/she needed more time to get up to speed after a case had been reassigned to him/her. Claimants also tell us of conversations in which it quickly became apparent that the newly assigned CE did not have a firm grasp of the case.

### **C. Staff was rude**

Claimants who contact us with complaints alleging inappropriate behavior often admit that they are fearful of retaliation. Consequently, in some instances claimants who approach the Office to complain of inappropriate behavior by DEEOIC staff members start out by: (1) confirming that what they tell us will be kept in confidence and/or (2) asking if it is possible to be assigned to a new CE. For many claimants the fear goes beyond what might happen with their current claim. Many claimants are keenly aware that their interactions with DEEOIC do not necessarily end with the issuance of a final decision. Consequently, there is a fear that once DEEOIC learns that a claimant has filed a complaint, DEEOIC will have many opportunities, oftentimes well after the issuance of the final decision, to retaliate. These opportunities include when a request for reconsideration and/or reopening is made, as well as when the claimant seeks wage loss, impairment, and/or in-home health care/medical benefits.

*I understand that you need my permission to share my letter with the U.S. Department of Labor's DEEOIC.*

*Before I do that, I have a fear that if I do anything to upset them, they may not pay XXX. I do not want to do anything to jeopardize my chances of getting XXX.*

*(Letter from claimant complaining of lack of assistance).*

*I just heard from XXXX. He was upset about a conversation he had with his claims examiner regarding his wish to have an impairment rating done. As a result of that conversation, he wants to know if he can be assigned another claims examiner.*

*(E-mail from our Office to DEEOIC (January 2015)).*

Most of the complaints received by the Office alleging rude or insensitive conduct involved telephone conversations. In particular, claimants frequently alleged that during the course of a conversation, the CE raised his/her voice, said something inappropriate, or displayed a lack of sensitivity towards their concerns. These complaints came from both claimants and ARs. In bringing these concerns to our attention, some claimants question the extent to which DEEOIC addresses their concerns. One reason for this concern is that most complaints involve exchanges that occurred during telephone conversations and thus the only support the claimant can provide is his/her account of the exchange. Some claimants feel that their allegations of inappropriate behavior are summarily disregarded, especially when they are unable to support the complaint with evidence other than their own testimony. As a result, some claimants believe that it would be helpful if DEEOIC recorded encounters between its staff and claimants.

One instance brought to our attention this year involved the claim of a terminally ill worker. As efforts were underway to expedite this claim, the AR endeavored to verify the claimant's employment by obtaining affidavits from former colleagues. The AR, who happened to be the worker's spouse, sought the assistance of the Iowa Former Worker Screening Program in obtaining these affidavits. The staff from the Former Worker Screening Program met with at least two of the affiants and wrote out the testimony which the affiants then signed. The signed affidavits were then forwarded to DOL. The Office

was contacted by the AR when he/she learned that the CE had contacted the claimant's social worker and in that conversation had suggested that the affidavits "looked forged." Claimant found the CE's comment to be insulting and contrary to DEEOIC's own policies. The claimant found it insulting that the CE had made this statement to a third party before contacting the AR to discuss any concerns. The AR contends that had the CE asked, he/she would have been able to resolve the CE's concern. This claimant also questioned whether the CE's actions were consistent with DEEOIC's own policy. Since DEEOIC usually maintains that it only talks to the claimant and/or the AR concerning a claim, this claimant questioned the appropriateness of expressing these unfounded suspicions to a social worker who was not the claimant's AR. When claimant's concerns were brought to DEEOIC's attention, DEEOIC responded by: (1) noting that the affidavits had apparently been accepted; and (2) suggesting that having someone fill out the form and then having the affiant sign the document created "oddities" that, out of due diligence, the CE could question. This response made no mention of the CE's statement that the affidavits looked forged; that the CE did not contact the AR or claimant to try to resolve their concern; or that the CE made this accusation to a third party.

A concern for many claimants is the belief that there is little, if any, meaningful review of their complaints alleging inappropriate behavior. The Office has been told that in response to complaints of inappropriate behavior, DEEOIC has sometimes responded by indicating that it looked into the matter by reviewing the electronic notes documenting the conversation prepared by the CE. Claimants question the sufficiency of this review. They question if it is reasonable to assume that a CE who just made rude comments will document those rude comments in the notes that he/she prepares in their electronic claim file. Consequently, some claimants have suggested that DEEOIC should record the CE's conversations with claimants. Claimants contend that this would resolve any doubts as to what was said during these conversations. They also contend that recording the conversations would not only show what was said, but would also show how it was said. In addition, claimants believe that if the staff knew that their conversations were being recorded, they would be less likely to engage in inappropriate behavior.<sup>79</sup>

Some claimants have questioned whether DEEOIC is really interested in receiving complaints of inappropriate behavior. In support of this concern, it is noted that while DEEOIC states that a claimant can file a complaint, DEEOIC does not appear to have any formal procedures for filing these complaints. Because they fear retaliation, claimants often indicate that they do not feel comfortable calling a random telephone number and registering a complaint with whoever answers the telephone. Claimants often report that they fear calling an office and registering a complaint while the subject of the complaint sits in the next cubicle (or they are talking to someone who is going to immediately share the complaint with the subject of the complaint). In our opinion, in light of their fear of retaliation and because they believe that the protections against retaliation are so few, some claimants choose not to file (or even raise) a complaint. Moreover, while most claimants want the Office to contact DEEOIC on their behalf, the exception to this rule involves complaints regarding inappropriate behavior. Due to their concerns with retaliation, claimants who contact the Office with complaints alleging inappropriate behavior by a DEEOIC staff member usually ask that we not contact DEEOIC.

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<sup>79</sup> In one instance this year, a health care provider responded to an allegation that one of its staff members had acted inappropriately by providing DEEOIC with a recording of the conversation between the claimant and the staff member. In the opinion of this provider, the recording showed that its staff had acted appropriately.

