

2017

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: **Savannah River Site; SRS at 60—Glove boxes.** Glove boxes are sealed containers that are designed to allow manipulation of objects where a separate atmosphere is desired. Gloves built into the sides of the glove boxes are arranged so that the user can place his or her hands into them and perform tasks inside the box without breaking containment so the user can work with hazardous substances, such as radioactive materials. Part, or all, of the box is usually transparent to allow the user to see the material he or she is working with. Photo courtesy of **energy.gov**.

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PREFACE TO THE REPORT

In this Annual Report to Congress the Ombudsman for the Energy Employees Occupational Illness Compensation Program sets forth the complaints, grievances, and requests for assistance that we received during calendar year 2017, and provides an assessment of the most common difficulties encountered by claimants and potential claimants in that year. However, before addressing the complaints, grievances and requests for assistance that we received in 2017, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in calendar year 2017 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA):

- In October 2016, DEEOIC announced the launching of a new Public Reading Room on its website. As of January 1, 2017, the records posted on this website included the Department of Labor's (DOL's) Response to the EEOICPA Ombudsman's 2014 Annual Report to Congress; EEOICPA Actuarial Reports for FY 2008-2015; and DEEOIC Staff Training Materials. Other materials posted on this website include: Accountability Review Reports; Contract Medical Consultant/Second Opinion Audits; and Program Summary Statistics.
- DEEOIC also announced the creation of a centralized medical bill processing unit staffed by medical benefits examiners (MBEs) who specialize in the review and adjudication of home health care and other ancillary medical benefits requests. The MBEs are located within various District Offices but will operate under the direction of the National Office.
- Teleconferences were held on May 23-24, 2017, and September 19-20, 2017, where medical providers were able to learn more about medical benefits and medical billing under the EEOICPA.
- DEEOIC's first authorized representative workshop was held on December 6-7, 2017 in Jacksonville, Florida. DEEOIC developed this hands-on workshop in order to provide information tailored to the specific needs of authorized representatives and attorneys who represent claimants under the EEOICPA. There were several sessions over two days, presented by DEEOIC claims supervisors, Resource Center (RC) staff, and representatives from National Institute for Occupational Safety and Health (NIOSH), Department of Energy (DOE) and this Office.
- The following workshops were held:
 - › Town Hall Meetings in Central California on March 15 and 16, 2017;
 - › A Town Hall Meeting in Metropolis, Illinois on June 14, 2017;
 - › Medical Benefits Meeting and a Traveling Resource Center in Shiprock, New Mexico on August 22, 2017;
 - › Medical Benefits Meeting and a Traveling Resource Center in Monticello, Utah on August 23, 2017;
 - › An Open House and Traveling Resource Center in Albuquerque, New Mexico on September 7, 2017; and,
 - › A Traveling Resource Center in Santa Fe, New Mexico on November 15, 2017.

In addition, we wish to acknowledge the many instances throughout the year where members of the DEEOIC staff assisted claimants and/or our office in resolving matters brought to their attention.

I. INTRODUCTION

A. An Overview of the Energy Employees Occupational Illness Compensation Program Act (the EEOICPA)

On October 30, 2000, Congress enacted the EEOICPA as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. Among the findings made in enacting this program Congress recognized that:

1. *Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapon production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.*
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).

The purpose of the EEOICPA is “...to provide for timely, uniform, and adequate compensation of covered employees, and where applicable, survivors of such employees, suffering from illnesses incurred by such employees in the performance of duty for the Department of Energy and certain of its contractors and subcontractors.” See 42 U.S.C. § 7384d(b). As originally enacted in October 2000, the EEOICPA contained two parts, Part B and Part D.

Part B, which is administered by the Department of Labor (DOL), provides the following compensation and benefits:

1. Lump-sum payment of \$150,000 and the payment of medical expenses (for the covered illness starting as of the date of filing) for:
 - a. Employees of the Department of Energy, as well as its contractors, subcontractors, and employees of atomic weapons employers (AWEs) with radiation- induced cancer if: (1) the employee developed cancer after working at a covered facility; and (2) the cancer is “at least as likely as not” related to covered employment.¹

¹ An atomic weapons employer is an entity, other than the United States, that: (A) processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and (B) is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program [EEOICPA]. See 42 U.S.C. § 7384l(4).

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 - b. Employees who are members of Special Exposure Cohort (SEC) and who develop one of the specified cancers outlined in 42 U.S.C. § 7484I(17).²
 - c. All federal employees, as well as employees of the DOE, its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and who develop Chronic Beryllium Disease (CBD).³

² If a claimant qualifies for inclusion in a SEC class and develops one of the specified cancers, that claimant receives compensation for that specified cancer without the completion of a radiation dose reconstruction by the National Institute for Occupational Safety and Health, and without a determination by DOL of the probability of causation that the cancer was caused by exposure to radiation at a covered facility.

³ Last year DOL's Office of the Solicitor informed us that every federal employee is a potential "covered beryllium employee" as defined in 42 U.S.C. § 7384I(7)(A), by virtue of inclusion of the Federal Employees Compensation Act (FECA) definition of "employee" in 5 U.S.C. § 8101(1) into that definition. This definition of the term, "covered beryllium employee" is more expansive than the definition of "covered beryllium employee" found on DEEOIC's webpage under the "Explanation of Benefits Under Part B and Part E" link. There are potential claimants who could benefit from being made aware of this clarification. See 42 U.S.C. § 7384I(7)(A).

- d. Employees of the DOE or its contractors and subcontractors who worked at least 250 days during the mining of tunnels at underground nuclear weapons test sites in Nevada or Alaska and who develop chronic silicosis.

Note: if the employee is no longer living, eligible survivors of the employees listed above are entitled to \$150,000 in lump-sum compensation under Part B.

2. A lump-sum payment of \$50,000 and medical expenses for the covered illness to uranium miners, millers, and ore transporters, or their survivors, who are awarded \$100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note.
3. All federal employees, as well as employees of the DOE, its contractors and subcontractors, whose claims for beryllium sensitivity are accepted under Part B are entitled to medical monitoring to check for the development of CBD.

Part D of the EEOICPA required DOE to establish a system by which DOE contractor employees and their eligible survivors could seek assistance in 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. However, on October 28, 2004 Congress abolished Part D and created Part E 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). Part E is administered by DOL.

The compensation and benefits allowable under Part E are as follows:

1. DOE contractor and subcontractor employees who develop an illness due to exposure to toxic substances at DOE facilities are entitled to medical expenses and may receive monetary compensation of up to \$250,000 for impairment and/or wage-loss.
2. Eligible survivors of DOE contractor and subcontractor employees receive compensation of \$125,000 if the employee's death was caused, contributed to, or aggravated by the covered illness. If the employee had between 10 and 19 years of wage-loss, the survivor receives an additional \$25,000. On the other hand, if the worker had 20 or more years of wage-loss, the survivor receives an additional \$50,000.
3. Uranium miners, millers, and ore transporters are eligible for medical benefits, as well as up to \$250,000 in monetary compensation for impairment and/or wage-loss if they develop an illness as a result of toxic exposure at a facility covered under Section 5 of the Radiation Exposure Compensation Act (RECA). Employees who qualify as uranium miners, millers, or ore transporters under Section 5 of RECA are eligible for compensation and medical benefits under Part E, even if they did not receive compensation under RECA.

DOL has primary authority for administering Part B and Part E of the EEOICPA. However, there are other federal agencies that are also involved with the administration of this program.

1. The DOE ensures that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or the National Institute for Occupational Safety and Health (NIOSH) with information related to individual claims such as employment verification and exposure records; (2) supporting DOL, NIOSH, and the Advisory Board on Radiation and Worker

Health with large-scale records research and retrieval efforts at various DOE sites; (3) conducting research, in coordination with DOL and NIOSH on issues related to covered facility designations; and (4) hosting the Secure Electronic Records Transfer (SERT) system, a DOE hosted environment where DOL, NIOSH, and DOE can securely share records and data.

2. 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; (3) using the dose reconstruction regulation to develop estimates of radiation dose for workers who have applied for compensation; (4) overseeing the process by which classes of workers can be considered for inclusion in the Special Exposure Cohort; and (5) providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and SEC petitions.
3. The Ombudsman to NIOSH helps individuals with a variety of issues related to the SEC petition process and the dose reconstruction process. The Ombudsman to NIOSH also conducts outreach to promote a better understanding of the EEOICPA, as well as the claims process.

B. The Office of the Ombudsman

Public Law 108-375, which was enacted on October 28, 2004, established within the DOL an Office of the Ombudsman (the Office). The duties of the Office are to:

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 regarding the location of resource centers for the acceptance and development of EEOICPA claims.
3. Carry out such other duties as the Secretary specifies.

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

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

See 42 U.S.C. § 7385s-15(e).

Claimants, family members, authorized representatives (ARs), home health providers, and others contacted us throughout the year with concerns and questions about the EEOICPA claims process.⁴ In most instances, these individuals did not contact us simply to register a complaint. Rather, they usually contacted us because they wanted assistance with a claim. In many instances, these individuals only turned to us for help when other efforts to obtain assistance had been unsuccessful.

Within the limits of our authority, we made every effort to assist the individuals who contacted us. Thus, as appropriate we: (1) directed individuals to the office or agency that could best provide needed information and assistance; (2) explained the benefits provided by this program, as well as the requirements and procedures for obtaining these benefits; (3) answered questions about the program; (4) made individuals aware of the tools and resources that had been developed to assist them; (5) provided guidance on how to access these tools and resources; and (6) provided individuals with a listening ear to hear their concerns and complaints.

⁴ Throughout this Report we will frequently refer to the EEOICPA as “the program”.



II. EXECUTIVE SUMMARY

Many of the individuals who contacted us were encountering a problem with their EEOICPA claim. Nevertheless, it is important to dispel the notion that most of these individuals contacted us simply because they were upset with the outcome of their claim. That simply is not true. Each individual who approached us came with their own unique set of facts and circumstances. Yet, there are some broad categories of concerns that the individuals we encountered raised:

1. Those who just learned about the program and were seeking additional information.

Some of the individuals who contacted us had just learned about the program. In many instances, these individuals had not filed a claim and contacted us to find out what they needed to do, and where they needed to go to file a claim. We frequently found that while they had not yet filed a claim, these individuals had already started to form negative opinions about this program. In particular, we frequently talked to claimants who found it troubling that it had taken so long to learn about this program. And it only added to their concerns when they had to learn about this program from others, rather than from the government. We also found that, even though they had not filed a claim, some individuals were already starting to worry that the delay in learning about this program would impede their ability to develop evidence to support their claim.⁵

2. Those who wanted to know what to do next.

Many claimants pursued their claim without ever having a good understanding of the EEOICPA claims process. Thus, it was not unusual to encounter claimants who approached us because they wanted to know the next steps they needed to take in pursuing their claim. In many instances, these claimants did not simply want to know what to do, they also wanted to understand why they were being asked (or needed) to take these next steps. Consequently, we frequently found that the claimants who approached us needed someone to provide a brief overview of the claims process, and to explain where they were in that process. And because this program can be complex, we frequently found that claimants needed an overview of the claims process even when this process had been previously explained to them. The claimants who approached us oftentimes hoped that we could explain the next steps in the claims process, and could explain these next steps in a manner that they understood.

Some claimants also found it difficult to follow the guidance/directives given to them. While difficulties following guidance/directives can arise at every stage of the claims process, a common scenario that we encountered involved instances where claimants were asked to submit additional evidence (or were advised that existing evidence was insufficient to prove a particular element of their claim). In these situations, claimants often turned to us because they: (1) needed guidance on where to look for evidence; (2) needed someone to clarify what DEEOIC wanted; and/or (3) they did not understand why the evidence they previously submitted was not sufficient. Before turning to us for assistance many of these claimants had already talked to DEEOIC. In turning to us, these claimants often complained that DEEOIC had not fully answered their concerns/questions.

⁵ In other instances, this concern arose later in the claims process, oftentimes when they subsequently encountered difficulties trying to locate evidence to support their claim.

3. Those who wanted to know the status of their claim.

Throughout the year it was very common to be approached by individuals who wanted to know the status of their claim. These requests frequently came from claimants who noted that their request was prompted by a lack of action (or a lack of updates from DEEOIC) on their claim. In some instances, claimants maintained that it had been weeks or months since they last heard (or received) anything about their claim.⁶ In other instances, we were approached by claimants who complained that DEEOIC's response to their status inquiry had not been very informative. Consequently, we were routinely approached by claimants who hoped that we might be able to provide a more detailed explanation for the delay they were experiencing. Although the response that we were able to provide oftentimes was not the detailed explanation that they wanted, most claimants were appreciative to receive any information we could provide.

When the delay continued for what the claimant deemed to be an extended period of time, we often observed an increase in the claimant's level of frustration. As the delay continued, frustrations would sometimes surface as the claimant repeatedly received the same vague response to his/her status inquiries. It further added to these frustrations when no one was able to provide them with an estimate of how long the delay would continue.⁷ In fact, some claimants complained that there did not appear to be any rules governing how long DEEOIC could delay their claim.

4. Those who had lost track of their claim.

We were approached by claimants who asked us to check on their claim, or asked us to explain what had happened with their claim. Although we usually assumed that these claimants were asking about the status of their claim, as the conversations continued, we sometimes discovered that these claimants had more basic concerns. In some instances, we found that these claimants were so overwhelmed by the claims process that they could not tell us if their claim was pending, or if they had received a recommended or final decision. In other instances, while they could tell us they had received a decision, they could not tell us if they had received a recommended decision, a final decision and, they oftentimes did not understand, and thus, could not explain the decision they had received. These claimants essentially did not understand what had happened in their case and why.

We find it worth noting that we most frequently encountered claimants with these basic questions about their claim at the outreach events we attended. Our conversations with them often revealed that while they may have wrestled for years with such basic questions about their claim, they had never felt comfortable seeking answers. However, when they encountered us at the outreach event, they decided, oftentimes after some hesitation, to take advantage of that opportunity to see if we could provide some insights and/or information.

Whenever we encountered a claimant who did not understand what had happened in their claim, we would make every effort to provide them with some level of information. In some instances, resolving the claimant's concern simply required providing the claimant with the status of his/her claim. On the other

⁶ In explaining why they did not directly contact the claims examiner (CE) for the status of their claim, many claimants indicated that they did not want to bother the CE. Thus, in contacting our office, claimants often hoped to obtain the status of their claim without "bothering" the CE. When advised that we would have to contact DEEOIC to obtain the status, some claimants asked that we drop the matter.

⁷ There were instances where in response to our status inquiry, DEEOIC not only provided the status of the claim but also provided an estimate of when the claimant could expect to see action on his/her claim.

hand, when our inquiry determined that a decision had been issued, we endeavored to explain the decision. Encounters such as these revealed to us the extent to which some claimants did not have a working understanding of the claims process.

5. Those who needed direct assistance.

In some instances, simply telling the claimant what action they could take was not sufficient. Some claimants needed assistance in carrying out these instructions. Many of the claimants we encountered were at an advanced age and/or were suffering from an illness. We heard from claimants who questioned whether these factors were taken into consideration when developing the policies and procedures applicable to this program. Others complained that while the program should have been well aware that many claimants would be at advanced age and/or suffering from an illness, little assistance was available to address these situations.

Yet, it was not just those who were of an advanced age and/or were suffering from an illness who needed assistance with this claims process. This can be a complex program and, as a result, some claimants found it difficult to fully understand the legal, scientific, and/or medical concepts that form the basis of the program. DEEOIC, and the other agencies involved in the administration of this program have developed a host of useful tools and resources to assist claimants. Yet, many of these tools and resources are only found online. Thus, those without access or only limited access to the internet oftentimes were unable to take advantage of these tools and resources. Moreover, even with access to the internet, some claimants found these tools and resources difficult to find and/or use.

In the report that follows we discuss the most common difficulties encountered by claimants and potential claimants in 2017. And in our opinion, these difficulties go beyond the fact that these claimants and potential claimants simply disagreed with the outcome of their claim.

III. TABLES

In our annual report we are to set forth the numbers and types of complaints, grievances, and requests for assistance that this Office received in the preceding calendar year, and we are to provide an assessment of the most common difficulties encountered by claimants and potential claimants in that year. The tables below set forth the numbers and types of complaints, grievances and requests for assistance that the Office of the Ombudsman received in calendar year 2017. In reviewing these tables, it is important to keep in mind that:

- In most instances, individuals did not contact our Office simply to register a complaint or grievance. Most individuals contacted our Office because they needed assistance with their claim, or had questions about their claim and/or the claims process.
- The claimants who came to us for assistance oftentimes were not familiar with this program and thus, found it difficult to articulate the specific assistance they needed.
- A common way of seeking information and assistance involved telling us their story, which could include details of their employment at a covered facility and/or outlining their experiences with the EEOICPA claims process. In listening to their stories, as well as through our efforts to obtain the limited information shared by the program, we identified and attempted to classify their grievances and complaints.
- In our experience, when individuals contacted us, we typically were required to explain the EEOICPA claims process in a general way, and then lay out for the individual where their case was in the claims adjudication process. Then, by listening to their story and asking them to read or share documents with our office, we could better appreciate the assistance they were seeking, or understand the problems they were attempting to bring to our attention.

Consequently, Table 1 is our effort to classify the types of complaints, grievances, and requests for assistance that we received in 2017.

TABLE 1.—COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE

	CONCERN	NUMBER OF COMPLAINTS, GRIEVANCES, & REQUESTS FOR ASSISTANCE	COMMENTS
1	Covered Employment	51	
2	Covered Facility	20	
3	Covered Illness	39	In some instances the issue involved efforts to establish a diagnosis of CBD.
4	Survivor Eligibility	27	
5	Exposure to a Toxic Substance	83	
6	Dose Reconstruction Process	38	Claimants often questioned: (1) whether all of their work had been credited or (2) the level of exposures to which they had been credited.
7	Issues Related to Special Exposure Cohorts	22	
8	Causation	73	
9	Impairment	17	
10	Wage-Loss	15	
11	Medical Benefits	46	
12	Home Health Care Issues	47	
13	Issues Related to Payment of Medical Bills	48	
14	Status Inquiries	77	These are instances where claimants specifically asked us to provide information on the status of their claim. In many of these instances, a delay in the processing of the claim caused the claimant to seek the status of his/her claim.
15	Delays	108	
16	Issues related to RECA	10	Many of these inquiries expressed a desire to extend the RECA program.
17	Interactions with DEEOIC <ul style="list-style-type: none"> ▪ Communication ▪ Inappropriate Conduct ▪ Not enough notice of upcoming hearing ▪ Other issues 	73 25 8 3	
18	Complaints about authorized representatives and providers	12	These complaints raised concerns about the services rendered by or the conduct of authorized representatives or providers.
19	Did Not Know Where to File a Claim	26	
20	Issues Related to Reopening/Reconsideration	43	Many of the complaints involved requests asking how to request reopening and burden of proof.
21	Due Process Concerns	56	Including 22 cases that raised questions about DEEOIC's current approach to hearing loss.
22	Needed more information about the program	97	
23	General Requests for Assistance	113	
24	Problems trying to locate records	41	
25	Cap on Benefits	9	
26	Miscellaneous <ul style="list-style-type: none"> ▪ General ▪ Problems contacting someone other than DEEOIC ▪ Offset/Coordination of benefits 	59 3 5 3	
	TOTAL	*1,297	

*The 1,297 complaints, grievances, and requests for assistance were the result of 733 interactions with claimants, authorized representatives, home health providers and others.

The complaints, grievances, and requests for assistance that we received in 2017 did not simply come from a few claimants situated in one area of the country. In 2017, we received complaints from claimants who had worked at 46 different facilities. Table 2 is a list of those 46 facilities. We note that in many instances the claimant did not identify the facility where he/she worked. Thus, this table is limited to those complaints, grievances, or requests for assistance where the facility was identified.

