

OFFICE OF THE OMBUDSMAN FOR THE
ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM

2021 ANNUAL REPORT TO CONGRESS



OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Cover Photo: Y-12 worker at Beta-3 control panel. c. 1945
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U.S. Department of Labor

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



July 29, 2022

The Honorable Kamala D. Harris
President
United States Senate
Washington, DC 20510

Dear Madam President:

I am pleased to present the 2021 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

A handwritten signature in blue ink that reads "Judith S. Boggs".

Judith S. Boggs
Acting Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

U.S. Department of Labor

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



July 29, 2022

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Pelosi:

I am pleased to present the 2021 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

A handwritten signature in blue ink that reads "Judith S. Boggs". The signature is written in a cursive style.

Judith S. Boggs
Acting Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

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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 received during calendar year 2021, 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 received in 2021, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in calendar year 2021 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA):

- DEEOIC published two updates, Version 5.0 and 5.1 of the Procedure Manual. The changes to the Procedure Manual included:
 - Clarity about the scope of the Special Exposure Cohort class coverage at the Oak Ridge K-25 plant. (Version 5.0).
 - Complete revision of the process by which the Final Adjudication Branch (FAB) schedules hearings. (Version 5.0).
 - Identifying the Medical Benefits Adjudication Unit (MBAU) as the National District Office. (Version 5.1).
 - Providing new procedures for the handling of Privacy Act requests. (Version 5.1).
 - Clarification that a six-minute walk test is an acceptable mechanism in rating impairment for respiratory disorders. (Version 5.1).
 - Updated and enhanced guidance on the evaluation of impairment reports. (Version 5.1).
 - Reissuance of Chapter 28 – Medical Bill Process in its entirety. (Version 5.1).
 - Renaming and reissuing Chapter 29 – Ancillary Medical Benefits in its entirety. (Version 5.1).
 - Updating the address to which claimants return a Form EN-20 for the payment of compensation benefits. (Version 5.1).

- The following webinars were hosted by DEEOIC:
 - Establishing Survivorship Under Part B and Part E on January 27, 2021,
 - District Office Roles and Responsibilities on February 24, 2021,
 - Final Adjudication Branch Roles and Responsibilities on March 24, 2021,
 - Medical Benefits Coverage on April 21, 2021,
 - Policy Discussion on May 19, 2021,
 - Medical Bill/Reimbursement Processing on June 30, 2021,
 - Stakeholder Update on July 14, 2021,
 - Office of the Ombudsman for EEOICP and for NIOSH on August 25, 2021,
 - The Role of the Health Physicist and Toxicologist on September 22, 2021, and
 - The Role of the Industrial Hygienist and Nurse Consultant on October 27, 2021.

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

INTRODUCTION

Section 7385s-15 of the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, requires the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (the Office) to submit an annual report to Congress. See 42 U.S.C. § 7385s-15. In this annual report, we are to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and (b) an assessment of the most common difficulties encountered by claimants and potential claimants during that year. See 42 U.S.C. § 7385s-15(e). The following is the Office's annual report for calendar year 2021.

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

Congress enacted the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, on October 30, 2000. 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 (DOE) and certain of its contractors and subcontractors. 42 U.S.C. § 7384d(b).

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).

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:

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

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.

- 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, are entitled under the EEOICPA to a lump-sum payment of \$50,000 and to medical expenses for the accepted illness.
- All federal employees, as well as employees of the DOE, and its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and 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 the 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 an accepted illness as a result of work-related exposure to a toxic substance at a DOE facility. On October 28, 2004, Congress abolished Part D and created Part E as 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:

- DOE contractor and subcontractor employees who develop an illness due to exposure to toxic substances at certain DOE facilities are entitled to medical expenses and may receive monetary compensation of up to \$250,000 for impairment and/or wage-loss.

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. § 7384I(4).

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.