## D. Delays in claim adjudication

This year we saw an increase in the complaints alleging a delay in the processing of claims. In many of the instances the delay was related to the backlog of cases awaiting review by IHs. Some of these delays exceeded one year. In almost all of the cases brought to the attention of the Office, DEEOIC had not informed the claimant or AR of the reason for the delay. DEEOIC recognizes that there is a backlog of cases awaiting review by IHs and in April 2016 announced a new contract that will provide more IHs. DEEOIC believes that this new contract will resolve the backlog.

However, the backlog of cases awaiting IH review does not explain every delay brought to our attention. Claimants also reported experiencing delays in the processing of claims following the assignment of the case to a new CE, as well as when the CE or HR went on leave (or was otherwise unavailable for a period of time). In addition, claimants complained when they, (1) encountered delays receiving a response to their request for a copy of all or part of their claim file; (2) encountered delays receiving a medical benefits card following approval of the claim; as well as (3) encountered delays after submitting documents to the DEEOIC central mail room to be scanned into their file.

There are some common features to almost every complaint of delay:

- Claimants maintain that DEEOIC usually does not inform them of delays. Rather, in most instances claimants contend that they only learned of the delay when they took the initiative to contact DEEOIC.
- There is a fear of what could happen if, while the case is pending due to a delay, the worker passes away. As already discussed, the death of the worker can impact the amount of compensation paid, especially with Part E claims.<sup>80</sup>
- Claimants find it unfair that DEEOIC can delay a case without providing notice to the claimant, and can delay the case for as long as it wants without any penalties and without providing the claimant with any notice or recourse.

## E. Scheduling of hearings and medical examinations

The scheduling of hearings and medical examinations has been brought to the Office's attention as instances where DEEOIC is not always sensitive to the needs of claimants.

- Scheduling of hearings – When claimants receive the letter from DEEOIC acknowledging their request for a hearing, they are also asked to identify any potential days they are unavailable. Claimants often tell us that when they received this letter, they assumed that the hearing would be held within weeks and at most within a month. Thus, they usually supply dates they are unavailable within the next few weeks and/or the next month. Claimants have complained that it sometimes

<sup>80</sup> Under Part B, when compensation is payable, both workers and survivors are entitled to a lump sum payment of \$150,000. In addition, where the worker is deceased, potential survivors under Part B include the spouse, any child, the parents, the grandchildren, or the grandparents. Consequently, we do not encounter many cases where the death of the worker has an impact on the compensation paid under Part B. It is more common to encounter instances where the death of the worker impacted compensation payable under Part E.

took months for DEEOIC to schedule the hearing. Problems arise when considerable time passes before the claimant is notified of a hearing date, and then the claimant realizes that he/she has a conflict. Some claimants have indicated that when they tried to reschedule the hearing, DEEOIC reminded them that they should have identified the potential conflict sooner. In response, claimants assert that it is unreasonable to ask them about potential conflicts and to then wait months to schedule the hearing. Claimants maintain that it is virtually impossible to anticipate potential conflicts months in advance. Moreover, while the PM allows postponement of a hearing for medical reasons or due to the death of a parent, spouse or child, claimants contend that these exceptions are too narrow when hearings may be scheduled months after the initial request was made. See EEOICP PM Chapter 2-1700.7d(3) and (4). To resolve this problem some claimants have suggested that DEEOIC ought to specify a specific time frame when the hearing might be scheduled. Otherwise, in the view of some claimants, it seems that once they request a hearing, they have to put their lives on hold until the hearing is scheduled. It is also noted that if DEEOIC cannot provide a time frame for when the hearing will be held, DEEOIC should take a broader view of the legitimate reasons a claimant may have for requesting a hearing be rescheduled.

- Scheduling of exams – The Office also received complaints alleging that inadequate notice was provided for DEEOIC-arranged medical examinations (second opinion and referee exams). We encounter claimants who note that due to their medical conditions and/or other factors of life, their mobility is significantly restricted. Thus, we encounter claimants who tell us that when advised of an appointment, they need time to arrange transportation. In addition, if the claimant wants a family member or friend to accompany them to the appointment, they will need time to coordinate with that other person. Thus, some claimants find it troubling when they are given short notice to attend a medical appointment scheduled by DEEOIC.

In one instance, a claimant received a letter from a DEEOIC case coordinator informing him/her of an examination scheduled for March 18, 2015. What concerned this claimant was that the cover letter from DEEOIC was dated March 2, 2015. The actual letter from the DEEOIC case coordinator (which accompanied the cover letter) was dated March 4, 2015. Thus, according to the date on the letter from the case coordinator, the claimant was provided 14 days' notice of this appointment. What really concerned this claimant was that he/she actually received this letter much closer to the date of the appointment. This claimant provided us with a copy of the routing sheet from FedEx. This routing sheet showed that the claimant received the letter from the case coordinator on March 16, 2015, notifying him/her of an examination scheduled for March 18, 2015.

When this claimant brought his/her concern to DEEOIC's attention, DEEOIC's response noted that the scheduling of appointments was through a contractor. DEEOIC also encouraged the claimant to follow the instructions provided if he/she needed to reschedule. Note – the cover letter from DEEOIC had strongly discouraged the rescheduling of appointments and indicated that rescheduling should only be done in cases of emergencies. The letter further warned that “[a]ltering an appointment schedule can hinder [DEEOIC's] ability to take substantive action on [a] claim and promptly deliver service...” Thus, claimants believe their benefits may hinge on their cooperation with respect to attending these appointments, even when they are not provided sufficient advance notice.

## F. Response times

A continuing source of complaints concerns the amount of time DEEOIC gives to claimants to respond to its requests for documents. Many of the complaints the Office received focused on the amount of time given to claimants to respond to letters from DEEOIC notifying them that additional evidence was required. As outlined in PM Chapter 2-0300.6, if the CE identifies a deficiency in the evidence that requires development, a letter is prepared which describes the deficiency and additional information necessary to overcome this deficiency. According to subsection (a) of this provision, “[o]ften 30 days will be sufficient time to allow for submission of additional evidence.” Claimants routinely argue that 30 days is way too little time to obtain and submit additional evidence. Claimants point to DEEOIC’s own problems obtaining reviews by IHs, as well as other delays encountered when DEEOIC, as proof of the difficulties one can encounter trying to obtain and submit evidence within 30 days.