TABLE 2.—COMPLAINTS BY FACILITY

FACILITY	LOCATION	NUMBER OF COMPLAINTS
Albany Research Center	Albany, Oregon	2
Allied Chemical Corporation Plant	Metropolis, Illinois	2
Amchitka Island Nuclear Explosion Site	Amchitka Island, Alaska	5
American Beryllium Company	Sarasota, Florida	1
Ames Laboratory	Ames, Iowa	3
Area IV of the Santa Susana Field Laboratory	Santa Susana, California	14
Argonne National Laboratory—East	Argonne, Illinois	2
Bethlehem Steel	Lackawanna, New York	1
Blockson Chemical Company	Joliet, Illinois	1
Bridgeport Brass, Company, Havens Laboratory	Bridgeport, Connecticut	2
Brookhaven National Laboratory	Upton, New York	4
Brush Beryllium Company	Cleveland, Ohio	3
Clarksville Modification Center	Clarksville, Tennessee	3
Dow Chemical Corporation (Madison Site)	Madison, Illinois	10
Feed Materials Production Center	Fernald, Ohio	8
General Electric Company (Ohio)	Cincinnati/Evendale, Ohio	2
General Steel Industries	Granite City, Illinois	10
Hanford	Richland, Washington	26
Hooker Electrochemical	Niagara Falls, New York	1
Idaho Nation Engineering Laboratory	Scoville, Idaho	7
Iowa Ordnance Plant (Line 1 and Associated Activities)	Burlington, Iowa	22
Kansas City Plant	Kansas City, Missouri	7
Lawrence Livermore National Laboratory	Livermore, California	6
Los Alamos National Laboratory	Los Alamos, New Mexico	9
Mallinckrodt Chemical Co.	St. Louis, Missouri	1
Mound Plant	Miamisburg, Ohio	4
Nevada Test Site	Mercury, Nevada	22
Nuclear Materials and Equipment Corp. (NUMEC) (Apollo)	Apollo, Pennsylvania	1
Oak Ridge K-25 Y-12 X-10	Oak Ridge, Tennessee	22 (Site not specified) 8 25 11
Pacific Northwest National Laboratory	Richland, Washington	2
Pacific Proving Ground	Republic of the Marshall Islands	3
Paducah Gaseous Diffusion Plant	Paducah, Kentucky	22
Pantex Plant	Amarillo, Texas	5
Pinellas Plant	Clearwater, Florida	10
Portsmouth Gaseous Diffusion Plant	Piketon, Ohio	16
Rocky Flats Plant	Golden, Colorado	47
Sandia National Laboratory	Albuquerque, New Mexico	6
Savannah River Site	Aiken, South Carolina	13
The Dayton Project	Dayton and Oakwood, Ohio	1
United Nuclear Corporation	Hematite, Missouri	1
Various Uranium Mines		19
Wah Chang	Albany, Oregon	9
Weldon Spring Plant	Weldon Spring, Missouri	1
TOTAL		400



ASSESSMENT OF COMMON DIFFICULTIES

CHAPTER 1

ISSUES WITH THE STATUTE

Some of the complaints brought to our attention in 2017 raised issues that directly involved the statute as written. Changes to the statute must be undertaken by Congress. However, there were some instances where the concerns with the statute also raised issues involving the administration of this program.

A. Employees of Atomic Weapons Employers (AWEs) are only covered under Part B and that coverage is limited to cancers caused by radiation exposure.

In 2017, former employees of AWEs continued to complain about the limitations of coverage under the EEOICPA. In particular, former AWE employees complained that under Part B they were only covered for cancers caused by exposure to radiation. It troubled these AWE employees that they were not covered under Part B for the other illnesses potentially covered under Part B, namely chronic beryllium disease, beryllium sensitivity, and chronic silicosis. See 42 U.S.C. § 7384I(9).⁸

AWE employees also questioned why they were not covered at all under Part E of the program.⁹ We routinely talked to AWE employees who maintained that their exposures to toxic substances had not been limited to radiation. These employees asserted that in the course of their employment they had been exposed to a variety of toxic materials. Thus, they could not understand why they were not covered under Part E for illnesses related to their exposure to these other toxic substances. For example, we encountered former AWE employees diagnosed with chronic beryllium disease (CBD) who maintained that in the course of their employment they were exposed to beryllium. These employees could not understand why they were not covered under this program for this illness.

The AWE employees who questioned why were only covered under Part B for cancers caused by radiation exposure, and not covered at all under Part E, did not want to hear that this was how the statute was written. They wanted someone to explain why the statute was written in this manner.

B. The program does not cover every employee who was onsite at a covered facility.

The statute specifically identifies and defines the employees covered under this program. See 42 U.S.C. § 7384I(1). Workers were often disappointed when they discovered that, although they had worked at a facility and now suffered from an illness potentially related to that employment, they did not meet the statute's definition of a covered employee. Upon discovering that they were not covered under this

⁸ Employees of AWEs only qualify under Part B as a "covered employee with cancer." See 42 U.S.C. § 7384I(9).

⁹ Part E covers DOE contractors and subcontractor employees per 42 U.S.C. §§ 7385 s and s-1, as well as employees who qualify as uranium workers under Section 5 of RECA, 42 U.S.C. § 2210 note.

program, workers often argued that it was unfair to limit this program's coverage to only certain employees. They argued that this program should cover all of the workers who were onsite and thus at risk for being affected by these toxic substances. This was the precise argument raised by some former employees of the Department of Defense who had worked at Bikini Atoll in the Marshall Islands. These employees could not understand why, in spite of their employment at Bikini Atoll, they were not covered under this program.¹⁰

"I have been referred to the Ombudsman office regarding the matter of EEOICPA denying/excluding DOD workers that served equally as energy workers but are continue[d] to be excluded..."

Email dated August 2017.

In 2017, we also encountered former workers who were dismayed when they learned that operations pertaining to the Naval Nuclear Propulsion Program were specifically excluded from coverage under this program. See 42 U.S.C. § 7384I(12).

Employees who did not meet the statutory definition of a covered employee frequently complained that little, if any, effort was undertaken to direct them to other programs that might compensate them and/or provide medical benefits for their illnesses arising from exposure to toxic substances while working at these sites. For example, former federal employees who were not covered under this program complained that in spite of numerous conversations with various federal agencies concerning their illness, they had not been informed of the Federal Employees' Compensation Act.

C. Chronic Lymphocytic Leukemia is not a specified cancer.

There continued to be confusion in 2017 regarding whether chronic lymphocytic leukemia (CLL) is a specified cancer. The answer is no, CLL is not a specified cancer. The confusion arose in 2012 when NIOSH made changes affecting its approach to radiation dose reconstructions on claims for CLL. Prior to March 7, 2012, NIOSH regulations excluded claims for CLL from radiation dose reconstructions, and all such claims were denied under Part B. However, on March 7, 2012, NIOSH announced a new rule instructing that CLL be treated as potentially caused by radiation. As a result of NIOSH's new rule, claims for CLL are now forwarded to NIOSH for a radiation dose reconstruction. The confusion arose because some claimants mistakenly assumed that NIOSH's new rule also meant that CLL would be added to the statutory list of specified cancers.

The EEOICPA statute contains a list of specified cancers. See 42 U.S.C. § 7384I(17). A claim for cancer can be accepted without having to undergo a radiation dose reconstruction if the worker (or former worker): (1) qualifies as a member of the Special Exposure Cohort (SEC) and (2) has a specified cancer. See 42 U.S.C. § 7384I(17). While the statute identifies leukemia as a "specified cancer," the statute excludes CLL from the

¹⁰ While these employees had worked at Bikini Atoll, at least some of them worked on the island during periods when remediation work was performed. It appears that at least some of these claims were denied because the remediation was done on the Department of Defense "side" on the island or through the Department of Interior.

list of specified cancers. See 42 U.S.C. §§ 7384l(17)(A) and (D).¹¹ Consequently, NIOSH's announcement recognizing CLL as a radiogenic cancer, and instructing that claims for CLL undergo a radiation dose reconstruction did not change the fact that the statute still specifically excludes CLL from the list of specified cancers.

Claimants were disappointed to discover that NIOSH's decision to treat CLL as potentially caused by radiation did not result in CLL being added to the list of specified cancers. In contacting us, claimants often questioned what needed to be done to bring this matter to Congress' attention.

D. The cap on monetary compensation.

Most claims accepted under Part B result in a lump-sum payment of \$150,000.¹² See 42 U.S.C. § 7384s(a). On the other hand, the maximum aggregate compensation permitted under Part E is \$250,000. See 42 U.S.C. § 7385s-12. During the year we encountered claimants who complained that as a result of one, or both, of the statutory caps on monetary compensation they were not fully compensated for their illnesses.¹³ For example, claimants who became ill at an early age, and thus reached the Part E statutory maximum well before their normal retirement age, sometimes complained that because of this statutory cap they were not fully compensated for all of the wage-loss they sustained as a result of their accepted illness.

In our experience, complaints about the statutory caps on monetary compensation usually arose when:

1. The accepted condition continued to deteriorate even after the claimant was paid the statutory cap; or,
2. Claimants who received the statutory cap subsequently developed additional illnesses.¹⁴

E. Attorney fees.

The fee schedule for attorney's fees found in the statute continued to cause difficulties for both claimants and authorized representatives (AR). See 42 U.S.C. §§ 7385g and 7385s-9.

1) Difficulties applying Section 7385g to Part E claims.

Under Part B, with respect to services rendered in connection with a claim, an individual cannot receive a payment that is more than:

¹¹ Section 7384l(17)(A) refers to a specified disease, as that term is defined in Section 4(b)(2) of RECA, 42 U.S.C. 2210 note. Section 4(b)(2) of RECA, in turn, excludes CLL as a specified disease. CLL is also excluded from the list of specified cancers by Section 7384l(17)(D) of the Act. See 42 U.S.C. § 7384l(17)(D).

¹² The exceptions are for claimants under Part B with an accepted claim for beryllium sensitivity who are limited to medical monitoring and no monetary compensation and, Part B claimants with an approved claim under Section 5 of RECA who are entitled to an additional \$50,000 lump-sum payment under Part B of the EEOICPA.

¹³ These caps apply only to monetary compensation, and do not include medical benefits.

¹⁴ A worker or former worker who received the statutory maximum compensation under the EEOICPA can still file claims for additional illnesses. If these additional claims are accepted, the worker or former worker will not receive additional monetary compensation. However, he/she will be entitled to medical benefits for the additional accepted illnesses.

- (1) 2 percent for the filing of an initial claim for payment of lump-sum compensation; and,
- (2) 10 percent with respect to objections to a recommended decision denying payment of lump-sum compensation.

See 42 U.S.C. § 7385g. In incorporating the Part B fee schedule into Part E, it is stated that Section 7385g shall apply to payments under Part E to the same extent that it applies to payments under Part B. See 42 U.S.C. § 7385s-9. Claimants and ARs routinely complained that it was not always easy to apply the Part B fee schedule to Part E claims. In particular, it was noted that when their claim is accepted under Part B, most claimants are entitled to a set lump-sum payment of either \$150,000 or \$50,000, as well as medical benefits. On the other hand, after a Part E claim filed by the worker/former worker is accepted, the claimant is initially entitled to only medical benefits for the accepted illness. The Part E worker/former worker can separately file for impairment compensation and/or wage-loss compensation, which must then be separately adjudicated by DEEOIC. Citing to this difference in awarding benefits, claimants and ARs complained that they did not always understand how the Part B attorney fee provision applied to their Part E claims.

2) Difficulties applying fee schedule for certain services.

Claimants and ARs also complained that the fee schedule did not address the fee to be paid for a variety of services often needed by claimants in pursuing an EEOICPA claim. For instance, it was noted that the fee schedule did not address the fee to be paid for assisting claimants in resolving home health care, durable medical equipment, or medical billing issues. Some claimants believed that the failure to address the fee to be paid for performing these services explained why some ARs refused to provide representation for these services. There was a belief that where the guidance was not clear regarding the amount that could be charged, many ARs declined to assist claimants in pursuing these benefits, and instead limited their representation to those services outlined in the fee schedule, i.e., obtaining payment of lump-sum compensation.

3) No consideration given to the complexity of the case.

We also talked to claimants who believed that as the fee schedule is currently written, some ARs found it advantageous to avoid the more complex cases. In advancing this argument, it was noted that the fee paid to the AR is a percentage of the compensation received by the claimant, and that the fee schedule did not give any consideration to the amount of time expended on the case, or the complexity of the case. As a result, claimants complained that there was little, if any, incentive for ARs to take on complex and/or time-consuming cases.

DEEOIC cannot change the fee schedule. Yet, there is a desperate need for more ARs, and for ARs who are willing to assist claimants with every aspect of the claims process, not just certain types of claims or issues.

CHAPTER 2

LACK OF AWARENESS OF THE EEOICPA PROGRAM

In 2017, we continued to encounter claimants and potential claimants who complained they only recently learned of the program, and/or that the delay in being notified of the program negatively impacted their ability to process their claim. We also encountered claimants who struggled with their claim because they did not fully understand the program. This chapter discusses the most common difficulties that arose from a lack of awareness of the EEOICPA.

A. Difficulties arising from delays in being made aware of the program.

“Loss for words”

The description used by a claimant to explain his/her reaction when he/she first learned of this program in 2017.

In its response to our 2015 Annual Report, DOL agreed that widespread direct notification to all of the individuals potentially impacted by the nuclear weapons program had been a challenge. DOL’s response then discussed some of the initiatives undertaken to increase awareness of this program. Yet, in spite of the efforts undertaken by the DEEOIC and the Joint Outreach Task Group (JOTG) to increase awareness, difficulties arising from delayed notification to claimants persisted.¹⁵

An encounter in November exemplified the problem that we continued to see. The surviving child of a former worker began his/her complaint by noting that the EEOICPA was created more than 35 years after his/her father retired from work at a covered facility. This adult child then told us that he/she was at a “loss for words” to describe how it felt to know that it took another 17 years after the creation of this program for his/her father to become aware of it. As with other claimants who raised similar concerns, this claimant firmly believed that his/her father had been negatively impacted by the delay in being notified of the EEOICPA. In this instance, the father passed away after filing his claim but before the processing of his claim was completed.¹⁶

B. DEEOIC’s outreach efforts tends to focus on areas near covered facilities.

In the past, DEEOIC focused much of its outreach activities on areas near covered facilities.¹⁷ We heard from claimants who felt that DEEOIC not only limited its outreach to areas near covered facilities, but also limited its outreach to areas near facilities that employed (or once employed) large numbers of employees. Claimants complained that this approach ignored the fact that over the years potential claimants had sometimes moved to other areas of the country.

¹⁵ The JOTG is comprised of representatives from DOL, DOE, the Office of the Ombudsman for EEOICPA, HHS, the Office of the Ombudsman for HHS’s NIOSH, plus representatives from DOE’s Former Worker Medical Screening Program. This task group allows these agencies the opportunity to exchange ideas, share resources, and develop outreach strategies for targeting current and potential claimants.

¹⁶ In this instance, none of the surviving children qualified as eligible survivors under Part E.

¹⁷ In response to our 2011 Annual Report, DEEOIC noted that due to limited resources with which to conduct outreach activities, it concentrated efforts to transmit program information in areas near covered facilities, and stated that this was done in order to reach the largest number of affected workers.

The need for outreach extends beyond the areas near covered facilities. Nevertheless, it can be beneficial to return to an area to hold additional outreach events. At most of the outreach events we attended in 2017 there were usually some attendees (sometimes one or two, sometimes more) who were just learning about the program. And we found this to be true even when the event was held in areas that had hosted previous outreach events. Our conversations with some of these individuals revealed that there can be a variety of reasons why some people were just learning about this program. Yet, regardless of why they were just learning about this program, returning to an area to hold additional meetings not only provided another opportunity to reach these individuals, but also increased the chances that when they had questions, there was an event where they could meet face-to-face with agency representatives.¹⁸

In discussing its efforts to increase awareness, DEEOIC noted its use of its network of the 11 Resource Centers to provide an initial point-of-contact for workers interested in filing claims. In spite of these efforts, some claimants questioned if the Resource Centers were doing enough to increase awareness in all areas of the country. We encountered claimants who indicated that they had attended outreach events where the Resource Center had simply emphasized its role in accepting new claims, and did not provide a basic overview of the program and/or explain what the claimant could expect to happen as they progressed through the claims process. Although these events were often held in areas that had hosted previous outreach events, claimants felt that more information should have been shared in order to assist those who were not familiar with the program, as well as those with specific questions/issues.¹⁹

In addition, we routinely encountered claimants who were under the impression that Resource Centers simply helped with the initial filing of the claim. This explains why some claimants never approached the Resource Center to ask questions or for help with other problems.

C. The efforts to increase awareness beyond the vicinity of covered facilities.

“...We moved from [near the covered facility] at that time and we just learned last spring of the possibility of occupational illness from radiation for certain former employees...”

Email dated August 2017.

In our opinion, one of the biggest challenges to increasing awareness of this program continued to be outreach to those who had moved away from the area where they once worked. Potential claimants sometimes moved away long before this program was created, and since moving away have not kept in contact with former colleagues. In some instances, potential claimants moved to areas of the country where it was rare to encounter other former nuclear workers, thus lessening the chances that they would encounter a colleague or a physician who would know about (or tell them about) this program. Moving to an area without a lot of other former nuclear workers also lessened the chances that DEEOIC, JOTG, or

¹⁸ It has been our observation that some claimants would prefer to speak to someone face-to-face.

¹⁹ While the Resource Center usually brought materials that discussed the program, some claimants felt that without an overview of the program, those who were not familiar with the program might not make the effort to pick up these materials.

one of the other agencies involved with this program would hold an outreach event nearby. In addition, just because a claimant who moved away later talked to a former colleague did not guarantee that they would talk about this program. We routinely encountered claimants who noted that it was entirely by coincidence that they learned of this program. Take, for example, an individual we encountered at an event in South Carolina. This individual did not have an illness, but approached us because he/she had just learned about this program and wanted more information. When we realized that this individual had lived and worked in the Midwest, we asked how this individual came to attend an event in South Carolina. The answer was that he/she was visiting a friend in the area and saw a newspaper article announcing this event. Encounters such as this have convinced us that there are potential claimants, especially potential claimants who subsequently moved to other areas of the country, who still are not aware of this program, and would benefit from being contacted directly by DOL.

In prior Annual Reports, we noted that the mailing list compiled and used by DOL to notify individuals of upcoming outreach events only contained contact information for individuals who had already filed claims. Thus, mailings that rely on this list are limited in their ability to reach individuals who do not already know about this program. On the other hand, the DOE and its Former Worker Medical Screening Program (FWP)²⁰ has compiled rosters containing contact information for former DOE employees, contractors, and subcontractors who worked at some of these covered facilities. The DOE and FWP rosters are not limited to those who have filed EEOICP claims, and have been used by the JOTG to notify claimants and potential claimants of upcoming JOTG events.²¹ However, at best, the JOTG holds 3 or 4 outreach events per year and these events are usually held near former or existing covered facilities. When our Office has sought their assistance, the DOE FWPs have been very receptive when asked to utilize their rosters to notify individuals about upcoming events that our Office has sponsored. DOE has assisted DEEOIC by using its roster to notify potential claimants of upcoming DEEOIC events. However it is not entirely clear the extent to which this assistance has been provided.²²

D. Notice to employees of Atomic Weapons Employers and Beryllium Vendors.

Over the years, we were approached by former AWE employees who alleged that DOL had let the employer take the lead in notifying employees of the EEOICPA.²³ Some of these AWE employees complained that their employer had undertaken little, if any effort to notify them of this program. We continued to receive similar complaints in 2017.

²⁰ The FWP was mandated by Congress in the Fiscal Year 1993 National Defense Authorization Act, which charged the DOE with conducting an on-going medical screening program, offered at no cost, for its former workers who may be at risk for occupational disease as a result of their work at DOE sites. Program activities were initiated in 1996 at seven defense nuclear facilities, and medical screenings began to be offered in 1997. The program now serves all former workers from all DOE sites in locations close to their residences. In FY 2017, the FWP conducted 2,814 initial medical screenings and 5,787 re-screen medical exams. When a condition is possibly work-related, the FWP physicians include causation language. This language can be helpful to participants who decide to file a claim under the EEOICPA. See 2017 Former Worker Medical Screening Program Annual Report, pgs. v, vii. [<https://www.energy.gov/sites/prod/files/2018/04/f51/2017-FWP-Report.pdf>].

²¹ The 2017 FWP Annual Report stated that invitations are sent by the FWP projects to individuals using the last known address, and when addresses are found to be outdated or inaccurate, the FWP projects use address-update services to obtain current contact information. The organizations administering the FWP also check list of workers' names against the National Death Index to ensure the letters of invitation are not sent to individuals who are deceased. See 2017 Former Worker Medical Screening Program Annual Report, pg. 5.

²² According to the 2017 Former Worker Medical Screening Program Annual Report, in 2017 the FWP participated in 525 outreach events and assisted the DOL with 9 of its outreach events. See 2017 Former Worker Medical Screening Program Annual Report, pg. 5.

²³ The DOE FWPs do not perform health screenings for former AWE employees, and thus, these workers are not included in mailings that use the DOE rosters.

In one instance this year, an AWE that had been at the center of a controversy over whether employees would have to pay to obtain documentation verifying their employment at the company was again brought to our attention when employees contacted us after receiving a letter from their employer. We were told that the letter was a very comprehensive letter explaining the EEOICPA program. While these employees were pleased to receive this letter, a number of them noted that this was the first notice they had received from their employer informing them of this program.