- 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. If the worker had 20 or more years of wage-loss, the survivor receives an additional \$50,000.
- 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 RECA. (These uranium miners, millers, or ore transporters 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, other federal agencies are also involved with the administration of this program.

- 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.
- NIOSH conducts activities to assist claimants and supports the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: (1) developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; (2) developing methods to estimate worker exposure to radiation (dose reconstruction) and using those methods to prepare dose reconstructions for claimants; (3) recommending that classes of workers be considered for inclusion in a SEC class; and (4) providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and SEC petitions.
- 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.

II. The Office of the Ombudsman

Public Law 108-375, which was enacted on October 28, 2004, also established within the DOL an Office of the Ombudsman. The National Defense Authorization Act for 2021, which became effective January 1, 2021, amended the EEOICPA to provide for the permanent extension of the Office of the Ombudsman within DOL. Public Law 116-283, § 3145 (Jan. 1, 2021). The EEOICPA outlines four (4) specific duties for the Office:

1. Provide information to claimants and potential claimants on the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits.
2. Provide guidance and assistance to claimants.
3. Make recommendations to the Secretary of Labor regarding the location of resource centers for the acceptance and development of EEOICPA claims.
4. 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 which sets 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)(2).

Additionally, not later than 180 days after the submission to Congress of the annual report, the Secretary shall submit to Congress in writing, and post on the public Internet website of the Department of Labor, a response to the report that—

- (A) includes a statement of whether the Secretary agrees or disagrees with the specific issues raised by the Ombudsman in the report;
- (B) if the Secretary agrees with the Ombudsman on those issues, describes the actions to be taken to correct those issues; and
- (C) if the Secretary does not agree with the Ombudsman on those issues, describes the reasons the Secretary does not agree.

See 42 U.S.C. § 7385s-15(e)(4).

SUMMARY OF ISSUES AND RECOMMENDATIONS

1. EEOICPA Awareness and Outreach Efforts: Given the COVID-19 pandemic-related challenges to conducting outreach over the past two years, DEEOIC is to be commended for its efforts to provide outreach via monthly online webinars. At ten webinars held in 2021, attendees were provided information regarding various aspects of the EEOICPA, including the roles of specific offices within DEEOIC, the Office of the Ombudsman for the EEOICPA, and the NIOSH Ombudsman. Attendees were also able to submit written, non-case specific, questions to the panelists during each webinar. However, as noted in our 2020 annual report, those with limited or no internet access were unlikely to be aware of the webinars or able to participate in them.

In order to promote awareness of the EEOICPA, our recommendation is for DEEOIC to expand its outreach efforts by coordinating with DOE and the DOE's Former Worker Programs to utilize the FWPs mailing lists of DOE employees. DEEOIC has acknowledged coordination with the DOE FWPs to utilize such mailing lists to notify former DOE workers of in-person outreach events in their area. However, this limited use of the mailing lists should be expanded to provide notice of the EEOICPA to any/all former DOE workers, regardless of their proximity to in-person outreach meetings. Former DOE workers who do not live close to DEEOIC Resource Centers or near locations where in-person outreach events are conducted are much less likely to learn of the EEOICPA. We make this recommendation based upon the need for as many potential claimants as possible to be informed of the EEOICPA in a timely manner.

In response to the 2020 Annual Report to Congress, DEEOIC described its commitment to providing outreach to current and former employees, as well as the surviving family members, of employees of AWE facilities, beryllium vendors, uranium mines, uranium mills, and uranium ore transporters. Without the ability to utilize mailing lists of former workers to connect with these individuals, the challenge of notifying them of the EEOICPA requires greater creativity and, in some instances, resources. Given the positive feedback often received following in-person outreach events, our recommendation is for DEEOIC to plan events in areas of the country where these facilities are located, particularly areas where DEEOIC has previously not hosted events.