- In actuality, they have less than 30 days – A frequent complaint notes that the letter advising the claimant of the deficiency is sent by mail. Thus, claimants maintain that by the time they receive the letter, he/she has less than 30 days to respond.
- Not aware that extensions of time are possible – We routinely talk to claimants who are not aware that subsection (c) of PM Chapter 2-0300 provides that,

*As the EEOICPA is non-adversarial, the CE uses care when setting deadlines. The information requested is not always easily obtained because most employees were exposed many years ago. Thus, the CE must be as flexible as possible and advise the claimant that additional time will be granted if the claimants requests a reasonable extension of time.*

PM Chapter 2-0300.6(c). We often find that claimants are not aware that an extension of time is possible. We also find that because they are not familiar with the adjudication process, even when told that an extension of time is possible, some claimants fear that making such a request will have a negative impact on the processing of their claim.

- Amount of time provided to submit evidence following a recommended decision – We also receive complaints concerning the amount of time given to claimants to submit evidence when they object to a recommended decision. In particular, claimants have complained of confusion surrounding the amount of time they have to present evidence when objecting to a recommended decision. According to 20 C.F.R. §30.310 a claimant has 60 days from the date the recommended decision is issued to object to the recommended decision. If the claimant objects to the recommended decision and does not request an oral hearing, he/she receives an acknowledgement letter from DEEOIC, which reads, in part,

*Your objections, along with the information in the file, will be carefully considered and included in our final decision. If you have any additional evidence that you wish to be considered, it must be received by the FAB within 20 calendar days of this letter. After that date, a review of the written record will be made and a final decision will be issued.*

On the other hand, if the claimant objects to the recommended decision and requests a hearing, the acknowledgment letter from DEEOIC indicates that at the hearing the claimant will be provided with the

opportunity to present their objections to the recommended decision, along with any additional evidence they wish to present. Following the hearing, if one is held, the claimant receives a letter informing him/her that the record will remain open for 30 days from the date of the hearing for the submission of additional evidence.<sup>81</sup> Claimants, especially those who request a hearing, have complained when they discovered that they actually had more time to develop and submit evidence than they were initially informed. Because they initially thought they only had 60 days to submit their additional evidence, and they realized that 60 days was not sufficient time, some claimants have indicated that they did not try to develop additional evidence. According to some claimants, had they realized before attending their hearing that they had up to 30 days following the hearing to submit evidence, they would have at least tried to develop additional evidence or would have taken more time to better develop evidence.

A frequent complaint alleges that DEEOIC often appears to operate on the assumption that claimants are familiar with the rules and procedures governing EEOICPA. We routinely encounter claimants who assure us that they have little, if any, understanding and/or appreciation of this program. Consequently, claimants, as well as some ARs have noted that it would be helpful if the rules and procedures were better explained, and were explained at a time in the claim process when the information was relevant. For example, claimants believe that when they are given 30 days to submit additional evidence, they should also be informed of the opportunity, if necessary, to request an extension of time. Similarly, when it comes to objecting to a recommended decision, claimants would like a better understanding as to the total amount of time they have to submit evidence before a decision is issued.

## **G. The situation involving one AR**

During the course of this year, we received complaints stemming from the decision of DEEOIC to ban one AR from communicating by telephone with the district office. The AR was instructed to communicate with the district office via written communications. Our Office is not in a position to assess DEEOIC's decision. Still, comments raised by this AR, as well as clients of this AR raise questions concerning the process by which this decision was made. In particular:

1. We have been asked if there is a mechanism in place for obtaining review of DEEOIC's decision. We are not aware of any such mechanism.
2. It has been suggested that the ban is vague. For instance how long is this ban in place?
3. The AR has expressed concerns with the inconsistent application of this ban. For example, while the AR was told that he/she was banned from telephoning the district office, in at least one instance a DEEOIC staff member indicated that the ban also applied to FAB. Similarly, while the AR was told that he/she was banned, this AR noted that in at least one instance an office applied the ban to prevent someone who worked for this AR from talking to the district office.

<sup>81</sup> Chapter 2-1700.9 of the PM states that a claimant has 30 days from the hearing date to submit additional evidence. See PM Chapter 2-1700.9.

## Issues Concerning Authorized Representatives' and Attorneys' Fees

### 1. Attorneys' Fees

Claimants find the attorney fee provisions of the statute to be vague and confusing. In particular, claimants complain that the statute does not address many of the common scenarios that arise.

One concern notes that according to the statutory fee schedule, with respect to services rendered in connection with a claim for lump-sum compensation under Part B, an attorney may not receive more than:

- 2 percent for the filing of an initial claim for payment of lump-sum compensation, and
- 10 percent with respect to objections to a recommended decision denying payment of lump-sum compensation.

See 42 U.S.C. §7385g(b). Part B claimants have complained that the fee provision does not address the fee for services rendered in connection with medical benefits.

Confusion also arises because Part E simply incorporates the attorney fee provisions found in Part B. See 42 U.S.C §7385s-9. The problem is caused because the benefits and procedures in a Part E claim differ from the benefits and procedures followed in a Part B claim – and this is especially true when it comes to Part E claims filed by workers. As a general rule, if a Part B claim is accepted, the claimant receives lump-sum compensation of \$150,000, and if the Part B claim is filed by the worker, the worker is also entitled to medical benefits for the accepted condition. In Part E claims filed by a worker there is what many consider to be a two-step process. If the worker files a claim and that claim is accepted, the worker first receives a medical benefits card entitling him/her to medical treatment for the accepted condition. To receive monetary compensation under Part E, the worker must separately file and be accepted for wage loss and/or impairment compensation.