E. Difficulty ensuring that claimants know they are covered under this program.

In attempting to increase awareness of this program, it can also be a challenge to ensure that the target audience for a given outreach event understands that they may be covered under this program and that the event is intended for them. It has been our observation that because some claimants and potential claimants did not recognize the terms or acronyms that were used in the invitation, promotional material, or press release, they did not realize that they or a family member may be covered under the EEOICPA. For example, while the statute refers to DOE contractor and subcontractor employees, we found that some former workers never thought of themselves as DOE contractor or subcontractor employees. Rather, they viewed themselves as an employee of a particular contractor or subcontractor who happened to have performed work at a covered site. We often saw this with subcontractor employees who, in many instances, did not immediately associate themselves as being a DOE subcontractor employee. We encountered similar issues with surviving family members who sometimes knew so little about the worker's employment that it was difficult for them to recognize that they might be eligible under the EEOICPA. For this reason, in sending out notices of upcoming events, we have found it helpful, when possible, to include in our letter the names of the covered facilities in the area.²⁴

²⁴In our experience, while an individual may not recognize that they or a family member once worked as a DOE contractor or DOE subcontractor, they will often recognize the name of the facility where the work occurred.

CHAPTER 3**CLAIMANTS DO NOT UNDERSTAND THE EEOICPA**

"...What is part B and part E[?] I don't understand. I have COPD."

E-mail from potential claimant, May 2017.

A. Claimants do not have a basic understanding of this program.

The vast majority of the claimants who contacted our office came with a story to tell. Oftentimes, in listening to these stories it soon became clear that many of these claimants did not have a good understanding of this program. In fact, in its response to our 2015 Annual Report, DOL agreed that "[s]ome claimants go through the entire adjudication process without ever acquiring a good understanding of how this program works..." DOL also agreed that there were claimants who did not have access to information via the internet, and many others who may not have understood the information that was provided. Thus, in its response, DOL outlined some of the steps it had undertaken to increase the understanding of how this program works.

Consistent with this response, the Resource Centers and DEEOIC routinely distributes written materials at outreach events. In addition, the staffs of the Resource Centers and DEEOIC are available to provide claimants with information and guidance. In 2017, DEEOIC also sponsored the first, in a series, of authorized representative workshops. This workshop, held in Jacksonville, Florida, was a two-day event designed to provide training on a variety of subjects related to EEOICPA. Yet, in spite of DEEOIC's efforts, we continued to encounter claimants who struggled with their claim because they did not understand the EEOICPA and/or the claims process.

Our encounter with a Beryllium Support Group highlights the magnitude of this problem. In planning to attend this event, since we were going to an area that had hosted previous outreach events, we assumed that most of the attendees at this support group meeting would have a basic understanding of the EEOICPA and the claims process. However, once there, we quickly realized that our assumption was wrong. Attendees at this meeting had basic questions about EEOICPA, including claimants with accepted claims, who asked us to explain the difference between Part B and Part E.

As in past years, most of the claimants who contacted our office this year did not have an AR, or if they had an AR, the AR was a family member or friend. In either event, many of the individuals who contacted our office had little, if any previous experience with this program. These claimants and ARs usually began the claims process without first receiving an overview of the program, and oftentimes processed the entire claim without the benefit of such an overview. In fact, it often appeared to us that some claimants and ARs processed their EEOICPA claim simply relying on what others had told them about this program or based on their experiences with other compensation programs. We also frequently found that since they were never told about the various tools and resources that were available, many claimants and ARs struggled through the adjudication process without knowing there were online tools and resources that could have provided some measure of assistance.

This program is complex and there is a lot of information. A continuing frustration for many of the claimants that we encountered is that throughout the claims process no one took the time to explain the claims process. In this regard, claimants often complained that even when they were told what to do, no one ever explained why they were taking the suggested action, or what they could expect after taking this action.

B. Difficulties arising from misconceptions about this program.

There are some misconceptions about this program that persist to this day. In some instances, a claimant's decision whether to file a claim, or how to proceed in processing his/her claim can be impacted by these misconceptions. One of the most common misconceptions is that this program only compensates for cancer. Even in 2017, we encountered claimants who called this program "the cancer program" as well as others who made it clear that they thought that this program only compensated for cancer.

"...I am retired and I worked for xxx for over 30 years. Are you required to have cancer... or is this meeting for anyone who worked at xxx. I know friends who got settlements for cancer but did not know it was for other medical problems."

E-mail from potential claimant, May 2017.

Another misconception of claimants was that if their claim for cancer was denied, there was no point in filing for additional cancers that were diagnosed after the first claim was denied. We especially encountered this misconception among claimants whose original claim for skin cancer had been denied. In complaining to us about the denial of their claim for skin cancer, these claimants would often refer to subsequent skin cancers that had been diagnosed. When asked if they had filed claims for these additional skin cancers, the answer was often no. Encounters such as these were so common that when we attended outreach events we started to raise this issue on our own.²⁵

Appendix 2 outlines some of the common misconceptions that we encountered in 2017. Claimants could benefit from efforts to correct these common misconceptions.

C. Information only provided if claimants asked for it.

"We've been denied three times...Although the DOL references sections of the findings from the CMC report, we never received a copy, nor did we receive a copy of the IH report. Is this something you recommend I ask for?"

E-mail from a claimant who had been denied three times, yet was never told that he/she had the right to request a copy of the Contract Medical Consultant and Industrial Hygienist reports, January 2017.

²⁵ For instance, when speaking at outreach events, we often incorporate into our presentations statements that clarify some of the more common misconceptions.

When claimants asked their claims examiner (CE) or other DEEOIC staff for specific information, this information was usually provided. However, we talked to claimants who felt that if they did not specifically ask for (or about) information, it was not offered or provided to them. This concern was frequently raised by claimants who complained that, in spite of numerous conversations with DEEOIC while wrestling with a problem, useful information that could have assisted them was only brought to their attention well after the information could have been helpful.²⁶ Claimants who felt that useful information was not provided to them in a timely manner often argued that since they did not have a good understanding of the claims process, it was unreasonable to expect them to ask for (or about) specific information. In other instances, we heard from claimants who felt that in light of the questions they had asked, it should have been obvious to DEEOIC that they did not have a good grasp of the claims process. Thus, we talked to claimants who argued that DEEOIC should have been more pro-active in thoroughly answering questions and providing assistance. These claimants often expressed frustration at having to navigate such a complex program, and being expected to know what information or assistance to ask for.

D. Little effort undertaken to ensure that claimants understood the information provided to them.

Some claimants complained of instances where the information provided to them was vague. Others complained of instances where little, if any, effort was made to ensure that they understood the information provided to them by DEEOIC.

The Resource Centers and/or CEs are there to provide claimants with useful and timely information. In fact, we are aware of instances where the staff of the Resource Centers, District Offices and/or the National Office ensured that claimants were provided with useful information. However, we encountered other instances where after interacting with the Resource Center and/or the District Office the claimant still had questions. This explains why, after talking to their CE, some claimants would contact us with questions about what they had just been told.²⁷

DEEOIC frequently suggested that if, following a conversation with his/her CE, the claimant had additional questions we should refer the claimant back to the CE. In most instances this would be our preferable response. However, in many instances we were approached by claimants who were already highly frustrated because of their previous encounters with DEEOIC. In other instances, the claimant made it abundantly clear that he/she did not think that another conversation with DEEOIC would be helpful. In some situations claimants made it clear that they contacted us because they hoped that we would be able to better articulate their concerns (or hoped that we could articulate their concerns in a way that did not aggravate the situation). Moreover, there were some instances where we could sense that telling the claimant to again contact the CE would not be well received.

²⁶ Some claimants complained that only because of individuals outside of DEEOIC did they learn of useful information that the DEEOIC staff did not provide to them.

²⁷ Claimants often approached us hoping to obtain an immediate answer to their question, and hoping to obtain this answer without confronting a lot of bureaucracy. There were many instances where obtaining their answer proved to be more difficult than the claimant imagined. When this Office needs information from DEEOIC about a claim, we are required to ask the claimant to provide us with a signed Privacy Act waiver. Providing this waiver can be difficult for claimants who do not have access to the internet or a facsimile machine. In addition, some claimants made it clear that they viewed the need to submit a waiver as just another unnecessary hurdle to getting their questions answered. Moreover, when requesting information we also have to identify the information that we are seeking. This can often be a challenge since some claimants do not understand the claims process well enough to assist us in identifying the needed information.

This is not to suggest that DEEOIC did not try to answer the claimant's question. In fact, we recognize that there are a host of reasons why some claimants struggled with their claims. Yet, it appears that in some instances sufficient time was not taken to work with the claimant to ensure that he/she fully understood what was being said and/or what needed to be done. Some claimants and ARs could benefit from having access to a person with immediate access to their claim file who would assist them with understanding where they were in the claims adjudication process and could provide them with guidance in developing the evidence needed to prove their claim.

Some may ask why a claimant would need someone to guide them through the claims process if he/she had the option to utilize an AR. As noted earlier: (1) many ARs are family members or friends who themselves have little knowledge of this program; and (2) some claimants cannot find or do not want to use an AR.

CHAPTER 4

DIFFICULTIES OBTAINING ASSISTANCE

As previously noted, most of the claimants who approached us wanted assistance with their claim. Some claimants turned to us because they did not know where else to go for assistance. Others turned to us when their other efforts to resolve the concern/problem proved ineffective.

A. Claimants do not know where to turn for assistance.

Throughout the year, we talked to claimants who complained that they did not know where to turn for help. One problem is that while a host of resources have been developed to assist claimants, many of these resources are only available online. Claimants with limited, or no access to internet, oftentimes are not aware that these resources exist and/or do not have the ability to access these resources.²⁸

Nevertheless, having access to the internet does not guarantee that claimants will be aware of the various online tools and resources. In our experience, even when they had access to the internet, many claimants rarely, if ever, visited DEEOIC's website. Moreover, it has been our experience that most claimants do not receive a comprehensive overview of the program when they file their claim. This lack of an overview not only means that many claimants proceed with their claim without a good understanding of the claims process, it also means that many claimants are never aware of the resources and tools that have been developed to assist them.

We also found that many claimants did not realize that they could turn to the Resource Center or the CE for help. We routinely encountered claimants who believed that the mission of the Resource Centers was limited to assisting with the filing of new claims for benefits.²⁹ As a result, these claimants never thought to turn to the Resource Centers for further assistance. Similarly, we talked to claimants who admitted that it never dawned on them to approach their CE for assistance.

In a more general sense, after the Resource Center assists with the filing of a new claim, the claim is sent to the District Office where a CE is assigned to the case. The CE is then responsible for both answering the claimant's questions, as well as making a determination on the claim for benefits. Numerous conversations this year revealed that some claimants did not appreciate that a different level of service was provided by the CE. For instance, some claimants did not appreciate that while they could physically go to the Resource Center and talk to someone or could communicate with the Resource Center via the internet, their interactions with the CE were generally limited to telephone conversations and written correspondence. Consequently, some claimants did not approach their CE for assistance because they wanted to talk to someone face-to-face or via email.

²⁸ In some instances, locating the information online is the best, or the only, effective way to present the information. The Site Exposure Matrices (SEM) database and the list of enrolled health care providers are two examples of tools that can only be effectively presented online.

²⁹ According to Procedure Manual (PM) Chapter 4.3(b) (December 2017), the Resource Centers are to provide seven (7) types of assistance to claimants, as follows: (1) Provide information on claims process and program procedures to the DEEOIC claimant community; (2) Assist claimants in the completion of the necessary claim forms; (3) Take initial employment verification steps for all new EEOICPA claims filed with the RC; (4) Conduct occupational history development for certain employees; (5) Provide case-specific information and clarification to claimants and ARs; (6) Educate and assist the claimants regarding impairment and wage-loss benefits on cases with positive causation determinations; and (7) Provide medical bill payment assistance to claimants.

Moreover, when it came to approaching the CE for assistance, some claimants had other reservations. In particular:

- Some claimants worried about “bothering” the CE.
- As their claim progressed from developing evidence towards the issuance of a decision, some claimants were hesitant to seek advice from the CE or hearing representative (HR) since they were the person who would make the decision on their claim. Claimants were often concerned that the CE or HR might intentionally or unintentionally provide assistance that steered them towards the result that the CE or HR wanted. This sentiment was frequently expressed by claimants who felt that the CE or HR had already explicitly or implicitly indicated how they would rule on the claim. In these situations, some claimants questioned the quality of the advice that they could expect from someone who had already indicated how they would rule on the claim, while others felt that seeking advice from the CE or HR was a waste of time because a decision had already been reached.

B. Vagueness and lack of familiarity with program terminology.

In some instances, claimants encountered difficulties finding information because they were not familiar with the terminology and acronyms used by the program. The SEM database is a good example. If a claimant visited DEEOIC’s website, they would see a link to “Site Exposure Matrices – SEM.” We routinely heard from claimants who admitted that they had never clicked on this link because no one ever told them the meaning of the terms, “Site Exposure Matrices” or “SEM.”³⁰ As a result, when searching for toxic substances known to have been used at a covered facility, some claimants never realized that they could access this information by clicking on the link to the “Site Exposure Matrices-SEM.” And we found this to be true even when the SEM had been mentioned in conversations and in documents. In fact, some claimants noted that terms such as SEM were used so commonly that they were embarrassed to admit to anyone that they did not understand what these terms meant.

Claimants also complained that locating information on DEEOIC’s webpage could sometimes be difficult because of the vague descriptions found on the website. This complaint was highlighted by a claimant who contacted us looking for information about wage-loss and/or impairment. When advised that there was a link on DEEOIC’s webpage entitled “Brochures,” including brochures addressing wage-loss and impairment, this claimant complained that the title “Brochures” did not provide sufficient information to make him/her aware of the specific information found on this link.³¹ To address the vague descriptions found on DEEOIC’s website, some claimants questioned if it was feasible to add a rollover function to the webpage so that when they rolled over certain links with their cursor, they could see a more in-depth description of the information that could be found in the link.

³⁰ Some claimants told us that while the term “Site Exposure Matrices” or “SEM” was frequently mentioned, they had no idea what it meant.

³¹ “How Do I Qualify for an Impairment Award Under Part E of the EEOICPA,” and “Wage-Loss Benefits Under Part E of the EEOICPA” are two of the brochures available under this link.

C. Claimants unable to reach their CE by telephone and/or their messages are not returned.

"...I talked to [the CE], it is like pulling teeth...[the CE] never follows up..."

Email from a claimant, March 2017.

"If I call my claims examiner I often never get thru. I have been told they have 24 hours to respond. If you leave the house and they call and leave a message that they called you, you have to start the process all over. It makes it very difficult to speak to them..."

Email from a claimant, April 2017.

"...a claims examiner would call me on a private number when she was not in the office. Her calls always came at the end of the day. When I tried to return her calls, she was never in the office and she never returned my calls. Also when she called all she would say in her message was that she was calling about the claim of XXX..."

Email from an AR, July 2017.

A common complaint noted that claimants found it difficult to talk to someone when they needed help. For years we received complaints indicating that when claimants telephoned DEEOIC for assistance, their telephone calls were not answered, and if they left a message, the message was not returned.³² These complaints usually involved attempts by claimants to call their CE and/or the District Office.³³ DEEOIC initially responded to these concerns stating that it had 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 DEEOIC's response, claimants continued to complain that their telephone calls were not answered and/or their messages were not returned. See 2014 Annual Report to Congress, January 8, 2016.

Because these problems persisted, we redoubled our efforts to assess this issue. In a subsequent conversation with DEEOIC on this matter in 2017, DEEOIC noted that its data showed that most telephone calls were returned within 24 hours. In response, we provided DEEOIC with what we had learned from claimants:

- Most of the complaints that we received involved claimants who called his/her CE and had to leave a message because the CE was not available.
- If the claimant did not answer the telephone when the CE returned the call, then because of privacy concerns the CE simply left a message indicating that he/she had called.
- The short message indicating that the CE had called oftentimes dismayed claimants. This was especially true when the claimant had left a detailed message for the CE.³⁴

³² Due to DEEOIC policy, claimants cannot communicate with the CE or with DEEOIC staff by e-mail. Rather their questions or concerns must be communicated via the telephone or letter.

³³ We also receive complaints about interactions with DEEOIC's medical bill contractor, Conduent. In most instances these complaints did not allege that Conduent did not answer the telephone. Rather, the concern was with the quality of assistance provided.

³⁴ Claimants who lived alone or simply lived with their spouse frequently noted that had they been asked, they would have given DEEOIC permission to leave a detailed message.

- Since the CE's message had not answered his/her question or concern, the onus was on the claimant to again call the CE. When the claimant called the CE again, the CE oftentimes was still not available. Thus, the claimant would leave another message, and as a result, some claimants soon found themselves in an ongoing game of telephone tag with the CE.
- Consequently, some claimants complained that it could take over a week to simply verify that the CE had received information they submitted, or to get an answer to a question. These situations were intensified when the claimant felt that the matter was time-sensitive.

When we brought our observations to DEEOIC's attention, they vowed to look into these matters. Since that time we talked to some claimants who indicated that when they left a message for their CE, they received a return call fairly promptly. However, some of these claimants complained that the person who returned their call was not the CE.³⁵ These claimants asserted that it was a waste of their time to talk to someone who did not know their case, and thus, could not answer their questions. In addition, there were some claimants who continued to assert that their messages were not returned.³⁶

Following our discussion with DEEOIC, it came to our attention that the reason some claimants did not answer the telephone when the CE returned their call was because they did not recognize the caller or the telephone number. This came to our attention when claimants and ARs complained that CEs had called back using a "private line." It turned out that when CEs telephoned, caller ID did not identify the call as coming from DOL and did not display a telephone number that the claimant recognized as being associated with DOL. And this occurred even when the CE called back using a government telephone.³⁷ This explains why DEEOIC was sometimes able to show that it had tried to return the claimant's telephone call and yet the claimant complained that no one had returned his/her call.

D. Assistance with medical bills.

In 2017, we continued to receive complaints alleging a lack of assistance with medical bill-pay issues. We especially encountered these complaints at outreach events. By way of background, when claimants receive medical treatment from an "enrolled health care provider"³⁸ the enrolled provider submits the bills directly to DEEOIC for payment. Therefore, when a claimant utilizes an enrolled provider, they should have little-to-no reason to become involved in the bill-pay process. The situations where claimants needed help with the bill-pay process usually arose when:

- (1) They used a provider who was not enrolled in the program and subsequent difficulties arose when they tried to obtain reimbursement for these services; or,
- (2) They learned of an outstanding medical bill that was not paid by DEEOIC. In these situations claimants often intervened because they feared that failure to pay the bill could: (a) impact their credit; (b) result in a collection action; or (c) result in the termination of needed medical services.

³⁵ Many claimants find it troubling when the person with whom they are directed to talk to about their claim keeps changing.

³⁶ In some instances, it was difficult to determine if the claimant experienced his/her problems receiving a return call before or after DEEOIC vowed to look into this matter.

³⁷ It appears that when telephone calls are made from some of the telephone systems used by DOL agencies, the caller's direct telephone number does not appear on caller ID. Rather, caller ID displays a general number. In addition, caller ID does not identify the call as coming from DOL.

³⁸ An enrolled health care provider is one who has submitted the necessary paperwork to receive electronic payment for medical services directly from DEEOIC. A health care provider who does not enroll with DEEOIC will not receive electronic payments, and the claimant must directly pay this provider for any medical treatment and seek reimbursement from DEEOIC.

Thus, for many claimants becoming involved in the bill-pay process was a new experience. In addition, we found that when they encountered difficulties with bill-pay issues, claimants usually needed immediate help.

“I have had many... cancers treated over the years, but have used the DOL program very little...I asked the xxx office to submit the latest claim to DOL but have not heard whether it was settled or not.

During that visit, I was subscribed xxx to treat some cancers...This xxx was only partially covered by some form of insurance and my out of pocket cost was ...If I can be reimbursed for this cost, I would appreciate it.”

E-mail from a claimant, February 2017.

DEEOIC has resources to assist claimants with bill-pay issues and we are aware of instances where these resources assisted claimants in resolving medical bill-pay issues.³⁹ However, some claimants complained that when bill-pay issues arose, (1) they did not know where to turn for assistance, and (2) when they asked for assistance, they did not obtain adequate assistance. A common complaint involved situations where claimants asserted that they repeatedly approached DEEOIC with the same bill-pay issue and, in response, DEEOIC repeatedly provided them with the same guidance that did not resolve the problem. These claimants often felt that their problems could have been resolved (or resolved sooner) if instead of repeatedly telling them what to do, DEEOIC had taken the time to directly work with them and the provider to resolve the problem.

“The current issue is there is no process or ownership for an appeal of a fee [for services] being denied...I was told by multiple ACS [now Conduent] employees the codes determine if your claim is approved or denied, they didn't know anything about an appeals process. I was told by an ACS Supervisor there is no appeals process for when a fee is denied. There is only an appeals process if there is a fee reduction. I was told the Claims Examiner had to update my treatment package to add the missing procedure, diagnosis or NDC codes. My CE told me that they can't add codes to the treatment plan. I would have to get the charges processed through my medical insurance or have the billing facility change the codes and re-bill...No one has been able to tell me who reads the information submitted for a Fee Denied Reconsideration, what the process is or how a claimant is notified of the result.”