2. Medical Billing and Treatment Authorization Issues: The two common threads that developed in our discussions of medical billing and payment issues were: 1) a lack of communication and transparency for claimants and providers when systemic issues were impacting DEEOIC and its bill processing contractors' ability to provide timely service; and 2) the lack of a logical, streamlined process by which claimants and authorized representatives can understand who to contact for assistance and under what circumstances.

When medical bill issues arise, claimants and providers need better guidance and assistance. Many of the medical bill issues that we encountered involved "coding problems." In our experience, simply informing the claimant or provider that there was a coding problem did not provide the claimant or provider with the information needed to resolve the problem. Rather, claimants and providers often needed to be directed to someone who could explain why the code was wrong and the steps to fix it.

In addition, resolving medical bill issues often required explaining the matter to those who were in a position to resolve the issue. The claimants who approached us with medical bill issues often found it frustrating to be placed in the middle of a dispute between DEEOIC, Client Network Services, Inc. (CNSI), and the provider. Thus, in contacting our Office, claimants with medical bill issues oftentimes were simply looking for a way to get the parties involved to talk to each other, as opposed to using the claimant as the intermediary. More effort needs to be undertaken by DEEOIC to work directly with the other parties to resolve coding problems and other medical billing issues.

In 2021, claimants expressed frustration and concerns regarding difficulties in finding a doctor or other qualified health care provider who would accept DEEOIC medical benefits coverage as payment. Claimants who were aware of the Resource Centers sometimes sought assistance there and were directed to an online portal containing contact information for health care providers who have registered to receive payment from DEEOIC. However, some claimants were unsuccessful in searching the database and others were unsuccessful finding the appropriate type of provider in the database. OWCP acknowledged efforts by CNSI and the Division of Administration and Operations (DAO) to conduct general and targeted recruitment activities in the areas identified as being deficient in access to medical providers. It was also shared that CNSI outreach staff conduct enrollment reviews for potential “desert” areas of medical coverage. We are encouraged by this information and encourage DEEOIC to report further on these efforts and the impact such efforts have had to date.

Based upon the cases brought to our attention in 2021, we observed that medical benefits delayed were sometimes medical benefits denied, either because the treating physician had not responded to DEEOIC’s multiple requests for additional evidence, or the claimant was held to a higher standard than required. The common themes in the requests for assistance we received illustrate the need for consistency and efficiency. When one authorized representative complains of receiving letters from different claims examiners and medical benefits examiners on different cases involving similar requests for medical treatment and the development letters from those examiners are quite different, the lack of consistency is concerning. When claimants and authorized representatives continue to reach out to our office not fully understanding why they have not heard back from their claims examiner or medical benefits examiner, the need for greater communication and efficiency is apparent.

- 3. Difficulties with Part E Claims:** The complaints received involving Part E claims in 2021 highlighted the need for better communication between DEEOIC and claimants, as well as increased consistency during the claims adjudication process. The cases brought to our attention involved the use of the Site Exposure Matrices (SEM) database, industrial hygiene reports, and consequential illnesses. Other claimants brought concerns involving the occupational history questionnaire (OHQ) and the Statement of Accepted Facts (SOAF) sent from claims examiners to DEEOIC experts.

The OHQ is a document based entirely upon the claimant’s recollection of his/her own work history at covered DOE facilities, and therefore it is assumed by DEEOIC that the claimant will recall or have all of this information readily available to share, during an interview that sometimes takes hours to complete. While claimants are informed in advance of the topics the OHQ will cover it would be helpful for them to be provided a copy of the OHQ prior to the interview so that they could perhaps take notes or give their responses some thought ahead of time.

Likewise, one of the initial developmental steps taken by a claims examiner in a Part E claim is requesting documentation from DOE with respect to the claimant’s employment at a covered DOE facility. This highly probative evidence, which most claimants are unaware of, would assist them at the earliest stages in the adjudication of their claims to recall more specific information about their workplace history and/or exposures.