Questions often arise concerning the attorney fee that can be charged when a Part E claim is accepted and the worker receives a medical benefits card, but the worker is not eligible for monetary compensation. Since the attorney fee provision only refers to 2 and 10 percent of lump-sum compensation, we are asked how an attorney fee is determined when a Part E claimant is successful in obtaining a medical benefits card, but does not receive monetary compensation.

Similarly, Part E claimants question if and how ARs are paid for services rendered in connection with billing issues, as well as for services related to medical benefits – issues that often arise subsequent to the acceptance of the claim. Once again, since these are services that do not generate monetary compensation, claimants question the basis for determining the fee that an AR can charge.

A common complaint to the Office, by both claimants and ARs, is that they have nowhere to turn to get clarification on issues relating to attorney fees. In the opinion of some claimants, this lack of guidance has opened the door to situations where a few ARs take advantage of the vagueness found in the attorney fee provision. On the other hand, ARs find it strange that when they try to determine the proper

amount to charge a claimant, no one seems willing to provide them with guidance. Claimants and ARs understand that the fee schedule is found in the statute and thus may have to be addressed by Congress. Nevertheless, they question whether DEEOIC could do more to clarify its interpretation of this provision.

## 2. ARs

The conduct of a few ARs also continues to generate complaints.

Misleading representations – The Office received reports of ARs who try to give the appearance that they are affiliated with the government. One example brought to our attention this year was a brochure distributed by an AR. It was alleged that this AR took a brochure prepared by DEEOIC and inserted its name on the brochure. What concerned the person who brought this matter to our attention was that in copying the brochure, while the AR had inserted its name, the AR had left the words “U.S. Department of Labor;” as well as the DOL seal on the brochure. The fear was that those reading this brochure might think that this AR was affiliated with DOL.

Issues related to new SECs – The Office received complaints suggesting that when a new SEC is announced, some ARs immediately advertise in the local media, offering their services. Some people have called to complain that it does not appear that these ARs tell claimants (and many claimants are unaware) that if they previously filed a claim and that claim was denied, DEEOIC automatically reviews the claim to determine if it is included in the new SEC.

AR no longer assisting the claimant – Pursuant to the PM, a claimant can only have one AR at a time. See EEOICP PM Chapter 2-0400.2(b). Most claimants understand the intent behind this provision. Nevertheless, there are instances where this provision causes problems. The two most common problems that we encounter are: (1) instances where the AR is only assisting the claimant with certain issues pertaining to his/her claim, and (2) instances where claimants do not realize that they need to withdraw the AR’s authorization.

- The AR is only assisting the claimant with certain issues – There are instances when ARs only assist claimants with certain aspects of a claim, such as establishing entitlement to compensation or with the claim for wage loss and/or impairment, and do not provide assistance with other aspects of the claim, such as obtaining medical benefits or the payment of bills.<sup>82</sup> Problems arise when the claimant needs assistance interacting with DEEOIC on an aspect of their claim, and it is an aspect of the claim where the AR is not providing assistance. If someone else attempts to assist the claimant, DEEOIC informs that person that it will only discuss the claim with the claimant and/or the AR. While claimants understand the intent of this rule, we receive complaints asserting that this rule did not make allowances for situations where the AR is not assisting the claimant with certain aspects of their claim.

<sup>82</sup> It is not entirely clear why some ARs choose to only assist claimants with certain services. Some believe that ARs make this distinction because of the fee schedule. There is a belief that ARs are more likely to provide assistance when it is clear that the fee schedule applies – such as with establishing entitlement to benefits and obtaining compensation for impairment and/or wage loss. On the other hand, when it comes to services related to obtaining medical benefits and resolving billing issues, because the fee schedule is not clear if and how an AR is compensated, some feel that ARs tend to shy away from assisting claimants with these matters.

Moreover, many of the situations the Office encountered were further complicated by the incapacity of the claimant. We encountered instances where the problem at hand involved an issue where the AR was not providing assistance and unfortunately the claimant was not capable of interacting with DEEOIC. When a family member tried to assist their loved one, they discovered that DEEOIC would not talk to them since they were not the AR. And in many of these situations, the option of terminating the AR and having themselves appointed the AR is not very appealing. In many instances family members are hesitant to take actions that could significantly impact their loved one's case, and this is especially true when the family member is not familiar with EEOICPA. Often adding to the family member's desire not to negatively impact their loved one's claim is the hope that the loved one's incapacity will only be short term. Thus, in spite of the intent of this rule, family members find it frustrating when they are unable to assist their loved one with obtaining necessary medical care or preventing the initiation of a collection action on a bill because the AR is not handling those aspects of the claim and DEEOIC will not talk to them because he/she is not the AR.

- Claimants do not withdraw the AR's authorization – When a final decision accepts a claim, oftentimes the last thing on the claimant's mind is their authorization of an AR. Moreover, some claimants are under the assumption that the acceptance of the claim terminates the appointment of an AR. As a result, we encounter situations where months, and sometimes years after the acceptance of the claim, the claimant appoints a new AR only to be informed that this new appointment is not effective since the claimant never withdrew the appointment of the previous AR. This problem can be resolved by having the claimant withdraw the previous appointment. However, we are aware of instances where, due to health or other factors that diminished the claimant's capacity, obtaining the claimant's written authorization was problematic.

It has also been brought to our attention that because some claimants assumed that the appointment of the AR terminated with the acceptance of the claim, these claimants did not realize that DEEOIC continued to forward documents to the AR. We are aware of situations where this caused significant problems because when the claim was filed, DEEOIC was only provided with the address of the AR and not the claimant. Since it only had the AR's address, correspondence from DEEOIC was only forwarded to the AR. Over the year, the Office was approached by claimants who complained that DEEOIC was not communicating with them on matters such as medical benefits or the payment of a bill. In response to our inquiry, DEEOIC informed us that all correspondence was mailed to the only address it had - the address of the AR. When we informed the claimant of this response, some were adamant that they never received this correspondence from their AR.

As we draft this report, DEEOIC is in the process of revising its regulations. Claimants have expressed a hope that these revisions include a requirement that ARs must provide DEEOIC with claimant's address, thereby ensuring that a copy of all documents are directly mailed to the claimant as well.