E-mail from a claimant, June 2017.

We also talked to a few claimants who, while happy that their medical bill-pay issue had been resolved, complained that assistance was only provided after he/she persisted in pursuing, or escalating the matter beyond the CE, oftentimes to the National Office.

³⁹ As noted earlier, providing medical bill payment assistance is one of the types of assistance that the Resource Centers are to provide. See Chapter 4.3(b) (December 2017).

CHAPTER 5

DIFFICULTIES OBTAINING REPRESENTATION AND LOCATING PHYSICIANS

In Chapter 4, we discussed the difficulties encountered by claimants when attempting to obtain assistance, in general, with their claims. Claimants also complained that it was difficult to find an authorized representative (AR) to help process their claim; while others complained that it was difficult to find physicians who would write the medical reports necessary to support their claim.

A. Some claimants cannot find an AR who will represent them.

There were some claimants who did not want to use an AR to process their claims.⁴⁰ However, this was not true for every claimant. Many claimants wanted to utilize the services of an AR because they were overwhelmed by the legal, medical and/or scientific concepts that arose in their claim. In other instances, claimants sought the assistance of an AR because of physical and/or cognitive limitations that made it difficult to pursue a claim on their own. Yet, while they may have wanted to utilize an AR, some claimants found it difficult, if not impossible, to locate an AR, or to locate an AR who was willing to represent them.

Some claimants blamed their inability to find an AR on the inadequate fees provided by the attorney fee schedule. The difficulties with the current attorney fee schedule are discussed in Chapter 4. In a nutshell, claimants complained that:

- Where the fee schedule did not explicitly address the fee an AR could charge for representing a claimant with a particular matter, some ARs refused to represent claimants on issues related to those matters. Some of the most common matters for which claimants could not obtain AR representation were medical bill-pay issues, home health care issues and/or durable medical equipment or home modification issues.
- Some ARs avoided the more complex and/or time consuming cases because the fee schedule did not take these factors into consideration. We frequently heard from claimants struggling to retain an AR to assist with a complex Part E claim for benefits.
- As some cases became more complex and/or more time consuming, some ARs terminated their representation of claimants, recognizing that they would not be fully compensated for their time and effort.

B. Difficult to locate physicians to provide treatment and write narrative medical reports for claimants.

We also received complaints alleging that it was difficult to locate physicians willing to treat EEOICPA patients and/or willing to accept the EEOICPA medical benefits card. To be clear, in many parts of the country there is a

⁴⁰ The two most common reasons for why some claimants did not utilize the services of an AR were: (1) claimants realized that they would be responsible for any attorney's fees that had to be paid and they had more pressing needs for any compensation they received; and, (2) some claimants did not want to engage in actions that might be viewed as "fighting the government" and they feared that using an AR would be viewed as "fighting the government."

general shortage of medical personnel. Yet the claimants who approached us often felt that their search for a physician was made more difficult because of factors specifically related to this program.

For instance, we talked to claimants who were attempting to obtain a medical report addressing the link between their claimed illness and exposure to a toxic substance(s) at a covered facility who firmly believed that local physicians were reluctant to write such a report due to the perception they were being asked to “take on DOE contractors.” Claimants often attributed this reluctance to the fact that the DOE contractors were sometimes one of, if not the biggest employer in the area. As one might expect, this assertion was usually raised by claimants who still lived close to the covered facility. These claimants often told of situations where as soon as they asked about the relationship between their illness and their employment, the physician immediately indicated that he/she could not help them.

Other claimants complained of encountering physicians who were unwilling to become involved with workers’ compensation claims in general and/or with EEOICPA claims in particular. We routinely heard of instances where in explaining his/her reluctance (or refusal) to treat EEOICPA claimants, the physician had offered one, or both, of the following reasons:

- Prior problems receiving payment for medical treatment of DEEOIC claimants;
- Not wanting to be second guessed by DEEOIC claims staff and/or nurses. According to the complaints we received, some physician questioned the expertise of the person from DEEOIC who was second guessing their opinion and reports, and/or questioned the medical rationale of those who were doing the second guessing.⁴¹

We also encountered claimants who attributed the decision of some physicians to stop treating EEOICPA patients to some of the policies that had been adopted by DEEOIC. In particular:

- Some claimants noted they received development letters from DEEOIC asking them to submit additional medical causation evidence without being provided copies of the employment and toxic exposure evidence in their claim file (i.e., SEM search results, employment, and exposure records). These claimants argued that this essentially ensured that their medical evidence would be deemed insufficient, thus requiring them to return to their physician for a supplemental report, usually still without the benefit of the SEM searches or other exposure evidence from their claim file.
- It was also noted that copies of the reports prepared by DEEOIC’s specialists, such as Industrial Hygienists (IH) and Contract Medical Consultants (CMC), were only provided to claimants when they received their recommended decision. Once again, claimants complained that this essentially ensured that after they received their recommended decision and were facing a 60-day deadline to file objections to their recommended decision, they would have to return to their physician to ask him/her to review the reports prepared by the DEEOIC specialist, and write another report for them to send to DEEOIC.
- Some claimants felt that their inability to receive advanced guidance outlining the information that should be included in medical reports prepared by their physicians often resulted in these reports being found deficient, thus necessitating a supplemental report from these physicians.

⁴¹ Some years ago DEEOIC hired nurse consultants to assist in the evaluation and analysis of medical evidence. According to Chapter 30.2(j)(3) of the PM, DEEOIC medical staff serve as a technical resource to the District Offices in regards to claims-related issues and can assist in the determination of appropriate services and procedures that require authorization by DEEOIC. Instances of DEEOIC nursing staff calling and/or writing to treating physicians regarding the physicians’ treatment recommendations has been an ongoing concern for claimants and their physicians, who complain of the “second guessing” nature of the communication from some nurse consultants or the MBE/CEs they are assisting.

CHAPTER 6

DIFFICULTIES LOCATING EVIDENCE

In our prior annual reports, when discussing complaints concerning the lack of assistance provided to claimants, we focused on DEEOIC's statutory duty to provide assistance. In its response to our 2015 Annual Report, DOL noted that unless otherwise specified in the statute, the claimant bore the burden to prove by a preponderance of the evidence the existence of each criterion necessary to establish their claim for benefits. Therefore, DOL indicated that while it could assist claimants in gathering facts or finding evidence, it was incumbent upon claimants to utilize the available evidence to prove their case.⁴² To make clear, over the years and continuing in 2017, some claimants have questioned the efforts undertaken by DOL to assist them in gathering facts or finding and developing evidence.

A. Claimants were not given sufficient time to develop evidence.

After a claim for benefits is filed, DEEOIC sends claimants "development letters" asking the claimant to submit evidence in support of their claim. Moreover, when the evidence submitted by the claimant is deemed by DEEOIC to be insufficient, DEEOIC will send a letter asking the claimant to submit additional evidence. A common complaint arose when claimants were given a limited amount of time, usually 30 days, to submit evidence to support their claim. Claimants argued that it was unreasonable to expect them to obtain and submit additional evidence within 30 days from the date of the letter mailed to them from DEEOIC. We especially heard this argument when claimants were asked to submit medical evidence. Claimants routinely assured us that they felt lucky if they could get an appointment to see the physician within 30 days. Consequently, they argued that it was unreasonable to expect them not only to see the physician but to also obtain and submit the physician's report within 30 days. As a result, there were instances where because the claimant was convinced that he/she could not obtain a medical report from the physician within 30 days, the claimant did not even try.⁴³

Claimants who were given 30 days to submit additional evidence could have asked for an extension of time to submit this evidence.⁴⁴ However, the option to ask for an extension of time was one of the many aspects of this program that often was never brought to the claimant's attention, or only brought to the claimant's attention well after it would have been most useful. The claimants we encountered usually had not been told that they could request an extension of time to submit evidence.

We also received complaints from claimants who noted that while the initial development letter never mentioned they would be provided another 30 day period, they subsequently received a second development letter from DEEOIC affording them another 30 days to submit evidence in support of their claim. Some claimants maintained that they would have pursued their claims differently had they known

⁴² DOL further noted that while OWCP was required by 42 U.S.C. § 7384v to provide claims assistance under Part B, OWCP had chosen to voluntarily apply the same standards of assistance to claimants under Part E.

⁴³ For instance, we talked to claimants who noted that because the physician had already expressed reservations about getting involved with the EEOICPA and/or a workers' compensation program, they decided that it was better not to test the physician's patience by trying to obtain a medical report from him/her within 30 days.

⁴⁴ The EEOICP Procedure Manual at Chapter 16.5(d)(2) (December 2017) states that, "[r]easonable time extensions may be granted by the CE." Although the PM does not state that requests for an extension of time must be made in writing, in practice, it appears that DEEOIC requires them to be made in writing.

they would get a minimum of 60 days to collect and submit evidence to DEEOIC. In addition to indicating that they would have felt less stress, some claimants noted that believing that they only had 30 days to collect evidence had caused them to limit the evidence they tried to collect, or had led them to conclude that they did not have sufficient time to collect any evidence.

Claimants frequently argued that it was unfair that they were only given 30 to 60 days to submit evidence. In support of this argument claimants noted that while they only given 30 to 60 days to submit evidence, DEEOIC often took more than 30 to 60 days when it needed to develop evidence or needed to refer a claim to an expert for an opinion. This led claimants to ask why DEEOIC was not required to operate under the same deadlines that applied to claimants. In the opinion of many claimants, the fact that DEEOIC oftentimes needed more than 30 days to develop medical evidence underscored their argument that it was unreasonable to expect claimants to obtain and submit medical evidence within 30 days.

B. Assistance obtaining employment and exposure evidence.

When a claim is filed, DEEOIC contacts DOE to verify the claimed employment and, as appropriate, also attempts 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. In many instances, DEEOIC's efforts were sufficient to verify employment. However, complaints sometimes arose when DEEOIC was unable to verify claimed employment and then informed claimants that the burden was on them to verify each criterion necessary to establish employment at a covered facility.

While claimants fully understood that it was their burden to verify each criterion necessary for a claim, they routinely reminded us that, in most instances, the government or the employer had (or once had) sole possession of these records. Therefore, since they never possessed the necessary employment records, claimants often asserted that they needed assistance gathering the facts and finding the necessary evidence.

When the records needed to verify employment could not be located, some claimants asked DEEOIC for suggestions of other ways to prove their employment. A common suggestion offered by DEEOIC was for claimants to obtain affidavits from former colleagues. Claimants routinely responded to this suggestion by telling us that they had not kept in contact with former colleagues, and thus, they had no idea how to contact them. We were also told of instances where the colleagues who had knowledge of the claimant's employment and could be located did not have the capacity to complete an affidavit. Thus, in response to the suggestion that they obtain affidavits from colleagues, claimants often wanted to know if the government was willing to assist them in locating these former colleagues. The claimants who raised this question usually felt that since the government was well aware that such records were not publicly available, then the assistance offered to them in gathering facts and finding necessary evidence should have included efforts to assist them in finding these former colleagues. These claimants also believed that the government had access to resources that could facilitate the search for former colleagues. When told that privacy concerns prevented the government from sharing other people's contact information with them, claimants responded by suggesting that instead of providing them with the contact information, the government could directly contact the former colleagues on their behalf.⁴⁵

⁴⁵ Among other options, some claimants believed that OWCP could have reviewed previously accepted claims and could have identified former employees who performed the same work (at the same time) or who had worked nearby.

However, complaints concerning difficulties obtaining employment records were not limited to the efforts needed to locate former colleagues. During the DEEOIC training session in Jacksonville, Florida, at least one attendee took exception when it was suggested that since DEEOIC obtained employment records from DOE, it was not necessary for claimants to file Freedom of Information Act (FOIA) requests for employment information. A few of the ARs in attendance made it clear to us that they questioned the thoroughness of the process used by DEEOIC to obtain employment records. Over the years, we heard similar concerns from other ARs as well. We have been told of instances where employment documents obtained by claimants as a result of a FOIA request included additional documents that had not been included in the records provided to DEEOIC. From what we can tell, it is not common for claimants to seek records via a FOIA request, or for additional records to be produced as a result of a FOIA request. Yet, even a few instances of the production of additional documents through a FOIA request has caused some ARs (and claimants) to question the thoroughness of the search for records that occurs when DEEOIC requests employment records from DOE.

In another instance, an AR questioned the assistance provided to claimants in obtaining exposure records for former employees of Area IV of the Santa Susana Field Laboratory. In particular, this AR complained that delays in receiving exposure information from the employer had, in turn, delayed NIOSH's ability to promptly perform radiation dose reconstructions. At a meeting held to discuss this concern, the AR was assured that this matter was being addressed. Still, it troubled this AR that: (1) the inactions of the employer had delayed the processing of some claims; and, (2) it appeared that steps to resolve the issue were only undertaken when the matter was escalated.

This same AR questioned the efforts put forth by DEEOIC to assist in verifying the employment of some former Santa Susana employees. At Santa Susana, only employment at Area IV is deemed covered employment. This AR argued that it had been previously established that some workers who routinely worked in Area IV actually signed in at other areas of this facility before they began their work day. It concerned this AR that while DEEOIC had obtained some employment records, DEEOIC had not obtained all of the information needed to identify workers who signed in elsewhere, but worked at Area IV.

C. Difficulties locating evidence regarding the status of a facility.

Claimants complained about the assistance (or lack of assistance) they received when they questioned a facility's designation as a covered facility under the EEOICPA. Most of these complaints involved instances where claimant questioned the facility's designation as an Atomic Weapons Employer (AWE) facility, but not as a DOE facility. However, there was at least one instance in 2017 where the claimant argued that a facility designated as a Beryllium Vendor should have been designated as an AWE. In addition, there were a few instances where claimants took exception with the designated years of coverage for a particular facility.

Claimants complained that it was extremely difficult to locate the documents necessary to challenge a facility's designation (or lack of designation) as a covered facility. Attempting to challenge a facility's designation was often cited as another instance where a claimant's efforts to locate relevant evidence were severely hampered by the fact that he/she never had access to relevant records, and thus, had no idea where (or to whom) to turn to find this information.

We also talked to claimants who complained that the decision process surrounding a facility's designation was never fully explained to them. This issue was raised by some former Pacific Proving Ground (PPG) workers. While at least some of these employees worked at Bikini Atoll during a period of remediation, their claims were denied because they worked on the DOD side of the island or worked with the Department of Interior. In their conversations with us, these employees made it clear that they continued to have questions surrounding their work and whether they were covered employees working at a covered facility. Similar complaints were raised by former AWE employees who noted that while they had been told that their facility qualified as an AWE facility, and not as a DOE facility, the basis for this determination had never been fully explained to them.⁴⁶

It troubled some claimants that, as far as they could determine, the only way to obtain independent review of DEEOIC's determination regarding the designation of a facility was to possibly file an appeal in federal district court. Claimants complained that when the issue of a facility's designation was before the district office or the Final Adjudication Branch (FAB), the district office and/or FAB simply deferred to the previous determination made by DEEOIC and/or DOE on the matter. It troubled these claimants that the district office and/or FAB made no effort to independently review DEEOIC's prior determination. For example, a former employee of Blockson Chemical Company has repeatedly questioned the credibility of the document relied on by DEEOIC to determine the years of coverage for this facility. It troubles this claimant that he/she has not been able to obtain an independent review of DEEOIC's decision to rely on this document, a document which the claimant believes is flawed.

D. Lack of guidance developing medical evidence.

We continued to receive complaints concerning the lack of guidance provided to claimants when they were developing medical evidence in support of their claim for benefits under Part E of the EEOICPA. Specifically, claimants complained that when trying to develop medical evidence to establish causation between their illness and toxic exposure at a covered facility, it was often difficult, if not impossible to find guidance outlining what DEEOIC wanted in a medical report (or, specifically what they needed to ask their physicians to include in the report). Some claimants wondered why samples of acceptable medical reports were not available for review.

Others complained that when they initially asked for guidance, at best, they received very general instructions. Claimants who were not given any guidance (or only given general guidance) often found it troubling when, in finding their medical report was insufficient, DEEOIC would then inform them of specific information that was missing. These claimants would frequently ask why more specific instructions had not been provided to them earlier in the claims process.

Some claimants have blamed the lack of specific and timely guidance in developing medical evidence for causing unnecessary tensions between them and their physicians:

- Claimants shared instances where, in asking their treating physician to prepare a medical report for DEEOIC, the situation grew tense as the physician repeatedly demanded additional guidance and the claimant repeatedly explained that DEEOIC's letter asking for additional evidence was the only guidance he/she had received.

⁴⁶ We talked to former AWE employees who noted (or believed) that their employer had a contract with DOE (or one of DOE's predecessors). Thus, they wanted someone to explain why this contract with DOE did not qualify the employer as a DOE contractor.

- Claimants also indicated that things could become very tense when the physician had previously prepared a medical report and was now being asked to provide additional information. Some claimants noted that their physician did not find DEEOIC's letter asking for additional information to be very helpful. Others noted that their physician balked at providing additional information when the physician felt that his/her earlier report had provided all of the information that was necessary.⁴⁷

We also talked to claimants who believed that the lack of guidance, and the resulting need to submit supplemental medical reports, was such a common problem that some physicians had become frustrated and had stopped providing treatment for EEOICPA claimants. Throughout the year, we were told of instances where, in refusing to treat a claimant, the physician had specifically cited to the paperwork required by this program as one of the factors prompting this decision.

DEEOIC has responded to the suggestions that some physicians refused to treat EEOICPA patients because of the paperwork by emphasizing that physicians can submit a bill for the time they spend preparing reports. However, both claimants and providers have told us that money was not always the issue, and that money did not address all of the concerns raised by physicians who complained that they were asked to provide multiple clarifications to their report without ever receiving meaningful guidance. Thus, it was emphasized that for some physicians the decision to no longer treat EEOICPA patients was prompted by concerns with managing his/her time.

⁴⁷ We were told of instances where physicians balked at providing supplemental information because they were adamant that the information sought by DEEOIC had been discussed in their original report.

CHAPTER 7

DIFFICULTIES WITH THE WEIGHING OF EVIDENCE

A. Affidavits prepared by workers and close family members were discredited if not supported by other evidence.

The weight given to affidavits prepared by claimants on their own behalf continued to be an issue for some. Earlier in this report, we addressed the difficulties encountered by claimants when trying to locate evidence to support their claim. When they were unable to locate other evidence or former colleagues to help verify their employment, the only viable alternative in some instances was for the claimant to prepare his/her own affidavit (or to testify at the hearing on his/her own behalf). Claimants complained that DEEOIC has established a very high bar for accepting affidavits prepared by workers (or close family members). In particular, it concerns former workers that DOL generally will only accept the affidavits prepared by them or close family members if the affidavit is supported by other evidence in the record.

Most of the former workers that we encountered who submitted their own affidavit could not support their affidavit/testimony with other documentation. In some instances, relevant evidence was lost or destroyed through no fault of the claimant. In other instances, claimants contended that existing employment records merely outlined the procedures for how the work was supposed to be done, but did not actually describe how the operations at their facility were actually carried out on a day-to-day basis.

Former workers routinely reminded us that they had first-hand knowledge of how these facilities operated. Therefore, former workers found it troubling that as a result of DOL's insistence on additional documentation to corroborate their affidavits, it appeared that no consideration was given to the affidavits or testimony they provided. This concern was frequently raised by former workers who could not only name the toxic substances they worked with, but could also describe how they used these toxic substances in carrying out their duties. We also encountered former workers who not only asserted that they worked at a particular site, but could explain the precise work they performed; describe in great detail where this work was performed; and provide the names of others who worked with them. Yet, many former workers felt that providing DEEOIC with such detailed information was a waste of time since DEEOIC appeared to require that affidavits/testimony be consistent with SEM data or supported by other evidence in the record. Former workers found it frustrating when, after taking the time to develop and submit this evidence, DEEOIC did not undertake any effort to weigh and discuss the credibility of this evidence.

We also encountered claimants who believed that DEEOIC's insistence on other supporting documents was a reflection of DEEOIC's mistrust of claimants. In the opinion of these claimants, DEEOIC's insistence on other supporting documentation was an indication that DEEOIC questioned their credibility.

We also talked to claimants who believed that DEEOIC's approach to affidavits prepared by workers was prompted by DEEOIC's realization that some CEs do not have the technical expertise to judge the credibility of these affidavits. This belief was frequently expressed by workers who complained that in spite of including very specific and very technical facts in their affidavits, their affidavits had been summarily discredited. These workers were often confident that if someone with knowledge of the facilities had reviewed their affidavits, they would have been deemed credible.