Additionally, because some claimants do not know the names of the specific toxins they worked with or around, and may have never seen their DOE personnel records, it would be helpful for them to see what is, and is not, part of their DOE employment files. Incorporating these records into the DEEOIC claim file but not informing the claimant of their existence or providing them a copy, significantly limits claimant access to some of the most personal, probative evidence.

The SEM database is a valuable tool in the adjudication process; however, it must be used as prescribed in the DEEOIC Procedure Manual (PM) or the results may not be accurate. Moreover, SEM database searches that follow the guidance in the PM may reveal additional probative evidence that could impact the outcome of a claim. Consequently, we recommend DEEOIC's performance management branch consider compliance with the SEM database search guidance found in the PM as a topic for individual claim reviews.

Furthermore, when a specific illness or labor category is not listed in the SEM database, it should be clear when the omission from the database is deliberate, i.e., it has been determined that the illness or toxic substance should not be listed in the database. For example, hearing loss and asthma are illnesses that are not listed in the SEM database. This is different from a search of the SEM database that yields no results for a listed illness or toxic substance. Claimants and authorized representatives should be made aware of this distinction in written correspondence and decisions from DEEOIC in order to fully understand the limitations of the SEM database, as well as narrow the focus of claimants and authorized representatives as they seek to obtain evidence to perfect their claims.

Another ongoing area of concern for claimants and their authorized representatives is the continued use of language by DEEOIC contracted industrial hygienists (IH) that is similar in form and intent to the language in rescinded DEEOIC Circular No. 15-06. Many IH expert opinion reports continue to rely upon almost identical language. We recommend this practice be discontinued in accordance with Circular No. 17-04 and the potential for toxic substance exposure in all claims must be evaluated based upon established program procedure and the evidence presented in support of a claim. See EEOICPA Circular No. 17-04, Rescinding EEOICPA Circular No. 15-06, Post-1995 Occupational Toxic Exposure Guidance and its corresponding Program Memorandum dated February 20, 2015 (February 2, 2017). Our recommendation is consistent with the Advisory Board on Toxic Substances and Worker Health's (ABTSWH) November 2016 recommendation which made clear that the language of EEOICPA Circular No. 15-06 should be rescinded with respect to the adjudication of claims under the EEOICPA. See ABTSWH Recommendations Adopted at October 17-19, 2016, Meeting (November 4, 2016).

DEEOIC contractor expert opinion reports are based upon information and evidence that the claims examiner sends to the expert, along with specific questions to be answered by the expert. When an expert opinion report contains incorrect information, it can sometimes be traced back to the information and/or evidence provided to the expert. When incorrect information is incorporated into an expert opinion report, the incorrect information can then be relied upon by subsequent experts and DEEOIC staff. Similarly, failure to provide information or evidence to an expert can produce a less than adequate expert opinion report. And finally, because a claimant's first opportunity to review an expert opinion report is when it accompanies a decision recommending the denial of their claim, some claimants have expressed that it feels as if it is too late to surmount a challenge to the opinion of the expert. We recommend that expert opinions be fact-checked to accurately reflect the evidence of record. We also recommend claimants be provided with a copy of the expert opinion and be provided an opportunity to respond prior to a recommended denial. While it is understandable that errors will be made from time to time, greater consistency in the review of these reports would go a long way towards ensuring such errors are caught early and have not been permitted to perpetuate through the claims adjudication process.

Finally, most claimants are not aware of the fact that they will be required to file a new claim form for any additional new medical conditions, consequential conditions, or compensation they wish to claim. It is our suggestion that DEEOIC further streamline its adjudication process and provide greater transparency to claimants regarding how and why certain medical conditions must be filed separately as consequential conditions. It would also be helpful for claimants to have a separate claim form or a space on the existing Worker's Claim for Benefits Under the EEOICPA (Form EE-1) dedicated solely to claims for consequential conditions.