## Issues Related to Home Health Care Providers

### A. Aggressive Solicitations

The Office continued to receive complaints alleging that personnel associated with some home health care providers engaged in questionable conduct. Claimants complain of unsolicited telephone calls and aggressive visits to their homes. It especially concerns claimants when they receive unsolicited telephone calls or visits from people who know that they filed an EEOICPA claim (and sometimes appear to know when the claim was accepted). This prompts claimants to ask how a person associated with a home health provider knew so much about their claim. In some instances, claimants also suggested that the personnel associated with the home health care provider were overly aggressive in trying to convince the claimant to use the services of a particular provider.

### B. Conflict of Interest Confusion

#### Application of DEEOIC's Conflict of Interest Provision – Issue 1

According to EEOICPA Bulletin 14-04, DEEOIC will not recognize the designation of an AR when DEEOIC finds that the individual could directly benefit financially as a result of his/her role as the claimant's AR, aside from the fee authorized by law. See EEOICPA Bulletin NO.14-04 (Effective July 1, 2014). This provision, for example, bars an individual from serving as a claimant's designated AR while at the same time being paid as a home health care provider. The Office continued to receive complaints suggesting that this bulletin is too broad. In particular, claimants question the application of this bulletin in situations where the person serving as the AR and providing home health care is a family member – and especially where this person is a family member living in the same residence with the claimant. Claimants contend that this bulletin fails to appreciate how difficult it can be to find someone willing to provide care, let alone find someone who the claimant is willing to let into his/her house. Moreover, for many claimants, there is an issue of trust. An AR will have access to the claimant's social security number and medical records. In addition, some claimants have stressed that they are not in a position to closely monitor the home health provider who comes into their home. Consequently, some claimants prefer to entrust these jobs to someone they know and trust.

#### Application of DEEOIC's Conflict of Interest Provision – Issue 2

During the course of the year, we heard from home health care providers who conceded that there were some in their industry who abused the system. Most of the providers we talk to support DEEOIC's efforts to rein in abuse. However, many of these providers questioned DEEOIC's approach to the problem of abuse.<sup>83</sup> We talked to providers who described DEEOIC's approach to abuse as a "one size fits all" approach in which everyone was treated as a potential abuser. Providers suggested that rather than imposing broad rules, it might be more effective to directly address the abusers.

<sup>83</sup> Moreover, if the claim is accepted, the AR may have access to the claimant's bank routing number.

Specifically, providers suggested that DEEOIC's broad rules sometimes worked to prevent claimants from receiving needed advice. Some providers have complained that the sentiments underlying EEOICPA Bulletin 14-04 sometimes work to prevent them from ensuring that claimants receive needed care – and that this arises even when the provider is not attempting to also serve as the AR.

The Office heard from providers who believed that because of their experience with the EEOICPA program, as well as their regular visits with the claimant, they are often in an ideal position to identify when a claimant was struggling with an EEOICPA claim, as well as when a claimant was not fully aware of all of the assistance to which he/she might be entitled. While providers assured us that as a first step they usually tried to encourage the claimant to contact DEEOIC for assistance, instances arose, when for a variety of reasons, a claimant could not or would not follow up with DEEOIC on their own. Some providers have suggested that these situations present them with a dilemma. On the one hand, these providers feel obligated to assist these claimants. However, some providers have indicated that they fear that if they telephone or otherwise contact DEEOIC on the claimant's behalf, they will be accused of trying to take financial advantage of the claimant – and they fear that they will face these accusations even when they are not seeking to be designated as the AR. Some providers also indicated that they fear that once their efforts to assist a claimant are known, the case will be flagged as one posing a potential conflict of interest, thus possibly delaying the adjudication of the claim (and possibly subjecting the case to greater scrutiny).

We talked to providers who assured us that they did not want to assume the role of a claimant's AR. Yet they felt that there needed to be a mechanism (and a recognition) that because of their unique relationship with claimants there would be times when providers needed to at least alert the Resource Center and/or the District Office to a problem, as well as situations when a provider might be useful in assisting the claimant in articulating the problem.<sup>84</sup>

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<sup>84</sup> When we advise a claimant to contact the Resource Center (or the District Office), we routinely ask the claimant for permission to provide the Resource Center (or the District Office) with a heads up. We initiated this practice because we recognized that in spite of our suggestion, some claimants would not contact the Resource Center (or the District Office). Moreover, when the matter involves a complicated issue, we sometimes provide a brief outline of the issue.

## Case Study Six

Trying to set forth the number and types of complaints that the Office receives in a year is complicated by the fact that most claimants do not contact us just to report one incident or event. We often find that when claimants come to us, it is after a series of interactions with DEEOIC (or the other agencies involved in the administration of this program). Or they come to us after multiple efforts to resolve a problem have been unsuccessful. In addition, there are other claimants who contact us each time they encounter a hurdle with the processing of their claim that they are unable to overcome. Throughout this report we briefly discussed some of the complaints that we received during the year. We already discussed one aspect of the following case. Here is a full discussion of our interactions with one claimant.

The spouse serves as the claimant's AR. The first matter came to our attention when a concern arose as to the pace of the handling of this case. This former worker filed a claim on June 25, 2015. According to DEEOIC, while the EE-1 (claim form) had a request to expedite from a physician, the physician who signed the request was not the personal physician. The physician who made the request to expedite the claim subsequently followed up with DEEOIC on September 8, 2015. Thereafter, on September 14, 2015, the CE contacted the AR to inform him/her that DEEOIC was not aware of the claimant's terminal status. The CE then advised the AR of the need to submit a letter from a treating physician confirming the claimant's terminal status. When this matter was brought to our attention, the AR questioned why it had taken until September 14, 2015, and then only after the physician had followed up, to inform him/her of the need for a letter from the treating physician confirming the terminal status. The AR also questioned the amount of medical documentation needed to support the terminal status of someone who was in hospice care. In any event, DEEOIC received medical documentation supporting the terminal status on September 29, 2015.<sup>85</sup>

Around the same time the AR submitted the documentation supporting the terminal status, the AR learned that the CE had called a social worker at the hospice questioning the affidavits submitted to verify the worker's employment. Even if the CE wanted to inform the social worker that there was a problem with the claim, claimant questioned the necessity of telling the social worker that the affidavits "looked forged." Claimant also questioned the need to make such an allegation to a third party, especially before talking to the AR.<sup>86</sup>

<sup>85</sup> This case illustrates something we frequently encounter – claimants are often processing a claim while in the midst of other challenges.