In addition, some claimants complained that the bar set by DEEOIC for accepting affidavits prepared by workers (i.e., requiring other supporting documents in the record) was higher than the bar they would have encountered had their claims gone to federal court. Claimants felt that in a court of law their affidavits would have been judged on their credibility.

B. Claimants did not feel they were provided an adequate opportunity to supplement their evidence.

During the year some claimants complained that they did not have an adequate opportunity to supplement information they had provided to DEEOIC. In an effort to understand this concern, we reviewed many of the 2017 recommended and final decisions that claimants shared with us. Based on our review, and relying on the statements in these decisions, it appeared that prior to the issuance of the recommended decision DEEOIC often provided the claimant with an opportunity to submit additional evidence addressing deficiencies that had been identified. Yet, in spite of our findings, these complaints continued. Upon further review, what we observed was that as they learned more about the evidence needed to prove their claim, claimants were not always made aware that they could supplement any/all of the evidence they previously provided to DEEOIC.

The Occupational History Questionnaire (OHQ) illustrates the problem. When a new claim is filed, the Resource Center completes an Occupational History Questionnaire with each claimant. Claimants participating in the OHQ interview are encouraged to share as much information as possible about their employment and exposure(s) at covered facilities. However, many claimants have reported to us that it was impossible to tell the Resource Center staff everything about their employment in one interview, especially when their employment spanned many years, involved a variety of different job duties; and/or occurred many years ago. Therefore, in completing the OHQ, many claimants indicated that they provided an overview of their employment and assumed that as their claim progressed, DEEOIC would ask for additional information.⁴⁸ Consequently, it often came as a surprise to claimants when the reports prepared by DEEOIC's specialists and/or the decision issued by the CE or HR relied on information obtained during the OHQ.⁴⁹ Claimants frequently responded to these situations by asserting that if someone had suggested it, they would have taken the time to supplement the OHQ. There were also other instances where, in light of the additional evidence collected by DEEOIC (and/or the additional evidence they had submitted), claimants argued that it should have been obvious to DEEOIC that the OHQ needed to be supplemented.⁵⁰

We also found that when claimants provided DEEOIC with additional information to support their claim, they simply updated the one document they were asked to update, or merely focused on one specific fact/issue. Claimants did not always think (and no one suggested) that they take the time to review and possibly supplement all of the information they had previously submitted to DEEOIC.

⁴⁸ In our experience, most of the claimants we encountered were not aware that they could ask for a copy of their OHQ to review. And these claimants usually were not informed and did not understand how this information would be used in the adjudication of their claim.

⁴⁹ The versions of the PM published in 2017 do not indicate whether claimants are provided a copy of the OHQ to review prior to the RC forwarding it to the District Office.

⁵⁰ We also spoke to claimants who felt that to the extent DEEOIC had encountered a conflict between the information contained in the OHQ and the additional evidence that they had submitted, DEEOIC had not pointed this out to them or sought clarification from them. Many of these claimants maintained that had they been asked, they could have explained any perceived conflicts in this evidence.

In addition, we observed that some claimants did not take advantage of the opportunities presented to them to submit additional evidence; and others did not have any additional evidence to submit. However, we encountered many instances where claimants did not submit additional evidence because they overestimated the quality of the evidence that DEEOIC had obtained from DOE or other sources. A good example of this problem occurred in Part E cases where claimants overestimated the quality of the evidence obtained by DEEOIC from the DOE. In Part E cases, DEEOIC often sends a Document Acquisition Request (DAR) to DOE seeking copies of the worker's personnel file, to include medical, employment, and exposure records.⁵¹ Thus, there were instances where, by the time DEEOIC asked the claimant for additional information in support of his/her claim, DEEOIC had already obtained the DAR records. Many of the claimants we encountered were never told of and never thought to review their DAR records. Rather, they assumed that having obtained their records from DOE, the CE now had an accurate understanding of the work they performed and the toxic substances to which they had been exposed. It surprised these claimants when they learned that, even though DEEOIC had obtained their records, DEEOIC did not have an accurate understanding of their work and/or the toxic substances to which they had been exposed. All of this would make some claimants remark that had they realized DAR records existed in their claim, or that the records DEEOIC obtained were not complete, they would have taken time to review those records and, where necessary, provide DEEOIC with additional information.

C. Copies of reports by DEEOIC specialists.

In the past, claimants were not automatically provided copies of the reports prepared by DEEOIC specialists, and were not notified of their right to ask for copies of these reports. However, DEEOIC announced that it would now provide claimants with copies of some of the reports prepared by specialists. While pleased with this announcement, claimants still had concerns. For instance, DEEOIC's announcement indicated that claimants would be provided copies of the reports prepared by DEEOIC's specialist at the same time they received the recommended decision. Many claimants felt that this was too late in the process. Claimants argued that by the time the recommended decision was issued, they had already submitted medical evidence (and sometimes revised medical and exposure evidence per DEEOIC's request). Thus, claimants argued that receiving the specialist's report(s) along with the recommended decision often put them in a position where it would be necessary to return to their treating physician for a supplemental report (or additional evidence), which in turn would infuriate the treating physician and/or push the treating physician to the point where he/she refused further assistance on the matter, or in the worse instances, end their relationship with the claimant. In addition, it was argued that receiving the specialist reports along with the recommended decision almost always resulted in DEEOIC giving greater weight to the DEEOIC specialist, who had been given the opportunity to review the evidence submitted by claimant, without the claimant's physician or expert having the same opportunity to review any of the evidence from the claim file, i.e., SEM search results, DAR records, etc.

In similar fashion, claimants argued that providing copies of the specialist reports along with the recommended decision put claimants at a clear disadvantage when the CE weighed the report prepared by the CMC against the report prepared by their treating physician. Claimants noted that in many instances, the CMC had been given the opportunity to review the reports prepared by DEEOIC's specialists and the

⁵¹ DAR records consist of radiological dose records; incident or accident reports; industrial hygiene or safety records; pay and salary records; job descriptions, medical records, and/or other records. See PM, Chapter 15 (December 2017) for an explanation of the DAR.

claimant's physician, while the claimant's treating physician was not given the opportunity to review the reports prepared by DEEOIC's specialists or the CMC. Under such circumstances, claimants felt that it was a foregone conclusion that the CE would give greater weight to the opinion of the CMC.⁵²

Claimants also noted that when DEEOIC forwarded the claim to the CMC, DEEOIC provided a Statement of Accepted Facts (SOAF) which narrowed the issues the CMC was to address, and supplied the CMC with an outline, as well as copies of medical and exposure evidence from the claim file. Claimants argued that it was unfair that their physicians were not provided with the same opportunity to review the SOAF, as well as the evidence that the CE had determined to be relevant to share with the CMC.

In response, DEEOIC has noted that claimants can object to the recommended decision, and as part of their objections can review the specialist reports and submit supplemental (or additional) reports. However, claimants routinely argued that this was not an adequate remedy. Claimants believed that once DEEOIC has issued a decision recommending the denial of their claim, they face a steep, uphill battle to prevent the final decision from denying their claim. To resolve these concerns of unfairness, claimants argued that when the case was before the CE, both the CMC and the treating physician should be on equal footing, with each having the opportunity to review the same evidence and address the same issues.

D. Issue—the focus on the extent and level of exposure.

For the past few years, and continuing in 2017, there was a noticeable increase in complaints involving cases where the evidence submitted by claimants was deemed lacking because the claimant or their physician did not address the level and/or extent of exposures to a specific toxic substance(s). In response, some claimants complained that they were never aware that they needed to provide specific information addressing the level or extent of their exposures to specific toxic substances. Claimants pointed to this as another example of where, when they participated in the OHQ or asked their physician to prepare a medical report, they did not know that DEEOIC would need specific information on the level and extent of their exposure to specific toxic substances. In fact, some claimants noted that when they completed the OHQ or asked their physician to prepare a medical report, they had not received any of the toxic exposure information DEEOIC had developed, including exposure information from the SEM database and/or DAR records. To address this concern, claimants felt that as DEEOIC identified the specific toxic substances to which they may have been exposed, and began to narrow the focus of its inquiry to the level and extent of exposure to these toxic substances, DEEOIC should have provided them and/or their physicians with the opportunity to review this information, or at the very least, the opportunity to supplement their reports by specifically addressing the extent and the level of exposure to the particular toxic substances identified by DEEOIC. And they wished to do so before the deadline was approaching for them to make a decision regarding whether to file objections to a decision recommending the denial of their claim.

⁵² DEEOIC requires that medical causation reports from physicians be "well-rationalized," which is described as follows: Specifically, a well-rationalized causation opinion from a qualified physician is one that communicated an accurate understanding of an employee's toxic substance exposure; discusses an employee's medical history and pertinent diagnostic evidence; and applies reasonable medical judgment informed by relevant, credible medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused or aggravated the employee's claimed condition. PM, Chapter 15.13(b) (December 2017).

In our 2016 Annual Report, we noted that DEEOIC had made statements at various meetings of the Advisory Board on Toxic Substances and Worker Health (ABTSWH) indicating that it would provide treating physicians with the opportunity to review the results of DEEOIC's SEM searches and other exposure evidence in the claimant's file. See 2016 Annual Report to Congress. In response to these comments, some claimants and ARs have told us that their treating physicians have not been provided with the opportunity to review DEEOIC's SEM search results and other exposure evidence from their claim file. Still everyone hoped that this would soon become the norm.

In addition, while happy to hear that treating physicians will have the opportunity to review the results of DEEOIC's SEM search results and other exposure evidence in the file, some claimants have questioned the timing of this opportunity. Specifically, claimants questioned if this information would be provided to their physician prior to the issuance of the recommended decision. As noted earlier, many claimants firmly believe that once a decision recommending the denial of a claim is issued, they face a steep, uphill battle to change that result. Thus, claimants feel that it would be most effective if their treating physicians had the opportunity to review the results of the SEM searches, and other exposure evidence, prior to the issuance of the recommended decision.

E. The weight given to the SEM database and evidence provided by employers.

The Procedure Manual states that “[a] CE is not to discredit evidence from the DAR or other sources because SEM does not validate an exposure.” See EEOICP Procedure Manual Chapter 15.7(a) (December 2017). In spite of this statement, claimants argued that DEEOIC often used the SEM database as the measure by which all other evidence was evaluated. Claimants complained that other evidence was deemed credible if it was consistent with the information found in SEM, or was rejected (or given little weight), if it was not consistent with the information found in SEM. Since they questioned the accuracy of SEM, claimants often found this reliance on SEM to be problematic.⁵³

Concerns regarding the reliance on SEM were raised by former workers of the various gaseous diffusion plants. In complaining that their testimony and affidavits were dismissed because they were inconsistent with information found in SEM, former gaseous diffusion plant workers argued that: (1) they were not given an adequate opportunity to correct the information found in SEM; or, (2) their efforts to correct the inaccuracies in SEM were unsuccessful.⁵⁴

Similar complaints were raised by former security guards at the Iowa Ordnance Plant (IOP) who repeatedly questioned DEEOIC reliance on the information in SEM which indicated there were no known toxic substances to which security guards at IOP were exposed. These guards felt that if, instead of relying on the information in SEM, the CE or the IH had talked to them, they could have explained in detail why the information in SEM was incorrect.⁵⁵

⁵³ Some claimants were aware that the SEM homepage contained the disclosure, “The exposure and diagnosed illness information provided on this website is not complete.” Some claimants felt that this acknowledged limitation of the data in SEM was not taken into account during the claims adjudication process.

⁵⁴ In most instances, former workers did not have records or other documents to support their statements. Nevertheless, they were usually confident that if their statements were reviewed by someone with technical knowledge of these operations, their statements would be found to be credible.

⁵⁵ Some of these claimants have produced affidavits, facility maps, and other documentation they believe supports their position that the SEM data with respect to security guards at the IOP is incomplete, particularly because no toxic substances are currently linked to the “security guard” labor category in SEM.

A claimant who worked as a chemist complained that in preparing their reports, the IH and CMC had relied on inaccurate information found in SEM.⁵⁶ This claimant argued that it would have been beneficial if he/she could have talked to the IH and CMC before they issued their reports.⁵⁷ In light of his/her work at this facility, and his/her expertise, this claimant believed that he/she could have corrected many of the inaccuracies found in the SEM.

At its meeting on October 17-19, 2016, the ABTSWH recommended that DEEOIC establish a procedure whereby IHs could interview the claimant directly.⁵⁸ DEEOIC subsequently responded by agreeing that there were certain circumstances in which it might be beneficial for the IH to speak directly to the claimant. In response, DEEOIC noted that it had begun to develop procedures for claims examiners to use when such discussions between IHs and claimants are appropriate, and claimants look forward to the implementation of these procedures. Still, some claimants expressed reservations as to whether these new procedures would address their concerns. While claimants seemed pleased with this recommendation, and are hopeful that such a procedure is eventually developed, some questioned how much weight the IH would accord to the information they provided.

We also heard from claimants who questioned what they felt was DEEOIC's unfettered reliance on information provided by employers. Citing to the findings made by Congress in enacting this program, claimants routinely reminded us that:

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)(3). In light of this finding by Congress, claimants found it troubling whenever it appeared that DEEOIC did not give any consideration to their efforts to challenge the information provided by the employer. In this regard, claimants found it troubling that affidavits that they submitted had to be supported by other evidence in the record, yet documents submitted by the employer were generally accepted without any questions. This concern was frequently raised by claimants who could cite to documents or reports that questioned the accuracy of information or reports prepared by their employer. For example, former employees of the Rocky Flats Plant could not understand why, in spite of the documented violations found at Rocky Flats, DEEOIC continued to accept, without any hesitation, documents that had been prepared and created or submitted by this employer.

⁵⁶ While describing SEM as incomplete, this claimant conceded that there were times when it was beneficial to rely on SEM data. What troubled this claimant was the failure to discuss the document that he/she had prepared in light of the incomplete SEM data.

⁵⁷ DEEOIC recognizes that, "Since SEM is based on currently available evidence, the CE needs to be aware that other evidence may be obtained through DAR records or other development that may not correlate with the data in SEM." See Federal (EEOICPA) Procedure Manual, Chapter 15.7(a) (December 2017).

⁵⁸ One ABTSWH board member, who is an IH, noted that such interviews were a primary tool by which IHs obtained the information needed to form their expert opinions.

F. Lack of written policy regarding CMC's use of smoking history in Part E causation reports.

We were sometimes approached by claimants when their Part E claims were sent to a CMC for an opinion on causation (whether it was at least as likely as not that exposure to a toxic substance at a covered facility was a significant factor in causing, contributing to, or aggravating the illness). A frequent issue raised by these claimants concerned the CMC's use of their smoking history in forming their opinion on causation. In some instances, particularly after obtaining a copy of the CMC's report, claimants complained that the CMC either: (1) incorrectly stated that the worker was a smoker or had an incorrect smoking history; or (2) attributed the claimed illness to smoking instead of the toxic substance exposure. The claimants who contacted us often questioned the extent to which smoking was permitted to be a factor in adjudicating their EEOICPA claim.

In April 2017, while speaking before the ABTSWH, DEEOIC stated that,

"...Well one of the things we've actually tried to do is not consider smoking as part of causation because of the aggravation and contribution. We've in fact instructed doctors, when we refer this, to kind of look at the exposure to work over the smoking..."

See ABTSWH, Transcript at pg. 60 (April 19, 2017).

When asked where this information regarding smoking could be found in published policy, DEEOIC responded,

"...A lot of it's been in training. I don't know that we've said it in a procedural document. It's something we address in training when we talk to our claims examiners..."

See ABTSWH, Transcript at pgs. 60, 61, 62 (April 19, 2017). Claimants want to know the extent to which smoking is to be a factor in a causation determination. The claimants who asked this question were often aware of statements made by DEEOIC suggesting that their smoking history was not supposed to be considered.

One example of this confusion involved a claimant who contacted us in 2017 after reading the CMC report and discovered that his/her smoking history was inaccurate. It troubled this claimant that the CMC's opinion relied upon the inaccurate smoking history to determine that smoking was the "likely the cause of the [claimant's] condition." Although this claimant asked us to direct him/her to DEEOIC's policy addressing the extent to which smoking was to be considered in determining causation, we could not refer him/her to a published policy on this subject. Instead, we could only reference the statements by DEEOIC to the ABTSWH in answering the question as to whether the CMC should have considered the employee's smoking history.

CHAPTER 8

DIFFICULTIES WITH THE ADJUDICATION PROCESS

A. Decisions Do Not Acknowledge Evidence Submitted by Claimants.

Complaints arose when evidence submitted by claimants was not acknowledged or discussed in the reports prepared by DEEOIC specialists, and/or in recommended or final decisions. The failure to acknowledge and/or discuss evidence submitted by claimants often caused claimants to:

1. Question if their evidence had been overlooked.⁵⁹
2. Conclude that it was a waste of time to develop evidence if DEEOIC was not going to acknowledge or address the evidence in their decisions.⁶⁰

The following example highlights the concerns that arose when evidence submitted by claimants was not acknowledged or discussed by DEEOIC. In this instance, the claimant submitted a document to the Final Adjudication Branch describing his/her work and outlining the toxic substances to which he/she had been exposed. This claimant initially approached us when the evidence he/she submitted was not discussed in the reports prepared by the IH and the CMC, nor was it discussed in DEEOIC's final decision. The claimant worried that the failure to mention his/her evidence suggested that this evidence had been misplaced, and thus that the IH, CMC, and HR were not aware of it.⁶¹ Additionally, it troubled this claimant that throughout the claims process, DEEOIC had relied heavily on the information found in the SEM database. This claimant, who happened to be a chemist, felt that the document he/she submitted identified and clarified erroneous assumptions made by the IH and CMC, who had relied heavily on the SEM database in issuing their reports. Later, when his/her request for reconsideration was denied, this claimant responded by noting that had the CE asked for additional information (or identified issues that needed clarification) he/she would have gladly provided that information.⁶²

During the year, we again heard from former security guards at the IOP who raised similar concerns. Former security guards of the IOP have repeatedly complained that the information in the SEM database regarding their work-related exposures was inaccurate. These employees found it troubling that no one from DEEOIC had ever sat down with them to go over the evidence they had which they believed demonstrated that the SEM database was incorrect.

Moreover, as with the chemist discussed above, these former security guards argued that the SEM database search results were given too much weight. In particular, they argued that DEEOIC had summarily rejected information they provided simply because it was not in accord with SEM. In the opinion of these claimants, DEEOIC had made no effort to ascertain the accuracy of the information they provided. This perception

⁵⁹ Most claimants we encountered equated the failure to discuss the evidence they submitted to DEEOIC with the failure of this evidence to be considered.

⁶⁰ The failure to acknowledge evidence they submitted also caused some claimants to question the sincerity of those who encouraged them to submit evidence.

⁶¹ In this instance, the document prepared by the claimant was submitted to the CE prior to the issuance of the reports by the IH or CMC, and prior to the issuance of the final decision. The subsequent denial of his/her request for reconsideration was the first time claimant's evidence was acknowledged.

⁶² According to some claimants, when DEEOIC determined that information was lacking, DEEOIC did not always provide guidance that helped the claimant resolve the situation.

really troubled these claimants who felt that, if given the opportunity, they could have provided the IH or CMC with facts that would have verified the accuracy of their information over the absence of information in the SEM database.

B. Despite being rescinded in February 2017, the language and intent of Circular 15-06 is still being applied in cases.

From the moment EEOICPA Circular No. 15-06 was published in December 2014, claimants took exception to it. Circular 15-06 stated that in light of significant safety improvements that occurred throughout DOE facilities after 1995, absent compelling data to the contrary, it was unlikely that covered Part E employees working after 1995 would have been significantly exposed to any toxic agents at a covered facility. Consequently, this Circular stated that CEs could accept that for employees diagnosed with an illness with a known health effect associated with any toxic substance present at a DOE facility after 1995, any potential exposures would have been maintained within existing regulatory standards and/or guidelines.⁶³

Therefore, claimants were pleased when at a public meeting held in October 2016, the ABTSWH recommended that Circular No. 15-06 be rescinded, and were even more pleased when DEEOIC rescinded this circular on February 2, 2017. However, since February 2, 2017, claimants have complained of instances where reports by DEEOIC contract specialists and/or decisions issued by DEEOIC used language found in rescinded Circular 15-06. The language from Circular 15-06 that caused these concerns stated that,

"...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..."

See EEOICPA Circular NO. 15-06 (December 14, 2014). In the cases brought to our attention, subsequent to the rescinding of Circular 15-06 a specialist, CE or HR made statements such as,

"However, there is no available evidence (i.e., personal and/or area industrial hygiene monitoring data) to support that, after the mid-1990s, her exposures to asbestos would have exceeded existing regulatory standards."

Report from a Contract Certified Industrial Hygienist, June 2017.

"The CCIH concluded that there is no available evidence to support that after the mid-1990s that you would have exposures exceeding regulatory standards..."

DEEOIC Order, issued November 2017.