- 4. Delays, Customer Service, and Other Administrative Issues:** Some of the complaints and concerns relayed to our office in 2021 pertained to the ongoing impact of the COVID-19 pandemic on agencies such as the DOE and Social Security Administration (SSA). Other complaints pertained to the Department of Health and Human Services, National Institute for Occupational Safety and Health's (NIOSH) pause on performing radiation dose reconstructions for claimants with Part B claims. Our office also received complaints regarding delays in DEEOIC's processing of medical treatment authorizations, medical bill payments and compensation payments, as well as issuance of decisions. Moreover, both claimants and authorized representatives complained of insensitive and sometimes rude behavior by DEEOIC or DEEOIC contractor staff, and difficulties interacting with and obtaining assistance through the online portals and databases utilized by DEEOIC.

When a sizable portion of DEEOIC claims were simultaneously impacted because dose reconstructions stopped being processed by NIOSH for a period of time, claimants and authorized representatives found it incredibly frustrating not to receive more case-specific, timely information from DEEOIC. It is our understanding that DEEOIC knew the details of the cases it had referred to NIOSH (or were pending referral) that were impacted by the pause, and therefore the question remains why more was not done to communicate this information directly to affected claimants. Furthermore, as a result of the COVID-19 pandemic's impact on their agencies, both DOE and SSA experienced delays in providing information and/or documentation to DEEOIC. While DEEOIC cannot control the availability of records from other federal agencies, the concern raised by claimants and authorized representatives is that DEEOIC had continued to adjudicate claims without relevant evidence, and in doing so, had not fully informed claimants of the unavailability of records that are routinely provided to DEEOIC. We recommend that DEEOIC inform all impacted claimants and their authorized representatives in writing, ideally in the development letter, when it is unable to obtain evidence from specific agencies. Such notification would prevent claimants from unknowingly spending time and resources requesting information from the agencies unable to provide the documentation and allow them to focus on other ways to potentially obtain evidence.

Claimants are required to submit evidence under specific deadlines set by DEEOIC. However, it appears to be entirely up to the claims examiner to determine what and when information as to the timing of activities in the adjudicatory process will be shared with claimants. We suggest DEEOIC consider sharing with claimants the timelines for the issuance of decisions as well as routinely update claimants regarding the status of their claims, particularly when there are delays in the adjudication process. This would enable claimants to have a reasonable expectation regarding when they would receive a decision or move on to the next phase of their claims adjudication. This would also help claimants to be prepared for the next steps in their claims and less anxious regarding their claim status. Increased communication would create greater transparency and promote greater claimant understanding, as well as trust in the process.

In 2021, DEEOIC created a Customer Experience Team (CX) within the Branch of Outreach and Technical Assistance (BOTA) consisting of a Stakeholder Engagement Analyst and a Customer Experience Strategist. According to DEEOIC, the mission of this team includes soliciting feedback from stakeholders, conducting analysis

of data, and making data-driven recommendations for programmatic and procedural improvements. Consistent with our recommendations in this and previous annual reports to Congress, we encourage DEEOIC to create a single point of contact to receive complaints from stakeholders. Now that DEEOIC has implemented the CX Team, we suggest DEEOIC utilize the CX Team as that single point of contact. This team should, at a minimum, acknowledge receipt of complaints and provide the complainant with a response. In doing so, the single point of contact could help alleviate concerns of retaliation expressed by claimants and authorized representatives despite our assurances that DEEOIC is committed to hearing and addressing their complaints. A single point of contact could give claimants confidence that their complaints would be received, acknowledged, responded to, and kept in confidence.