<sup>86</sup> When notified of the concern with the affidavits, the claimant was able to explain that two of the affiants had received assistance from the Iowa FWP in preparing their affidavits

On October 14, 2015, the claimant's Part B and Part E claims were accepted. In terms of monetary compensation, the claimant received a lump sum Part B award, but now had to separately file for impairment compensation under Part E.<sup>87</sup> On October 19, 2015, claimant submitted Form EN-11A which serves to inform DEEOIC that he/she was selecting a physician to perform the impairment evaluation and rating. The impairment rating was also submitted on the same date. Unfortunately, the claimant passed away on October 24, 2015, prior to payment of the impairment award. Since the covered employee died prior to the payment of Part E compensation, the survivor was not eligible to receive the impairment award. 20 C.F.R. §7385s-1(2). Instead the survivor had to file a Part E survivor's claim. 20 C.F.R. §§7385s-1(2) and 7385s-2. Consequently, this surviving spouse believes that he/she was financially impacted by the delay in designating this as a terminal case, as well as by the delay surrounding the acceptance of the affidavits.

The survivor then filed a survivor's claim. In response, the survivor received a letter from the CE acknowledging receipt of the marriage certificate, but noting that the marriage certificate was unclear as to when the claimant and employee married. The letter suggested that in order to confirm the wedding date the claimant could send a copy of a wedding announcement or a copy of a wedding photo with the date on it. When this matter was brought to our attention, the survivor could not understand why the marriage certificate was not clear. In addition, this survivor, who had lost his/her spouse less than two months earlier, was not eager to search for a wedding announcement or a wedding photo with a date on it. When the survivor's concern was brought to DEEOIC's attention, DEEOIC explained that the copy forwarded to the CE was illegible. Claimant wished that the initial letter from DEEOIC had been as clear in articulating the problem. The matter was resolved by forwarding a better copy of the marriage certificate to the CE.

The letter from the CE also acknowledged receipt of the death certificate. Under "MEDICAL EVIDENCE YOU NEED TO SUBMIT," the letter indicated that the claimant "may" submit a physician's narrative report detailing the covered medical conditions. The letter also suggested that the claimant provide the physician with a copy of the EE-7 (Medical Requirements under the Energy Employees Occupational Illness Compensation Program Act) when requesting the necessary medical records. This request puzzled the survivor. He/she had already submitted the death certificate, the worker died ten days after acceptance of a claim for the same covered conditions, and the worker was in hospice care during the entire processing of the claim. This survivor was at a loss as to the additional medical evidence sought by the CE. When this matter was brought to DEEOIC's attention the claimant was informed that upon further review, no additional evidence was required.

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<sup>87</sup> It does not appear that the claimant filed a claim for wage loss.

# SUMMARY

As in previous years, the complaints the Office received in 2015 addressed virtually every aspect of the claims process. Thus, the concerns brought to our attention in 2015 spanned from issues involving the delayed notice of the existence of this program to issues involving the receipt of home health care following the acceptance of a claim. Moreover, as in previous years, the complaints that we received did not simply come from claimants with denied claims, or those whose claims were about to be denied. We also received complaints from individuals who were in the midst of processing a claim, as well as some who encountered problems following acceptance of their claim. In addition, as Table 2 illustrates, complaints are not centered on any one part of the country and are not limited to a few facilities.

Yet, while the Office received complaints addressing virtually every aspect of the claims process, there are some common themes that arose from the issues we encountered in 2015.

1. We continue to encounter claimants who contend that they only recently learned of this program. These claimants often question why it took so long for them to learn of this program. Some of these claimants find it troubling that the government never notified them of this program and instead, they only learned of this program from a friend or neighbor. Regardless of how they learned of the program, claimants who feel that there was a delay in notifying them of this program often believe that the adjudication of their claim was negatively impacted by this delay. Some believe that due to the delay evidence was destroyed. There are also claimants who believe that the amount of compensation paid on their claim was impacted by a delay in receiving notice of this program. Based on our observations, we believe that there are potential claimants who still do not know about this program.
2. Some claimants go through the entire adjudication process without ever acquiring a good understanding of how this program works and in some instances, this can have an impact on a claimant's ability to develop his/her claim. For example, while a lot of useful information can be found on DEEOIC's website, we encounter claimants who do not know that this website exists, or do not appreciate the value of information found on this website. Moreover, even when they are aware of DEEOIC's website, some claimants find it hard to use this website because: (1) they do not have access to the internet, (2) they are unable to navigate this website, and/or (3) they do not understand the information that they locate. A common complaint suggests that in developing tools and providing information, DEEOIC often appears to assume that claimants fully understand the program. However, we frequently encounter claimants whose understanding of EEOICPA is cursory at best. Claimants suggest that it would help if more effort was made to show them how to access and use the various tools/resources that have been developed. They have also indicated that they could benefit from a better guide or index directing them where to locate information.
3. Questions arise concerning coverage under this program – specifically who is covered, the facilities covered, and the illnesses covered under EEOICPA. Claimants would like someone to explain the rationale for covering some employee and some illnesses, while other employees and other illnesses are not covered under this program. Similarly, claimants would like a better understanding as to why certain facilities are not covered under this program. Since Congress has already recognized that state workers' compensation programs oftentimes do not provide a uniform means of ensuring adequate compensation for the types of occupational illnesses and diseases related to these sites, individuals who are not covered under this program would also like someone to direct them to a program that will compensate them for the illnesses that arise from employment at these facilities.