⁶³ The Circular further noted that CEs could accept that; (1) if there was compelling, probative evidence that documented exposures at any level above this threshold or measurable exposures in an unprotected environment, the CE was to contact the Lead IH for guidance on whether a formal IH referral was required, and (2) any findings of exposure, including infrequent, incidental exposure, required review of a physician to opine on the possibility of causation.

The use of the language found in Circular 15-06 has led to complaints suggesting that although DEEOIC has stated that it rescinded Circular 15-06, this circular was still being applied by DEEOIC specialists, CEs and HRs in adjudicating claims.⁶⁴

C. Most DEEOIC policy changes are only posted online, leaving claimants unaware of them.

When DEEOIC issues a new bulletin, circular or other significant policy change, this change is usually announced on DEEOIC's website under "Latest Program Highlights" or under "Program News." Changes to the PM are described in EEOICP Transmittals, which are also only available online. Throughout the year, we were approached by claimants who had just learned of a change in law, policy, or procedure, and it troubled them when: (1) they first learned of the change well after the change had been made; (2) when it negatively impacted their case; and/or (3) instead of being informed of the change by DOL, they learned of the change from a friend or colleague. There were also some instances where claimants first learned of changes in law, policy, or procedure that could impact their claim when our Office brought the change to their attention. Because policy changes are only posted online:

- Claimants who did not have access to, or only limited access to the internet, oftentimes never saw these notices and thus, were not aware of these changes.
- Even when they had access to the internet, many claimants did not periodically visit DEEOIC's website to stay abreast of changes. This was especially true when their claim had been denied. After the denial of their claim, most claimants did not routinely check DEEOIC's website for updates and changes.
- Changes announced under "Latest Program Highlights" or "Program News" only appeared on the DEEOIC website for a limited period of time.

It should be noted that DEEOIC's website now contains a link that allows individuals to subscribe to receive Medical Provider Updates via email.⁶⁵ However, as with other online resources, it has been our observation that many claimants were unaware of them. We also found that because they did not appreciate the value of these resources, many claimants made no effort to explore these website links, even when they were aware that there were resources available online.

D. Claimants are not advised when DEEOIC conducts internal reviews to determine if reopening of certain claims are required.

Some DEEOIC procedures require the review and identification of previously denied claims that might be impacted by a change in policy or rule. These procedures often direct each district office to prepare a list of previously denied claims (affected by the change) and to have the district office(s) or FAB review the claims on this list to determine if reopening of a claim is warranted. However, DEEOIC does not require the claimant be notified if DEEOIC's internal review determines reopening is not warranted.⁶⁶ Thus, we encountered

⁶⁴ Some claimants questioned whether DEEOIC had informed IHs and other specialists that Circular 15-06 had been rescinded.

⁶⁵ Moreover, in 2018, DEEOIC added a link allowing individuals to subscribe to program and policy updates via email.

⁶⁶ DOL's procedures for the review of previously denied claims does not always limit the District Office and FAB to reopening. For instance, EEOICPA Bulletin 16-02 (Presumption Available for Accepting Chronic Obstructive Pulmonary Disease (COPD) Under Part E of the EEOICPA) outlined a procedure whereby a claim could also potentially be reversed and accepted if it was under review while at FAB. See EEOICPA Bulletin 16-02 (Dec. 28, 2015).

claimants who learned about a change in policy from a non-DOL source and wanted to know: (1) why were they just learning about the change in law or policy; and (2) if anyone had reviewed their claim to determine if it was impacted by the change.⁶⁷

When informed by our office that DEEOIC had conducted an internal review of their claim and determined that reopening was not warranted, claimants often responded by arguing that had they known about the change in policy and DEEOIC's review process, they would have wanted the opportunity to submit additional evidence. The claimants who expressed this view often felt that the change in policy outlined in these bulletins or circulars impacted what they understood to be the evidence necessary to prove their claim. Thus, these claimants argued that before DEEOIC determined whether reopening was warranted, they should have been given notice and the opportunity to develop additional evidence consistent with the policy outlined in the new bulletin, circular, or policy directive.

This argument asserting that they should have been given notice and the opportunity to develop additional evidence was frequently raised when claimants with previously denied cancer claims learned of a new SEC.⁶⁸

- Some claimants noted that in pursuing their initial claim for cancer, they saw no reason to quibble over a few more days or weeks of employment they believe they should have been credited by DEEOIC. Yet, had they been notified when the new SEC was added, they would have taken the time to try to verify the extra days or weeks needed to establish 250 days of work.⁶⁹
- Some claimants noted that in pursuing their initial claim for cancer, they did not consider it relevant to submit evidence showing that the cancer had metastasized. However, specified cancers can include cancers that have metastasized to the bone, lung, or kidney. Thus, we talked to claimants who stressed that had they known about the new SEC class, they would have taken the time to determine whether the non-specified cancer had metastasized to the bone, lung or kidney.

Similar concerns arose regarding other policy changes. For instance, EEOICPA Bulletin No. 16-02 not only created a presumption for accepting claims for COPD under Part E, but also outlined a procedure for reviewing previously denied claims to determine if they were impacted by this bulletin. Based on our conversations, we believe that there are claimants who, if they had been notified of this bulletin, might have made an effort to identify and submit additional evidence in order to meet the new policy criteria.

Where DEEOIC has undertaken an internal review and determined that reopening was not warranted, claimants who are aware of the policy change through their own efforts can request a reopening of their claim if they feel that they have additional evidence that should be considered. However, in many of the instances that we encountered, claimants only became aware of the change in law or policy when notified by a friend or by this office. Unless and until they are notified of the subsequent change in law or policy, claimants have no reason to think that evidence that was not initially relevant to their claim is now relevant.

⁶⁷ As noted before, while a notice announcing a new bulletin or circular was usually posted on DEEOIC's website, many claimants did not routinely visit DEEOIC's website to check for such updates, and thus never saw these notices. We especially found that once their claim was denied, many claimants never reviewed DEEOIC's website again.

⁶⁸ EEOICPA Bulletin 11-07 outlines the procedures for reviewing and processing claims under new SEC class designations, including how and when reopening decisions are to be analyzed and sent to claimants.

⁶⁹ In order to qualify for a SEC class, the worker must have worked for a number of work days, usually aggregating at least 250 work days, occurring either at the one particular SEC or in combination with work days within the parameters established for one or more other classes of employees included in the SEC.

E. Are previously denied claims always reviewed?

As previously discussed, there were instances when in announcing a change in policy, the bulletin or circular also outlined the procedures by which the district office or FAB were to review previously denied claims that could be impacted by the new policy. However, there have been other instances where the bulletin or circular did not indicate whether a change in policy would result in review by DEEOIC of previously denied claims. In these instances, it has often been difficult to determine if such a review was ever undertaken.

For instance, EEOICPA Bulletin No. 17-01 (October 5, 2016) outlined what was described as a “procedural change.” This “procedural change” impacted the circumstances in which a Part E survivor could elect to receive monetary compensation that the employee would have received had he/she not died prior to payment. This bulletin did not mention whether DEEOIC would perform an internal review to identify previously denied claims potentially impacted by this new bulletin. It also did not outline the steps to be taken to notify previously denied claimants of this new bulletin.

Similar concerns were raised about DEEOIC’s decision to rescind EEOICPA Circular No. 15-06. At the full board meeting of the ABTSWH on November 16, 2017, DEEOIC noted that it did not have the mechanism to identify specific cases impacted by Circular No. 15-06. Rather, DEEOIC indicated that they were doing “more of a manual process.”⁷⁰ See ABTSWH—Full Board Meeting, November 16, 2017, Transcript pages 36-37. Some claimants believed that since DEEOIC could not identify all of the cases potentially impacted by Circular 15-06, then DEEOIC needed to do more to notify claimants and ARs that this Circular had been rescinded. In raising this point, it was stressed that it would not be sufficient to simply post a notice online informing claimants that this circular had been rescinded. Rather, claimants felt that this notice needed to be widely distributed.

F. DEEOIC’s approach to hearing loss claims.

Over the years and continuing in 2017, claimants complained about DEEOIC’s approach to hearing loss claims. Such complaints consistently arose over whether DEEOIC’s policy presumption regarding hearing loss is a legally binding rule, which if not satisfied results in the automatic denial of the claim; or whether it is, as titled by DEEOIC, a policy presumption which, if the criteria are not satisfied, allows claimants to pursue their claims under the Part E standard of causation.

1) DEEOIC did not follow its own policy.

Appendix 1 of the EEOICPA PM states that Part E causation can be presumed without referral to National Office specialists if three conditions are satisfied. See EEOICPA PM Appendix 1, Exhibit 15.4(8) (December 2017). The first condition requires medical evidence to prove the diagnosis of bilateral sensorineural hearing loss. The second condition requires verified covered employment within at least one specified job category for a period of 10 consecutive years, completed prior to 1990. [The list of specified job categories is included in Exhibit 15.4(8).] The third condition requires that, in addition to working in a specified job category, the employee had been concurrently exposed to at least one the specified organic solvents. [The list of the specified organic solvents is included in Exhibit 15.4(8)].

⁷⁰ DEEOIC indicated that it had been able to identify a cohort of cases and had provided minimum lists to their claim staff to begin the process.

We routinely received complaints asserting that DEEOIC did not follow its own policy. Claimants routinely reminded us that the PM characterized the conditions outlined in Exhibit 15.4(8) as a “presumption” and specifically stated that causation could be presumed without referral to the National Office specialist if the three conditions were satisfied. Yet, in spite of this explicit language, when hearing loss claims did not meet all three of the conditions outlined in this Exhibit, these claims were not referred to the National Office for review by a specialist, or reviewed under the Part E standard for causation.⁷¹

2) Did DOL’s response to our 2015 Annual Report apply to the specific issues raised in our 2015 Annual Report concerning hearing loss claims?

In our 2015 Annual Report, we noted that with respect to claims for hearing loss, some claimants continued to grapple with whether the criteria for hearing loss claims outlined in the Exhibit 15.4(8) were a rule or a policy. We explained that in the opinion of claimants, if these criteria were a rule, then they must be met in order for their claim to be accepted. However, if the criteria were merely a policy presumption, then they expected that if their evidence did not meet the criteria outlined in the PM, their case would still be evaluated under the Part E causation and exposure standard. See 2015 Annual Report to Congress, December 21, 2016, page 51.

In its response to our 2015 Annual Report, DOL generally addressed our concerns about the weight given to PM provisions, bulletins, circulars, and teleconference policy notes stating that,

“...Lack of a presumptive illness is never justification, standing alone, for a denial of a claim. A claimant is always legally entitled to prove his/her case, regardless of any presumption. The case will still be fully adjudicated, but exposure and/or a causal relationship must be proven by the claimant without the use of a presumption. Awards of benefits are routinely entered on the strength of the evidence alone, without applying any legal presumption.”

See DOL’s Response to Office of the Ombudsman 2015 Annual Report to Congress, pages 6-7. In spite of this response, in 2017, we continued to encounter claimants whose claims for bilateral sensorineural hearing loss had been denied by DEEOIC solely because they did not meet all of the criteria outlined in Exhibit 15.4(8). These claimants complained that in denying their claim for hearing loss, DEEOIC had impermissibly given Exhibit 15.4(8) the full legal force and effect of law.

“...Furthermore, in accordance with guidelines in the Federal (EEOICPA) PM 2-1000.18, hearing loss can be compensable under Part E of the EEOICPA if such loss arises as a result of exposure to one or more of the organic solvents listed in subsection 18b. Additionally, the employee must meet all conditions under subsection 18a as follows...”

A 2015 decision shared with the Office, January 2017.

⁷¹ The Part E standard of causation is whether it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in causing, contributing to, or aggravating the illness; and, it is at least as likely as not that the exposure to such toxic substance was related to employment at a DOE facility. See 42 U.S.C. § 7385s-4(c).

“Hearing loss is compensable under Part E if certain medical, employment and exposure criteria are met, and the guidance closely defines the specific labor categories, time frames, and particular organic solvents which are qualifying under this provision. The evidence must establish that the employee has a diagnosis of sensorineural hearing loss in both ears, and the employee was exposed to one of the specified chemical solvents, and worked within a certain job category for consecutive and unbroken period of ten years, completed prior to 1990.”

A 2006 decision that a claimant continued to question when he/she encountered us in October 2017.

Some of these claimants also assured us that, in recent conversations, their CE had again insisted that meeting all of the criteria outlined in Exhibit 15.4(8) was the only way to be compensated for hearing loss under Part E of this program. Thus, it is unclear if DOL’s response stating that claimants are always legally entitled to prove his/her case regardless of any presumption applies to claims for bilateral sensorineural hearing loss.⁷²

3) DEEOIC gives PM Exhibit 15.4(8) the full force and effect of law.

As noted earlier, in its response to our 2015 Annual Report, DOL stated that, “[a] claimant is always legally entitled to prove his/her case, regardless of any presumption.” Claimants have difficulty reconciling this statement with the language in Exhibit 15.4(8) stating that,

*This policy guidance represents the sole evidentiary basis a CE is to use in making a decision concerning whether it is “at least as likely as not” that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateralsensorineural hearing loss. **Claims filed for hearing loss that do not satisfy the conditions for acceptance outlined in this procedure cannot be accepted, because these standards represent the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance.** [Emphasis Added].*

Claimants contend that Exhibit 15.4(8) takes away their legal entitlement to prove their case, regardless of any presumption. They argued that unless they meet all of the conditions outlined in Exhibit 15.4(8), they are essentially precluded from establishing that their hearing loss is related to exposures sustained while working at a covered facility. For this reason, claimants argue that Exhibit 15.4(8) is given the full legal force and effect of law.

This argument is frequently raised by claimants who question the reasonableness of the criteria outlined in Exhibit 15.4(8). For instance, we encountered claimants who questioned the basis for compensating those who worked in the labor categories specified by this Exhibit while refusing to even consider whether the hearing loss sustained by those who did not work in one of these specified labor categories was caused, aggravated, or contributed to by one of the organic solvents identified in Exhibit 15.4(8). During the year, we

⁷² Exhibit 15.4(8) is included in an Exhibit 15.4 which is entitled, “Exposure and Causation Presumptions with Development Guidance for Certain Conditions.”

also talked to claimants who questioned whether the scientific studies relied upon by DEEOIC specifically indicated that 10 consecutive years of exposure was necessary in every case. This question was frequently raised by claimants who argued that, while they did not have 10 consecutive years of exposure prior to 1990, they still should have had the opportunity to show that they sustained levels of exposures that were at least as likely as not a significant factor in causing, aggravating, or contributing to their hearing loss. Similarly, there were claimants who felt that they should have the opportunity to establish that their exposures after 1990 were no different from their exposures prior to 1990. Claimants argued that if this hearing loss provision was a policy presumption, then they should be able to challenge it because it is not legally binding on all cases. On the other hand, if this provision was to be given the full legal force and effect of law, claimants complained that they were not given an opportunity for notice and comment prior to such a rule being enacted.

4) Subsection (e) of Exhibit 15.4(8) does not resolve the concerns with DEEOIC's policy towards hearing loss claims.

Subsection (e) of Exhibit 15.4(8) provides in pertinent part,

...If a claimant seeks to argue that the standard by which DEEOIC evaluates claims is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. Any claimant submission of scientific documentation including journals, periodicals, or other literature (including citations to literature) has to relate to the topic of the correlation between hearing loss and toxic substance exposure. Scientific evidence that does not relate to or reference hearing loss is insufficient.

See PM Exhibit 15.4(8)(e). Claimants complained that subsection (e) did not resolve or minimize their concern over the fact that Exhibit 15.4(8) was given the full legal force and effect of law, instead of being a policy presumption.

- Claimants noted that they were prevented from establishing that, while they did not meet all of the criteria outlined in Exhibit 15.4(8), their hearing loss was nevertheless related to exposures sustained at a covered facility.
- According to subsection (e), claimants can argue that the standard by which DEEOIC evaluates claims is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists. We heard from claimants who argued that subsection (e) unduly limited the challenges that they could raise. In particular, claimants felt that Exhibit 15.4(8) did not allow them to argue that additional labor categories should be considered and/or added to the list of specified job categories chosen by DEEOIC.
- Claimants also argued that subsection (e) made it very expensive to challenge DEEOIC's hearing loss policy. Claimants feared that trying to show that DEEOIC's standard was not based on a correct interpretation of available scientific evidence could quickly become cost prohibitive. Thus, the claimants we talked to were pleased to know that DEEOIC's policy on hearing loss was being reviewed by the ABTSWH.

CHAPTER 9**INTERACTIONS WITH DEEOIC****A. Telephone calls not returned.**

With respect to interactions with DEEOIC, one of the most common difficulties raised by claimants in 2017 involved their inability to talk to someone when they called their CE or the district office. This difficulty is also discussed in Chapter 4.

To summarize, the complaints brought to our attention usually involved situations where claimants called the CE and when no one was available to take their call, the claimant left a message. Later, when the CE returned the call, the claimant was not available. Thus, the CE left a message simply indicating that he/she had called. We later discovered that in some instances, because the claimant did not recognize the caller or the telephone number, the claimant did not answer the telephone when the CE called back. Since the CE simply left a short message (or the claimant did not answer the telephone), if the claimant still needed to talk to the CE, the onus was on the claimant to again call the CE, who oftentimes again was not available to take the claimant's call. As a result, some claimants found themselves in a cycle of telephone tag with the CE. When we brought these observations to DEEOIC's attention, DEEOIC vowed to look into them. Subsequently, we talked to claimants who indicated that when they left a message for the CE they received a timely response. However, in a few instances claimants complained that the person who returned their call was not their CE, and thus, was unable to answer their specific questions. In addition, there continued to be a few instances where claimants complained that no one returned their call.⁷³

"If you leave the house and they call and leave a message that they called you, you have to start the process all over. It makes it very difficult to speak to them. I would like them to set up an appointment so it is easier to connect with DOL and get your problems resolved...I would like to see an exact time appointment set up when the CE cannot take the call. This way you are not a prisoner waiting for their call."

Statement by a claimant, April 2017.

Another issue brought to our attention was that when some claimants called the district office to speak with their CE, they were automatically transferred to someone in another district office. According to the complaints we received, the person to whom the claimant was transferred oftentimes could not respond to case-specific questions. Thus, some claimants described these interactions as counter-productive and frustrating. In one instance, in approaching our office, the claimant noted that he/she had made 19 phone calls to DEEOIC regarding the rejection of covered prescription medication by a local pharmacy. This claimant complained that although he/she had spoken to at least four different individuals in district offices and the FAB, he/she was still having trouble obtaining the necessary medication. Only after the issue was elevated to a supervisor in the National Office was the claimant's telephone call returned and the prescription issue resolved.

⁷³ In some of these instances it was impossible to determine exactly when the claimant had called the CE or district office.

We also talked to claimants who complained that when they tried to call their CE, the person at the district office who answered the telephone would not transfer them to their CE. According to these claimants, they were asked to present their question or concern to the person who answered the telephone, and while this person may have attempted to help, some claimants indicated that they did not receive sufficient assistance. The experience of having the person who answered the telephone refuse to transfer them to their CE led some claimants to suggest that in order to avoid this situation in the future, they simply stopped trying to call their CE.

B. Inappropriate conduct.

In most instances, claimants did not call us simply to complain about an incident of inappropriate customer service. Rather, the incident of inappropriate customer service was usually just one aspect of the story that the claimant or the AR wanted to tell us. In recounting their story, claimants and ARs would sometimes mention a negative encounter or would utter a statement reflecting their dissatisfaction with the customer service they had received. Generally, when we followed up on these comments, claimants were quick to emphasize that their problem was with one particular CE or staff member, and not with the DEEOIC staff as a whole. In fact, after recounting their negative encounter with one CE, claimants would often make it a point to tell us about a positive encounter they had with another CE or DEEOIC staff member. Thus, when it came to the problems with customer service, most claimants were not looking for wholesale changes. Rather, they simply wanted an adequate means to register their concerns, in hopes of avoiding future problems. In fact, in many instances claimants felt that their problems could be resolved if they were given a new CE.⁷⁴

In response to issues raised in our 2015 Annual Report about inappropriate customer service, DOL agreed that reporting and resolving inappropriate customer service issues was of the utmost importance. DOL stated that it would review and examine additional ways to publicize the process (for reporting inappropriate customer service) to the claimant community. DOL also noted that customer service complaints could be submitted to OWCP in writing, by phone, via public email, or by using the customer satisfaction surveys that were available on the OWCP website and through the OWCP Interactive Voice Response (IVR) phone system. In addition, DOL indicated that claimants could direct their complaints to a supervisory CE, unit manager, assistant district director, or district director. DOL's response concluded with a statement indicating that every complaint would be reviewed and appropriate action would be taken.

This Office does not question DOL's commitment to providing good customer service. Yet, in spite of DOL's commitment to good customer service and the various ways claimants can report inappropriate customer service, claimants continued to come to us with concerns:

"I just spoke to the manager at the Resource Center for XXX. XXX was very unhelpful, rude and unprofessional..."

E-mail, dated June 2017

⁷⁴ While claimants can certainly request a new CE, it has been our understanding that such requests are not routinely granted.

“XXX correspondence to me is rude and dismissive...”

Letter, dated January 2017.

“People in XXX (District Office) are “really bad people...”

Telephone call, September 2017.

1) Claimants not aware of DOL's commitment.

In its response to our 2015 Annual Report, DOL agreed that reporting and resolving any inappropriate customer service issues is of the utmost importance. Nevertheless, in 2017, claimants who complained of encountering instances of inappropriate customer service often questioned DEEOIC's commitment to good customer service. This was especially true when the claimant felt that he/she had encountered a blatant instance of inappropriate customer service. Yet, most of the claimants who complained about inappropriate customer service had not reported the conduct to DEEOIC and oftentimes were hesitant, if not absolutely opposed to reporting this conduct. In our experience, the three main reasons that claimants did not report instances of inappropriate customer service to DEEOIC were: (1) they felt that their complaints would be ignored; (2) they feared retaliation; and (3) they did not feel comfortable reporting such conduct to the CE's supervisor, or to a general DEEOIC email address.

2) Claimants fear retaliation.

Many of the claimants we encountered admitted that because they feared retaliation, they were hesitant to report instances of inappropriate customer service. From what we can tell, in most instances this fear of retaliation was not prompted by something that had been said or done. Rather, this fear was usually prompted by the realization that CEs (as well as others associated with DEEOIC) had a lot of sway over the outcome of a claim, and that the person about whom they were complaining could be assigned to their claim for many years. Claimants routinely questioned the wisdom of leaving negative comments about a CE (or the program in general) when the CE or the administrators of this program were in a position to impact their claim, and would oftentimes be in this position for a long time. Claimants frequently reminded us that even if the claim was denied, they might later want to request reopening of that claim or want to file a new claim. Former workers routinely noted that if their claim was accepted, they might have ongoing issues related to medical benefits. Thus, claimants often expressed the need to be cautious in deciding when and where to complain about inappropriate customer service. In fact, when claimants approached us with complaints about inappropriate customer service they usually began the conversation by asking if they could be assigned a new CE. When we informed them that we could not make such a change and could not guarantee that DEEOIC would make such a change, many claimants then asked that we keep what they shared with us confidential. We also heard from claimants who questioned the anonymity of DEEOIC's customer satisfaction survey conducted after a call to the CE or other member of the DEEOIC office. Most claimants that we talked to believed that DEEOIC had the capability, if it wanted, to identify anyone who took the survey and left negative comments.

3) Claimants not comfortable reporting inappropriate customer service to the CE's supervisor or to a general DEEOIC email address.

Many claimants have often told us they felt uncomfortable forwarding their complaints of inappropriate customer service to the district office where the CE worked, or blindly sending an email/letter of complaint to an unidentified person at DEEOIC. Claimants routinely expressed their fear of calling the district office and making their complaint to a supervisor while the subject of their complaint was in close proximity to the supervisor. They also did not feel comfortable forwarding their complaints to an unknown person. Rather, claimants made it clear that they preferred to send their complaints (or speak) to a specific person designated to receive and address complaints of inappropriate customer service, and, very importantly, who they hoped would not be directly involved in the adjudication of their claim.

C. Delays.

Towards the end of 2015, we began to see an increase in complaints alleging delays in the processing of some claims. DEEOIC later confirmed it had been experiencing delays in the processing of some claims that had been forwarded to IHS for their review and reports. Subsequently, during the ABTSWH's meeting on April 28, 2016, DEEOIC announced that it had entered into a contract with a company to perform industrial hygienists work.⁷⁵ Those who heard this announcement hoped that this contract would resolve the delays that arose when some claims were forwarded to an IH for review.

Since April 28, 2016, there has been a decrease in the complaints involving delays that arose when claims were forwarded to an IH. However, in 2017, there were complaints alleging other delays in the processing of claims. In particular, in 2017, claimants, ARs, and home health care providers approached us complaining of delays in receiving authorization or re-authorization for home health care. It is interesting to note that while claimants were more likely to raise this issue when they encountered us at an outreach event, home health care providers were more likely to raise this issue via telephone, mail, or email. We also found it interesting that when home health providers called or wrote to us, they often came with multiple instances where they encountered (or were encountering) a delay in receiving authorization/reauthorization.

For example, one home health care provider copied our office when they submitted to DEEOIC a long list of cases where the authorization or reauthorization had been pending for more than 30 days. In September 2017, DEEOIC responded to this provider indicating that over half of the cases had been adjudicated, and that the vast majority of the remaining cases were requests for authorization where the prescribing physician had not offered sufficient rationale or justification of medical necessity to allow DEEOIC to approve the requests. DEEOIC also indicated that it was following up on those pending cases to obtain clarification or additional information from the treating physician. Approximately three months later, the same provider shared with this office another letter they sent to DEEOIC. In this letter, the provider provided a long list of different cases that had been waiting authorization/re-authorization for home health care for more than 30 days. Thus, it appeared to be an ongoing issue for this provider.

⁷⁵ DEEOIC previously utilized in-house IHS prior to entering into the contract with this outside company.

A representative from another home health care provider contacted us on at least three separate occasions in 2017 to complain about delays in receiving authorizations/reauthorizations for home health care. Having talked to us before, this representative understood that without a Privacy Act waiver from the claimant or the AR, we could not inquire to DEEOIC about these claims. Still, this representative contacted us because he/she wanted to make sure that we were aware that delays in receiving authorization/reauthorizations for home health care persisted, and wanted to provide us with some insights into the frequency and extent of the delays.⁷⁶

In another instance, we were presented a situation where the alleged delay not only impacted the claim filed by the employee, but also the subsequent claim filed by the employee's spouse. In September 2014, the employee filed claims identifying three distinct illnesses. A final decision issued in May 2015 denied the claims for two of the illnesses, and noted that the third claim was "pending." It is not clear why they called, but in December 2016, the local Resource Center attempted to reach out to the employee. When the family informed the Resource Center that the employee had passed away without receiving a decision on his/her third claim, the Resource Center urged the spouse to file a claim for survivor's benefits. The spouse immediately filed the claim for survivor benefits and appeared to be in line for acceptance of the claim when he/she passed away in January 2017. When the spouse passed away, there were no other family members who could qualify as eligible survivors. Yet, what disturbed this family the most was that they never received any explanation as to why the employee's original pending claim was not adjudicated following the May 2015 decision, particularly because it was the only one with the potential for a favorable outcome.

1) Emergency care and lapses of care.

For many of the claimants we encountered, a delay in receiving authorization/reauthorization for home health care meant a delay in receiving care that had been prescribed by their treating physician. Chapter 30.2(k) (December 2017) of the EEOICPA Procedure Manual permits the medical benefits examiner (MBE), in certain circumstances, to authorize home health care for a preliminary 30-day period while additional development is undertaken. We seldom, if ever, encountered claimants who were aware of Chapter 30.2(k). Rather, in contacting us, claimants would often argue that their medical condition was such that they should not have to forego needed care while DEEOIC undertook further development of their claim. This was another instance where because they were not aware of this PM provision and were not informed by a CE or MBE, many claimants never thought (or took the time) to ask whether such an option was available to them.

2) Delays in reauthorizing health care strains the resources of health care providers.

Home health care providers emphasized that they did not want to deny care to (or walk away from) patients simply because DEEOIC was slow to reauthorize claimant's care. This was especially true when the provider had an established relationship with the patient. Providers also frequently indicated that they had a moral, if not legal duty not to abandon patients. Thus, some providers complained that it strained their resources to provide services while awaiting DEEOIC's decision to reauthorize care. And they argued that their ability to provide care without a reauthorization became more problematic as the delay dragged on. This concern was raised by a variety of providers, including some who identified themselves as small companies. These small companies argued that because of their limited resources they were more severely and immediately impacted by delays in authorizing/reauthorizing home health care.

⁷⁶ This provider wanted us to know that in some instances claimants went without prescribed medical care as they awaited reauthorizations, while in other instances, claimants continued to receive care only because the provider did so with the hope that DEEOIC would eventually approve the reauthorization.

3) Other delays.

“I applied to receive an impairment evaluation...I was told by [the doctor’s office] that they could not schedule my evaluation until they received approval from [DEEOIC]. I called the branch...this morning and no one was available to tell me whether the approval had been sent...”

Email, January 2017.

“After requesting my file copy approximately 15 months ago, and requesting it several times, I received a copy of my file today...”

Email, March 2017.

In 2017, the vast majority of the complaints raising concerns about delays involved delays in authorizing/reauthorizing home health care. Still, we also received complaints alleging problems arising from delays that did not involve the authorizations/reauthorization of home health care. In particular, we talked to claimants who complained of the amount of time it took for DEEOIC to respond to the requests they submitted. While complaints alleging delays arose at practically every stage of the claim process, there were some commonalities among these complaints.

- Most of the complaints contended that claimants were not notified of delays caused by DEEOIC. Claimants asserted that they only learned about a delay caused by DEEOIC when they contacted DEEOIC, usually to inquire about the lack of progress on their claim.
- Claimants complained that when they inquired into these DEEOIC caused delays, they often received vague responses. For example, claimants routinely complained of enduring long delays while repeatedly being told that DEEOIC was developing more evidence, or the case was still under review. Repeatedly receiving the same response often increased the claimant’s frustrations.
- It concerned claimants that there did not appear to be any limit as to how long their claim could be delayed by DEEOIC.
- As the delay progressed, claimants often found it troubling that there did not appear to be anyone they could turn to help them resolve the delay.

D. Claimants advised to withdraw a claim.

Throughout the year, there were claimants who told us that they had been advised by their CE to withdraw a claim for benefits. To be clear, this is another example where claimants rarely contacted us to specifically complain about an issue. In most instances, that the claimant had been asked to withdraw a claim only came up as the claimant was recounting his/her story. The few instances where claimants raised this issue on their own usually arose when claimants wanted to know if and when they could refile the withdrawn claim. In either event, claimants usually did not understand why their CE or MBE had advised them to withdraw a claim.

When we could not explain why they had been asked to withdraw a claim, most claimants asked that we not pursue the matter. Claimants usually assumed that being asked to withdraw one claim was somehow related to the processing of another claim, and they did not want to do anything that might jeopardize their existing claim. Many claimants also feared that there would be retaliation if they started to second-guess the CE's instructions. Therefore, even when they had reservations about being asked to withdraw a claim, claimants usually preferred to wait until the existing claim had been adjudicated before questioning what to do with the claim that had been withdrawn. In all of these cases, claimants did not ask or fully appreciate how this action could benefit or potentially harm their claim for benefits.

E. Terminal Cases.

We are aware of instances where DEEOIC went to great lengths to process a claim for a terminally ill claimant as quickly as possible. However, in other instances we encountered family members and ARs who complained when claimants passed away after filing a claim, but before compensation was paid. These family members and ARs sometimes questioned DEEOIC's handling of the claim after being notified that the claimant was terminally ill. We also encountered instances where claimants and/or their family members were not aware that DEEOIC has a process whereby it can expedite the processing of a claim for a terminally ill claimant.

As noted, DEEOIC has a procedure for expediting claims where the claimant is end-stage terminally ill. See EEOICPA Procedure Manual, Chapter 11.8 (December 2017). A common problem that we see is that some claimants think that expediting a claim means that certain steps normally associated with processing a claim are eliminated. This is another misconception that causes problems. In expediting terminal claims, DEEOIC endeavors to process the claim as quickly as possible, however, DEEOIC does not eliminate or skip any of the steps in the claims process.

Another problem that we encountered with such claims involved the medical evidence needed to establish that the claimant was terminally ill. The PM refers to expediting claims of claimants who are end-stage terminally ill. See PM, Chapter 11.8(a) (December 2017). We received complaints alleging that valuable time was lost as family members or ARs went back and forth with the CE trying to establish that the claimant was end-stage terminally ill. For example, family members and ARs complained of instances where the CE repeatedly insisted that the physician provide an estimate of how long the claimant had to live, while they repeatedly tried to explain to the CE that the physician was unwilling to provide such an estimate. It often appeared (or was stated) that the physician did not find it appropriate to try to guess how long a person had to live. There were also instances where, according to family members and ARs, the physician firmly believed that having stated that the claimant was in hospice care should have been sufficient to establish that the claimant was end-stage terminally ill, and as a result could not understand why he/she was being asked to provide additional medical documentation.⁷⁷

We also received complaints from family members and ARs who questioned DEEOIC's response after they submitted medical documentation that the claimant was terminally ill. These complaints usually arose when the claimant passed away before the claim was completed, and family members or the AR felt that they did not receive a sufficient explanation for the delays they believed they encountered after notifying DEEOIC that the claimant was terminally ill.

⁷⁷ Some family members and ARs found it confusing that the CE would not accept a notice that the claimant was in hospice care as sufficient to establish that the claimant was end-stage terminally ill since a request for hospice care was listed in the PM as an indicator that a claimant was end-stage terminally ill. See PM Chapter 11.8(a).

CHAPTER 10**CIRCUMSTANCES CONFRONTING CLAIMANTS NOT ADEQUATELY ADDRESSED BY THE PROGRAM**

“As my health has rapidly declined, I am unable to advocate for my claim...”

E-mail, April 2017.

In telling their stories, claimants frequently mentioned the other life challenges they faced. In previous annual reports, we characterized these life challenges as factors that underlined the complaints that we received. However, after further reflection we realized that having to pursue an EEOICPA claim while facing these challenges is, in and of itself, the issue for some claimants.

Many claimants firmly believe that, in creating this program, Congress was well aware that many claimants would be of an advanced age or ill when they first pursued their EEOICPA claim. Thus, there is a belief that in creating this program Congress intended that these life challenges be taken into consideration.

A. Some claimants do not have the ability to process a claim on their own.

In their conversations with us, we are often told how age, health, or other challenges added to the difficulties encountered by some claimants while processing their claim. We routinely heard how a lack of mobility impacted a claimant’s ability to search for records, or how cognitive limitations made it difficult for some claimants to carry out instructions they were given, especially where the instructions involved complicated legal, scientific, or medical concepts. We also sometimes talked to claimants who told us that due to cognitive limitations they simply could not remember instructions. And yet other claimants shared how their vision and/or hearing impairments made their ability to communicate with RC and DEEOIC staff very challenging.

In fact, the inability to carry out instructions was one of the main reasons claimants turned to us for help. Some claimants needed someone to explain the instructions, while others needed assistance carrying out these instructions. Claimants who lived in areas of the country where DEEOIC, our office and/or the JOTG conducted outreach often had the opportunity to sit down and have face-to-face discussions with representatives from the various agencies. However, those living in other areas oftentimes found themselves trying to determine who to call for help, or hesitant to call because they did not know what type of help they needed. We heard from many such claimants in 2017.

B. Application of DEEOIC policies is too rigid.

Claimants sometimes complained that DEEOIC was too rigid in its application of its policies and procedures. For instance, claimants recuperating from surgery (or undergoing medical treatment) routinely questioned why they were only given 30 days to submit evidence or to respond to a request for additional

documentation. And while we sometimes suggested that the CE may not have known about the challenges facing the claimant, in some instances, the CE was well aware the claimant was recuperating from surgery or undergoing medical treatment, and yet still only gave them 30 days to submit evidence. In one instance, a claimant who lived in Europe questioned DEEOIC's lack of flexibility in helping to resolve bill-pay issues.⁷⁸ In approaching us, this claimant noted that the nine (9) hour time difference presented a major hurdle when trying to resolve these issues over the telephone.⁷⁹ In particular, this claimant complained of never being able to talk to anyone when he/she called and never being available when (and if) the CE called back. This claimant fully understood that DEEOIC did not correspond by email. Yet, this claimant felt that his/her situation warranted some flexibility, especially since DEEOIC had been unable to resolve the difficulties that made communicating by telephone so problematic.

Throughout the year, we talked to other claimants who also felt that their claim presented special circumstances that warranted some flexibility in the application of the policies and procedures.

⁷⁸ This claimant is adamant that before moving to Europe he/she asked if moving there would be problematic, and was assured that DEEOIC had many claimants living in Europe. It is unclear exactly who gave this assurance to claimant.

⁷⁹ This claimant was communicating with the District Office in Seattle, Washington.



SUMMARY OF THE ISSUES AND DIFFICULTIES ENCOUNTERED IN 2017

Throughout this assessment of the most common issues and difficulties encountered by claimants and potential claimants in calendar year 2017, we discussed a host of issues. The following is a summary of these issues and difficulties:

1. Difficulties with the statute:

- a. Difficulties involving the statute must be addressed by Congress. The status of CLL as a specified cancer; difficulties related to the fee schedule; the cap on benefits; and issues involving coverage are issues that DOL does not have the authority to resolve.
- b. Some of the complaints with the statute raised administrative matters. For instance, claimants and ARs complained that it was difficult to obtain guidance when trying to understand/apply the fee schedule.
- c. Claimants questioned if it was possible to have a procedure that would allow them to file their claim, thereby establishing a date of filing, and yet postpone pursuing that claim while they addressed the other pressing life challenges.

2. Difficulties arising from a lack of awareness of the EEOICPA program:

- a. There are many potential claimants who still are not aware of this program.
- b. Much of DEEOIC's efforts at outreach tends to focus on areas near covered facilities.
- c. There are particular concerns regarding whether sufficient effort is being undertaken to bring awareness of this program to those who have moved away to other areas of the country.

3. Claimants do not understand the EEOICPA program:

- a. In spite of DEEOIC's efforts, we continue to encounter claimants who do not have a basic understanding of this program.
- b. This program is plagued by some widely held misconceptions.
- c. Some claimants complained that information was only provided if and when they specifically asked for information. This presented a problem since many claimants were not familiar with the program and thus did not know what information or assistance to ask for.
- d. Claimants complained that they received vague information, or only received pertinent information well after the information would have been most useful to them.

4. Difficulties obtaining assistance:

- a. Some claimants do not know where to turn for assistance, and a claimant's lack of familiarity with the program can hinder his/her ability to seek assistance.
- b. In particular, it was common to be approached by claimants who encountered difficulties trying to resolve issues related to medical bills.

- c. Claimants who do not have access to the internet or who are not familiar with using the internet are at a distinct disadvantage when it comes to obtaining information about the EEOICPA.
- d. Likewise, the use of program terminology and acronyms proved a formidable barrier to some claimant's understanding of the claim process and what was expected of them.

5. Difficulties obtaining representation and locating physicians:

- a. Some claimants could not find an AR who was willing to assist them.
- b. There were also instances where ARs were unwilling to assist claimants with certain aspects of their claim, usually authorization for medical treatment, medical bills, and/or durable medical equipment or home health care.
- c. Claimants also encountered difficulties finding a physician to treat them. When refusing to treat EEOICPA claimants, physicians often cited to one, or more, of three reasons: (1) prior problems getting paid; (2) not wanting to be second-guessed by DEEOIC; or (3) too much paperwork.

6. Difficulties locating evidence:

- a. Claimants complained that 30 days was not sufficient time to develop and submit evidence, especially medical evidence.
- b. The claimants who complained when given 30 days to submit evidence usually were not aware that they could have asked for an extension of time.
- c. Claimants questioned the assistance they received when trying to locate employment and exposure records. This question often arose when relevant records were not available. In such instances, claimants questioned the assistance they could expect from the government in gathering evidence and finding facts.
- d. While there has been improvement, some claimants continued to complain that when asked to submit additional evidence they did not receive adequate guidance outlining what DEEOIC needed from them in order to approve their claim.

7. Difficulties with the weighing of evidence:

- a. Claimants complained that DEEOIC did not independently assess the credibility of the affidavits prepared by claimants and close family members.
- b. Claimants complained that they were not provided an adequate opportunity to supplement the evidence they submitted.
- c. Claimants felt that DEEOIC did not credit evidence they submitted if it was not consistent with the information found in SEM.
- d. Claimants do not understand why DEEOIC specialists are provided a SOAF and documentation from their claim file before issuing a report, but neither they nor their physician are provided this documentation when being asked to produce similar reports or evidence.
- e. Claimants do not understand why they are not provided a copy of their OHQ; why they are not permitted to speak to the IH and/or CMC; or, why they are not provided DEEOIC specialist reports prior to receiving their recommended decision.