4. Another common issue involves the problems encountered by claimants when trying to locate evidence. Section 7384v of the statute states that the President shall “provide assistance to the claimant in connection with a claim...” 42 U.S.C. §7384v(a). We routinely talk to claimants who believe that this provision was passed because Congress realized that there would be instances when relevant evidence had been destroyed and other relevant information was never collected. In response to claimant’s complaints that there needs to be more assistance, DEEOIC has indicated that under EEOICPA, the burden of proof is on the claimant. Claimants understand that they bear the burden of proof. Nevertheless, they also believe that §7384v must have some meaning. Therefore, claimants would like clarification as to the assistance anticipated by this provision, as well as clarification as to who is expected to provide this assistance.
5. While DEEOIC has made strides in providing well-reasoned decisions, the weighing of evidence in decisions continues to generate complaints. Claimants still complain that decisions (or letter decisions) merely informed them of the outcome of the claim. As one would expect, these complaints are most frequently raised when decisions merely inform the claimant that the claim was denied. Claimants contend that merely being informed that the claim was denied is not sufficient. According to claimants it is critical to know why the claim was denied – this not only helps to explain the decision, it also provides guidance as to what the claimant needs to do to further develop his/her claim. Claimants also complain that there are instances when relevant factors are not considered when evidence is weighed. These relevant factors include, the qualifications of the respective physicians; the length of time or the number of times a physician saw the claimant; the documents the physician reviewed in making his/her determination; as well as the physician’s familiarity with the facility in question. When these factors are not even mentioned by the CE or HR, claimants question the extent to which they were recognized and/or considered.
6. There are concerns with the application of the burden of proof. One concern involves the fact that claimants are not always certain when the “at least as likely as not” standard applies and when the “more likely than not” standard applies. Another concern involves the fact that some claimants believe that there are instances when the burden placed on them is greater than either the “at least as likely as not” or the “more likely than not” standard. For example, claimants argue that DEEOIC’s refusal to rely solely on the affidavit of the worker, and to insist that there be documents in the record to support the affidavit, results in placing a higher evidentiary burden on them than that used in criminal proceedings. We also continue to hear from claimants who believe that they were required to prove facts with almost near certainty. Some claimants have suggested that the requirement to prove facts with documentary evidence often means that they must prove the fact with near certainty.
7. Claimants continue to have questions concerning the weight given to PM provisions, bulletins, circulars and policy teleconference notes. In particular, concerns arise when these documents are the only basis cited in drawing conclusions of law in decisions. Claimants question DEEOIC’s interpretation of the word “presumption”, particularly as it relates to policy guidance for Part E claims. Claimants assume that if a presumption exists under Part E, should they fail to meet the presumption, their case will still be fully adjudicated under the Part E standard of causation. Thus, claimants have expressed frustration and confusion when they are informed that presumptions under Part E must be met or their claim must be denied.

8. In recent years, a large number of the complaints that we received involved issues related to home health care and medical billing. In a general sense, claimants believe that decisions concerning home health care need to be better explained. For instance, claimants believe that if after previously approving the same level of care DEEOIC subsequently decides it needs more information, DEEOIC ought to explain why more information is needed, and needs to be specific as to what it is seeking. In addition, claimants and providers believe that if they respond to a request for information and DEEOIC determines that the information provided is not adequate, DEEOIC should not simply resend the same request for information. Rather, claimants and providers suggest that if additional information is submitted and DEEOIC determines that this information still is not sufficient, DEEOIC ought to make an effort to better explain what is being sought.
9. With respect to medical billing, claimants contend that it would be useful if more assistance was provided. If a claimant utilizes a provider enrolled in the program, that provider is able to directly submit his/her bill for payment. However, there will be instances where claimants are seeking reimbursement for bills that he/she paid out of pocket – such as instances where the claimant paid bills out-of-pocket while the claim was pending. Claimants believe that it is not reasonable to expect them to be intimately familiar with the bill paying process and the various forms that must be filed. Consequently, claimants contend that it would help if instead of simply rejecting a bill, they received an explanation, in terms they could understand, outlining why the claim was denied, and where appropriate, explaining what needed to be done to correct any deficiencies. Similar concerns are raised by some providers who contend that the process for paying bills can be burdensome and that assistance is not always easy to locate.
10. We encounter claimants who have concerns with some of their interactions with DEEOIC. Most claimants who come to us with complaints alleging inappropriate behavior are adamant that their concerns reflect the actions of just one or two employees, and stress that their complaints are not meant to reflect on the DEEOIC staff as a whole. In fact, claimants who come to us with complaints alleging inappropriate behavior usually go out of their way to emphasize that they also encountered other staff members who were very helpful. Yet, it concerns claimants that they encounter instances where certain staff members are rude or not very helpful. What really troubles claimants is the feeling that there does not appear to be any formal mechanism for addressing their concerns. Because DEEOIC is usually reluctant to grant a request to change CEs, claimants feel “stuck” with a CE regardless of how inappropriately that CE may conduct him or herself. Moreover, claimants find the suggestion that they report such conduct to be useless since there is no established procedure for reporting such conduct. Claimants are usually reluctant to call a telephone number to discuss a complaint about one staff members when they do not know who they are talking to or how their complaint will be handled. Claimants frequently tell us that they fear that when they call to report an incident of inappropriate behavior, the person who is the subject of their complaint will be sitting in the next cubicle (or they will report their complaint to someone who immediately tells the subject of the complaint everything that was said). For some claimants it would help if there was a designated procedure for reporting such complaints. Other claimants have suggested that recording all telephone conversations between CEs and claimants would ensure that DEEOIC had an accurate account of these conversations.