8. Difficulties with the Adjudication Process:

- a. Claimants complained of instances where evidence they submitted was not acknowledged or discussed in the reports prepared by DEEOIC specialists and/or discussed in the decisions issued by DEEOIC.
- b. The continued use of language from Circular 15-06 in recommended and final decisions, as well as in reports prepared by DOL specialists, has spurred concerns that this Circular is still being applied in the adjudication of claims.
- c. When DEEOIC undertakes, on its own initiative, to determine if reopening of a claim is warranted, the claimant is not notified that reopening is under consideration. And if the claim is not reopened, the claimant is not informed that his/her claim was reviewed and that it was determined that reopening was not warranted. Claimants are only provided an opportunity to participate after a Reopening Order is issued and their claim is in a posture for a Recommended Decision to be issued to them.
- d. Claimants are confused by DEEOIC's current approach to hearing loss claims. In particular, claimants would like to know whether there is a presumption of causation for hearing loss, or if the presumptive language in the PM Exhibit is a rule which must be satisfied in order to have a claim accepted.

9. Interactions with DEEOIC:

- a. Early in the year we encountered claimants who complained that it was difficult to talk to the CE when they called the District Office. DEEOIC vowed to address this matter.
- b. DEEOIC's statement outlining how claimants can report incidents of inappropriate customer service is only available online.
- c. Many claimants are wary of reporting inappropriate customer service to the district office where the person they have a complaint about is employed. Claimants prefer to direct their complaints to a specific person who is not part of the team or office adjudicating their claim for benefits.
- d. There are continuing problems with delays. In addition to the anxiety that arises when delays occur, claimants also complain that they are not notified of delays caused by DEEOIC; and when they ask, they do not receive a full explanation for the delays they experience.
- e. It troubled claimants that there did not appear to be any limitation regarding how long a claim could be delayed.
- f. When there was a delay in reauthorizing home health care benefits, many claimants reported that they experienced a lapse in service.

10. Circumstances confronting claimants not adequately addressed by the program:

- a. Due to a variety of significant factors, some claimants have physical and/or cognitive limitations which prevent them from handling their claim on their own.
- b. DEEOIC does not have adequate procedures currently in place to accommodate this growing population of claimants.

APPENDIX 1ACRONYMS (ABBREVIATIONS)
USED IN THIS REPORT

ABTSWH	Advisory Board on Toxic Substances and Worker Health
ACS	Affiliated Computer Services
AEC	Atomic Energy Commission
AR	Authorized Representative
AWE	Atomic Weapons Employer
BeLPT	Beryllium Lymphocyte Proliferation Test
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CLL	Chronic Lymphocytic Leukemia
CMC	Contract Medical Consultant (formerly known as District Medical Consultant)
CPWR	Center for Construction Research and Training
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DME	Durable Medical Equipment
DOD	Department of Defense
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FAB	Final Adjudication Branch
FECA	Federal Employees Compensation Act
FOIA	Freedom of Information Act
FWP	Former Worker Medical Screening Program
HHS	Department of Health and Human Services
HR	Hearing Representative
ICD-10	International Classification of Diseases, 10th Edition
IOP	Iowa Ordnance Plant
IH	Industrial Hygienist
IOM	Institute of Medicine of the National Academies
JOTG	Joint Outreach Task Group
MBE	Medical Benefits Examiner

MED	U.S. Army Corps of Engineers Manhattan Engineer District
NDAA	National Defense Authorization Act
NIOSH	National Institute for Occupational Safety and Health
NO	National Office
OWCP	Office of Workers' Compensation Programs
PM	Procedure Manual
PoC	Probability of Causation
RECA	Radiation Exposure Compensation Act
RESEP	Radiation Employees Screening and Education Program
RC	Resource Center
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SSA	Social Security Administration
The Act	Energy Employees Occupational Illness Compensation Program Act
The Office	Office of the Ombudsman, U.S. Department of Labor

APPENDIX 2

COMMON MISCONCEPTIONS ABOUT THE EEOICPA PROGRAM

1. Some claimants believe that in creating this program, Congress intended to cover anyone who worked onsite at a facility associated with the development and building of U.S. nuclear weapons.
2. We routinely encounter claimants who believe that the EEOICPA only compensates those with claims for cancer.
3. Some claimants do not realize that if their claim is denied, they can file additional claims if they suffer new illnesses.
4. Because Part B specifically compensates for only four illnesses, some claimants incorrectly assume that there is a list of the illnesses potentially covered under Part E. Consequently, some claimants delay filing their claim while they first try to determine if there is a similar limitation on the types of illnesses covered under Part E.
5. Many claimants are not aware that they can appeal a final decision to U.S. federal district court.
6. The cap on monetary compensation under Part E is \$250,000. Some claimants mistakenly believe that every successful Part E claim will, over time, result in the receipt of \$250,000.
7. There was a belief that when a claim was expedited because the claimant was terminally ill, DEEOIC eliminated certain steps in the claims process.
8. While many claimants know that Resource Centers will assist with the filing of new claims, many are unaware that they will also assist claimants with a variety of other claim processes, such as help with finding a physician or resolving medical bill-pay issues.
9. Many claimants erroneously believe that the SEM database includes links between toxic substances and illnesses that can be aggravated by or contributed to exposure to these substances. In fact, the SEM database only includes illnesses that have a causal link to a toxic substance.
10. Employees of AWE employers may have worked with toxic substances other than radiation, but under the EEOICPA they are only covered for cancers caused by exposure to radiation.

APPENDIX 3

DOL'S RESPONSE TO THE 2015 ANNUAL REPORT TO CONGRESS

RESPONSE TO THE OFFICE OF THE OMBUDSMAN'S 2015 ANNUAL REPORT**1 - Notification About the Program**

The Ombudsman's summary states: "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."

Response: I agree that widespread direct notification to all those individuals potentially impacted by the nuclear weapons program has been challenging. OWCP understands the critical importance of outreach to the nuclear weapons community and welcomes ideas and suggestions on how to increase awareness.

Since the onset of the program, OWCP has utilized its network of Resource Centers (RCs) to provide an initial point-of-contact for workers interested in filing claims. These RCs, located at or near 11 major DOE sites across the country, frequently meet with various organizations in an effort to inform the community about the program. A traveling resource center was implemented to further these efforts and reach an even larger geographical area. Town Hall Meetings have also been conducted, and, more recently, OWCP has developed an informational campaign involving teleconferences and a subscription email service, specifically targeting physicians and home health care providers who are likely to come into contact with potential claimants. OWCP also meets with advocacy groups and attends a host of conferences/meetings aimed at informing workers and unions about the program.

A Joint Outreach Task Group (JOTG) was formed to allow representatives from DOL, DOE, HHS, the office of the Ombudsman for EEOICPA, and the Office of the Ombudsman for HHS's National Institute for Occupational Safety and Health (NIOSH), plus representatives from DOE's Former Worker Medical Screening Program, the opportunity to exchange ideas, share resources, and develop outreach strategies for targeting current and potential claimants. All four federal

agencies publicize EEOICPA via their websites and provide links to the other three sites to ensure easy access of information and resources. OWCP's EEOICPA website links to DOE's web listing containing descriptions of the covered DOE facilities, Atomic Weapons Employer facilities, and beryllium vendor facilities, in order to assist workers in identifying a possible covered employer. Information is also disseminated through brochures, pamphlets, and other printed material and publicized in press releases, newspaper articles, radio advertisements and via social media.

2 - Claimants' Understanding of EEOICPA

The Ombudsman's summary states: "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 own 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 of index directing them where to locate information."

Response: I agree there are claimants who do not have access to information via the internet and many others who may not understand the information that is provided. EEOICPA is a complicated statute, and more can be done to make both the law and the process understandable. OWCP is undertaking a review of its website and printed material with the end goal of better communication and usability of available information.

Improved written material, which answers more questions and minimizes confusion, will also have the added benefit of allowing OWCP staff to concentrate its attention on specific claimant issues. OWCP and Resource Center staff provide assistance both in person and via telephone to help claimants understand the claims process and what happens once their claims are transferred to a District Office. The claims examiners (CEs) at the District Offices also serve as contacts for any claimant questions, concerns, and "next steps." The Final Adjudication Branch (FAB) hearing representatives and CEs assist with reconsideration requests, the hearing process, remands, and final acceptances or denials. Once a claimant is awarded benefits under EEOICPA, OWCP provides additional guidance on the payment process, the award of medical benefits and medical care authorization, and the medical billing process. OWCP provides toll-free numbers for claimants to use if they have questions or concerns and responds promptly to phone calls.

3 - Statutory Eligibility under EEOICPA

The Ombudsman’s summary states: “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 employees 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.”

Response: The issue raised here, regarding the rationale behind the enactment of various specific eligibility provisions of EEOICPA, is not an issue with which I can appropriately agree or disagree. The statute sets out the numerous criteria for the various facilities that are covered, the employees who are covered, and the types of illnesses that are covered. OWCP’s role is to impartially and accurately apply the law as written. OWCP works to faithfully execute the statute and to provide a fair approach to the adjudication of claims and the delivery of benefits under the existing law which fully considers the information provided by the claimant and the requirements of the statute. OWCP will look for ways of improving its communication when a claim is denied and look into other resources that might be of assistance to claimants.

4 - OWCP’s Obligation to Provide Assistance in Connection with a Claim

The Ombudsman’s summary states: “Another common issue involves the problems encountered by claimants when trying to locate evidence. Section 7348v 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 provisions 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.”

Response: I understand that claimant may have varying understandings of OWCP’s actual statutory obligations under § 7384v of EEOICPA, and I offer the following by way of clarification. Under the EEOICPA, unless otherwise specified in the statute, the claimant bears the burden of proving by a preponderance of the evidence the existence of each criterion necessary to establish their eligibility. To help them meet this burden OWCP is required by § 7384v to provide claims assistance under Part B; specifically, assistance in securing medical testing and diagnostic services for covered beryllium illnesses, chronic silicosis or radiogenic cancer; and such other assistance as may be required to

develop facts pertinent to the claim. In other words, OWCP can assist claimants in gathering facts or finding evidence under Part B, but it is then incumbent upon claimants to utilize the available evidence to prove their case.

To meet its statutory obligation to assist claimants, OWCP has implemented a number of policies and processes. OWCP has further chosen to voluntarily apply the same standards of assistance to claimants under Part E. The following descriptions are some of the resources that OWCP has developed to assist claimants.

OWCP, with the assistance of DOE, conducted extensive research and investigation into sites, facilities, groups of workers (i.e., job categories, job duties, etc.), exposures, diseases, and exposure links. Based on this research, OWCP developed a relational database called the Site Exposure Matrices (SEM). The SEM contains information about the types of known toxic substances at the DOE facilities (and uranium mines and mills) covered under the EEOICPA, the associated job categories likely exposed to the toxic substances, and the possible health effects of exposure. This assistance goes a long way toward helping claimants meet their burden of proof to establish work-related exposure to toxic substances under Part E.

OWCP provides the services of contract medical consultants (CMCs) to assist claimants in establishing work-related causes of illnesses, particularly in cases where a claimant's treating physician may not be able to provide the necessary medical support for the claim.

OWCP also contracted for the services of industrial hygienists to conduct individual exposure assessments for Part E claims. This is particularly important when claimants may not have been aware of the extent of their exposure to toxic substances while performing their jobs.

OWCP works closely with DOE, DOE's Former Worker Medical Screening Program, and the Center for Construction Research and Training to help claimants verify their employment. OWCP has implemented interagency agreements with both DOE and the Social Security Administration (SSA) for access to employment/earnings records, and in the case of DOE, any retained health records or other work-related documents.

5 - Weighing of Evidence

The Ombudsman's summary states: "While DEEOIC has made strides in providing well-reasoned decisions, the weighing of evidence 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 claimant 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.”

Response: I agree that the clarity of OWCP’s decisions initially needed improvement. Significant improvements were implemented, and claimants are now provided with written decisions that include a more detailed explanation of why a claim was denied, information on how the evidence was weighed, and DEEOIC’s rationale for the decisions. I further agree it is critically important that we continue to strive for decisions that are clear, well-reasoned, and solidly supported by the law.

The Federal (EEOICPA) Procedure Manual, which guides the actions of OWCP’s claims staff, states that in writing decisions, staff must address all facets of the evidence that led to a conclusion, including any interpretive analysis relied upon to justify the acceptance or denial of a claim. Beginning in 2015, OWCP set a higher bar in terms of performance, providing additional training to claims examiners and hearing representatives, specifically to improve the quality of written decisions. OWCP has implemented an ongoing improvement process that includes feedback, editing, and rewriting of decisions. The training stresses the importance of providing a full explanation regarding the adequacy or inadequacy of evidence submitted, i.e., how each piece of medical evidence was reviewed and weighed, including the medical evidence, reports, and determinations provided by the claimant’s physician. Staff are instructed that a written decision must identify that a CMC may have assisted in the adjudication of medical issues or causation and why studies or other reports may have been used or rejected in adjudicating the claim. OWCP also implemented a procedure requiring claims examiners to provide claimants with any underlying supporting documents upon which s/he relied in reaching his/her recommended decision. For example, when any recommended decision to deny a case is based, in part, on the decision of a CMC, the CMC report is provided to the claimant along with the recommended decision. The claimant then has the opportunity to object to any findings in the report at the FAB level before a final decision on his/her claim is issued.

6 – Evidentiary Burdens in Proving Claims

The Ombudsman’s summary states: “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’ standards. 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.”

Response: I disagree that OWCP applies a higher evidentiary burden to claimants in substantiating their claims that that required by the statute. I do, however, understand the frustrations of claimants in trying to meet their burden of proof. The claimant bears the burden of proving by a preponderance

of evidence the existence of each and every criterion necessary to establish eligibility under any compensable claim category. One criteria is causation, and the legal test for showing compensable causation is the “at least as likely as not” standard. While program staff see to aid claimants in establishing their entitlement to an award of benefits, the program does have a legal responsibility to apply the law. The following brief summary of the review and appeal proves may prove instructive:

- Once the district office issues a recommended decision the case file is automatically transferred to the FAB. The FAB will review the entirety of the case and may issue a final decision affirming the findings made by the district office, remand the case to the district office for issuance of a new recommended decision, or reverse the recommended decisions. Reversal, however, may occur only when the recommended decision was to deny and the FAB determines that the record contains sufficient evidence to warrant accepting the case.
- Following the final decision, the claimant has the right to request reconsideration, in which instance a new hearing representative will review the case and may either deny the reconsideration request or accept it and remand the case to either the district office for a new recommended decision or to the FAB for a new final decision.
- The claimant may also request a reopening of the case at any time following a final decision, or in the alternative, file suit in District Court.
- To provide a general sense in terms of the number of final decisions issued compared to the number of reconsiderations receive, I offer the following additional information. In FY2016, approximately 20,250 final decisions were issued by the FAB, including those requiring a hearing. That same year, 930 requests for reconsideration were received and completed. Thus, less than 4.5 percent of decisions received a request for reconsideration.

7 – The Ombudsman’s summary states: “Claimants continue to have questions concerning the weight given to PM provisions bulletins, circulars and teleconference policy 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.

Response: I disagree that OWCP is improperly relying on its policies and bulletins in dividing claims or otherwise improperly adjudicating Part E claims where a presumption is implicated. I nevertheless understand how this may be an area of confusion for some claimants. I offer the following explanation.

Federal agencies like OWCP use procedure manuals, bulletins, and circulars to disseminate policy and procedures to their staffs. While these documents do not have legal force, *per se*, they are meant to advise program staff and the public of how and agency interprets the statutes and rules that *do* have the force of law, and they provide the foundation for program implementation and operations.

OWCP conducts research to develop its procedural manuals, bulletins, and circulars and works with the department's Solicitor's Office to ensure that those and other program documents are consistent with the program's statute and regulations. OWCP publishes the material on its website making it available to the public.

Regarding the use of a "presumption" under Part E, OWCP has conducted significant research which supports the creation of certain presumptions regarding *exposure* (e.g., if an individual worked in a particular labor category for at least 250 days prior to 1995, it can be presumed that the worker had *significant exposure* to asbestos). Research also supports OWCP's creation of certain presumptions regarding *causation* (e.g., if the employee was significantly exposed to asbestos and was diagnosed with asbestosis, laryngeal cancer, ovarian cancer, or mesothelioma and had a particular latency period, OWCP can presume that the *condition was causally related to the exposure* to asbestos). We have been able to make such presumptions through research for a number of different conditions under Part E.

The fact that a claimant may not have a designated presumptive illness, however, does not mean his/her claim will be denied. Lack of a presumptive illness is never justification, standing alone, for denial of a claim. A claimant is always legally entitled to prove his/her case, regardless of any presumption. The case will still be fully adjudicated, but exposure and/or a causal relationship must be proven by the claimant without the use of a presumption. Awards of benefits are routinely entered based on the strength of the evidence alone, without applying any legal presumption.

8 – Home Health Care Benefits & Medical Billing

The Ombudsman's summary states: "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 netter 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 ore 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."

Response: I agree that additional clarity and communication regarding the requirements for home health care (HHC) medical benefits under EEOICPA would be helpful.

In FY 2016, DEEOCI took steps to create a centralized unit responsible for the review and adjudication of all HHC and other ancillary medical benefits requests. The new unit is staffed by Medical Benefits Examiners (MBEs) who specialize in the review and adjudication of HHC requests and operate under the direction of the National Office. This centralization of staff allows

DEEOIC to provide a more efficient and consistent decision-making process with respect to HHC requests and provides better communication between claimants, their doctors, and HHC providers.

All HHC authorizations require review and updated medical information prior to reauthorization. Sixty (60) days prior to expirations, MBEs send notification letters to providers and claimants reminding them of the need for updated medical information. A failure to provide updates information can result in a reminder letter again stating the need for updated medical information. A failure to produce updated medical evidence may ultimately result in a denial letter advising that care cannot be reauthorized due to the lack of necessary medical evidence. If the physician or claimant is not clear about the exact information that is needed, s/he may contact the MBE, and the MBE will seek to provide the physician or claimant with an explanation of what is required and why.

Upon receipt of medical evidence, it is the MBE's responsibility to evaluate any such evidence and determine if the information provided is sufficient to authorize the care requested. If the medical information is deficient or unclear, the MBE is to explain the nature of the deficient evidence and the specific information needed by DEEOIC in order to proceed with adjudication of the HHC request.

9 – Assistance with Medical Billing Issues

The Ombudsman's summary states: "With respect to medical billing, claimant 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 instance 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 carious forms that must be filed. Consequently, claimant 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."

Response: I agree the medical billing approval process can be confusing, and we are working on ways to improve the system.

OWCP/DEEOIC currently utilizes a three-tiered system for medical billing. The first tier of communication involves bills that are received with deficiencies that prevent them for being processed. In these instances, the bills are returned with a letter that outlines the deficiencies that must be fixed prior to resubmission. If there are not upfront deficiencies, OWCP moves on to the second tier and either issues a payment or denial. Details concerning the denial are communicated to the submitter including the reasons for denial. OWCP will review current explanation of benefits to ensure reasons for denial are clearly articulated to ensure better understanding by claimants. The third tier involves the medical bill pay contractor call center, Resource Centers, and District

Office staff, all of which are available to provide further assistance on any denials. Within the last two years, DEEOIC has begun sending out email blasts to subscribers that provide ongoing and new information about the medical bill process and related issues. The program also now has quarterly calls with physicians and physicians' staff to answer questions about the process.

10 – Procedures for Reporting Inappropriate Customer Service

The Ombudsman's summary states: "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 member 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."

Response: I agree that reporting and resolving any inappropriate customer service issues is of the utmost importance. Our reporting process will be reviewed, and we will examine additional ways to publicize the process to the claimant community.

Customer service complaints may be submitted to OWCP in writing, by phone, via public email, or by using the customer satisfaction surveys that are available on the OWCP website and through the OWCP IVR phone system. Claimants are encouraged to complete the phone survey after a call is conducted with their CE or other member of the EEOICPA office. The survey is anonymous. The public email for complaints is Deeoic-public@dol.gov. Claimants may also direct their complaints to a supervisory CE, unit manager, assistant district director, or district director. Every complaint will be reviewed and appropriate action taken.

CONCLUSION

OWCP administers its responsibilities under the EEOICPA with the intent of following the will of Congress in enacting the EEOICPA: to pay compensation and medical benefits to all eligible nuclear weapons workers (or their eligible survivors) who incurred illnesses in the performance of duty at a covered facility. Our statistics show that as of November 26, 2017, DEEOIC has awarded compensation and medical benefits totaling more than \$14.37 billion under both Part B and Part E of the EEOICPA. During this time 117,723 workers or their families have received more than \$10.60 billion in compensation and more than \$3.76 billion in medical expenses associated with the treatment of accepted medical conditions.

Feedback from EEOICPA stakeholders is central to our collective success. Whether feedback is received via the thousands of phone calls fielded by CEs, the concerns brought to the attention of DEEOIC leadership, or the recommendations from the Advisory Board on Toxic Substances and Worker Health, all input is important to ensuring that OWCP/DEEOIC carries out its Congressional mandate. The Ombudsman's 2015 Annual Report provides OWCP with valuable information that we will use to further improve the administration of EEOICPA.



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UNITED STATES DEPARTMENT OF LABOR