## Acronyms (Abbreviations) Used in this Report

<b>ACS</b>	Affiliated Computer Services
<b>AEC</b>	Atomic Energy Commission
<b>AR</b>	Authorized Representative
<b>AWE</b>	Atomic Weapons Employer
<b>BeLPT</b>	Beryllium lymphocyte proliferation test
<b>CBD</b>	Chronic beryllium disease
<b>CE</b>	Claims examiner
<b>CLL</b>	Chronic lymphocytic leukemia
<b>CMC</b>	Contract Medical Consultant (formerly known as District Medical Consultant)
<b>CPWR</b>	The Center for Construction Research and Training
<b>DEEOIC</b>	Division of Energy Employees Occupational Illness Compensation
<b>DME</b>	Durable medical equipment
<b>DOD</b>	Department of Defense
<b>DOE</b>	Department of Energy
<b>DOJ</b>	Department of Justice
<b>DOL</b>	Department of Labor
<b>EEOICPA</b>	Energy Employees Occupational Illness Compensation Program Act
<b>ERDA</b>	Energy Research & Development Administration
<b>FAB</b>	Final Adjudication Branch
<b>FECA</b>	Federal Employees' Compensation Act
<b>FOIA</b>	Freedom of Information Act
<b>FWP</b>	Former Worker Medical Screening Program
<b>FY</b>	Fiscal year
<b>HHS</b>	Department of Health and Human Services
<b>HR</b>	Hearing Representative

<b>ICD-10</b>	International Classification of Diseases, 10th Edition
<b>IOP</b>	Iowa Ordnance Plant
<b>IH</b>	Industrial hygienist
<b>IOM</b>	Institute Of Medicine of the National Academies
<b>JOTG</b>	Joint Outreach Task Group
<b>MED</b>	U.S.Army Corps of Engineers Manhattan Engineer District
<b>NDAA</b>	National Defense Authorization Act
<b>NIOSH</b>	National Institute for Occupational Safety and Health
<b>NO</b>	National Office
<b>OWCP</b>	Office of Workers' Compensation Programs (United States Department of Labor)
<b>PM</b>	Procedure Manual
<b>PoC</b>	Probability of causation
<b>RECA</b>	Radiation Exposure Compensation Act
<b>RESEP</b>	The Radiation Employees Screening and Education Program
<b>SEC</b>	Special Exposure Cohort
<b>SEM</b>	Site Exposure Matrices
<b>SSA</b>	Social Security Administration
<b>The Act</b>	The Energy Employees Occupational Illness Compensation Program Act
<b>The Office</b>	The Office of the Ombudsman, Energy Employees Occupational Illness Compensation

# APPENDIX 2

## EEOICP Program Statistics

Data as of 01/03/2016

### Combined Part B and E Summary

		CLAIMS	CASES
<b>Applications Filed</b>		275,996	183,827*
<b>Total Compensation Paid</b>	Payments	102,661	74,697
	Dollars	\$9,490,849,913	
<b>Total Medical Bills Paid</b>	Dollars	\$2,615,233,971	
<b>Total Compensation + Medical Benefits (Dollars)</b>		<b>\$12,106,083,884</b>	

\*The above number of applications filed represents 109,469 unique individual workers.

### Part B Claims

		CLAIMS	CASES
<b>Applications Filed</b>		152,674	96,886
<b>Final Decisions</b>	Approved	73,769	47,313
	Denied	64,026	43,667
	Total	137,795	90,980
<b>Compensation Paid</b>	Payments	69,297	44,435
<b>Total Dollars</b>		<b>\$5,853,227,844</b>	

### Part E Claims

		CLAIMS	CASES
<b>Applications Filed</b>		123,322	86,941
<b>Final Decisions</b>	Approved	48,037	39,860
	Denied	60,870	39,431
	Total	108,907	79,291
<b>Compensation Paid</b>	Payments	33,364	30,262
<b>Total Dollars</b>		<b>\$3,637,622,069</b>	

# APPENDIX 3

## EEOICPA Coverage

**Chart 1 identifies the employees covered under Part B and Part E.**

EMPLOYEES COVERED UNDER PART B	EMPLOYEES COVERED UNDER PART E
DOE contractor	DOE contractor
DOE subcontractor	DOE subcontractor
Beryllium Vendor	Uranium miners, millers, and ore transporters covered under Section 5 of the Radiation Exposure Compensation Act (RECA) <sup>88</sup>
Atomics Weapons Employer	
DOE employees	
Approved RECA Section 5 Claimants	

**Chart 2 identifies the illnesses covered under Part B and Part E.**

POTENTIAL PART B ILLNESSES	POTENTIAL PART E ILLNESSES
<ul style="list-style-type: none"> <li>• Radiation induced Cancer</li> <li>• Chronic Beryllium Disease</li> <li>• Beryllium Sensitivity</li> <li>• Chronic Silicosis (if mining of atomic weapon test tunnels in Nevada or Alaska)</li> <li>• "Supplement" for RECA Section 5 uranium workers</li> </ul>	Any illnesses or death (including illness or death related to cancer or beryllium) where it is at least as likely as not that exposure to a toxic substance at a covered facility was a significant factor in aggravating, contributing to, or causing the employee's illness or death.

**Chart 3 outlines the employees covered under Part B and the illnesses for which these employees are covered under Part B.**

PART B COVERED EMPLOYEES	CANCER CAUSED BY RADIATION EXPOSURE	CHRONIC BERYLLIUM DISEASE	BERYLLIUM SENSITIVITY	CHRONIC SILICOSIS
DOE Employee	YES	YES	YES	YES
DOE Contractor	YES	YES	YES	YES
DOE Subcontractor	YES	YES	YES	YES
Atomic Weapons Employer	YES	NO	NO	NO
Beryllium Vendor	NO	YES	YES	NO

<sup>88</sup> A claimant with an approved RECA Section 5 claim is eligible for additional compensation under Part B. In addition, a claimant who qualifies as a RECA Section 5 uranium miner, miller, or ore transporter may be eligible for compensation and benefits under Part E. Unlike Part B, under Part E, there is no requirement that the RECA Section 5 miner, miller, or ore transporter have an approved RECA claim.







**UNITED STATES DEPARTMENT  
OF LABOR**

Office of the Ombudsman  
Energy Employees Occupational Illness  
Compensation Program

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