- 5. Issues Related to Impairment Claims:** Any physician who wishes to provide an impairment rating for a DEEOIC claimant must submit credentials to DEEOIC that verify their qualifications to conduct an impairment rating consistent with the *AMA's Guides to the Evaluation of Permanent Impairment*, 5th edition. It was brought to our attention in 2021 that DEEOIC nurse consultants were analyzing the impairment evaluation reports submitted by physicians whose qualifications to conduct impairment ratings had already been approved by DEEOIC. We are concerned that claimants and their authorized representatives are not being provided copies of notes or guidance provided by nurse consultants as part of the claims adjudication process. Absent the ability to read and potentially rebut the opinion of a nurse consultant, claimants appear to be at a disadvantage as they seek to understand the posture of their claim. Claimants and their authorized representatives find it helpful to be aware of contradictory opinions and/or information that may impact their claim for benefits. Moreover, it is important for them to understand when and who has provided that information and be afforded an opportunity to review and respond prior to a decision being issued in their case.

TABLES

Background

The Office of the Ombudsman is required to submit to Congress an Annual Report that sets forth: (1) the number and types of complaints, grievances, and requests for assistance that we receive in the preceding year, and (2) an assessment of the most common difficulties encountered by claimants and potential claimants received in the preceding year. 42 U.S.C. § 7385s-15(e)(2). Setting forth the number and types of complaints, grievances, and requests for assistance that we receive in the calendar year is often a challenge.

First, each claimant we encounter comes with their own unique set of problems which they articulate to us in their own unique manner. Under these circumstances identifying the type or nature of a complaint can be difficult since claimants rarely express their concerns using the terms and phrases commonly utilized by those who administer the program.

Second, the Office typically attends 20-25 in-person outreach events each year, and at those events we hear from many potential claimants, claimants, authorized representatives (AR), and health care providers. Meeting in person affords us the time to connect with individuals and hear not only their initial questions or concerns, but their whole story, which frequently reveals additional questions, concerns, and requests for assistance. During 2021, as a result of all in-person outreach events being cancelled, our opportunities to connect with and to assist the claimant community at in-person outreach events were eliminated.

Moreover, when our Office hosts in-person outreach events, we routinely provide notice to those living in a large geographical area around each event location. While those who live farther away from the event location may not be able to attend the event itself, we have found that many people contact our Office by telephone or email after receiving notice of the event. And it is in these conversations that we also hear the questions and complaints of claimants in that particular area of the country. Furthermore, identifying the specific complaints, grievances, and/or requests for assistance raised by claimants is generally achieved by asking questions, and obtaining additional documents that shed light on the claimants' concerns. Unfortunately, the inability of our Office to attend or host in-person outreach events had an impact on the number of individuals we communicated with and assisted in 2021.

In the table that follows, the focus is on the concerns or requests that prompted the claimant to contact us, not every issue that was discussed in the conversations that ensued in order to provide the claimant with a full understanding of the EEOICPA and the EEOICPA claims process.

TABLE 1**COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE BY NATURE OF COMPLAINT**

| NATURE OF COMPLAINT | NUMBER OF COMPLAINTS |
|---|-----------------------------|
| Difficulties collecting records/evidence | |
| Employment records | 8 |
| Exposure records | 11 |
| Concerns with the dose reconstruction | 4 |
| Concerns with information found in SEM | 6 |
| Difficulties establishing terminal status | 4 |
| Difficulties establishing causation | 27 |
| Request for assistance | 48 |
| Request for status of claim | 26 |
| Issues involving interactions with staff of DEEOIC | |
| Telephone calls not returned/cannot get through | 23 |
| Rude and/or insensitive behavior | 9 |
| Complaints involving claims for impairment | 13 |
| Complaints regarding Contract Medical Consultants and Industrial Hygienists | 15 |
| Complaint concerning the cap on benefits | 1 |
| Requests for assistance with issues concerning RECA claims | 1 |
| Medical Benefits | |
| Difficulties obtaining authorization for and/or complaints regarding the denial of a requested medical benefits | 12 |
| Issues involving home health care benefits | 13 |
| Complaints alleging a delay in the processing of a claim | 23 |
| Claimant needed assistance verifying that he/she was a covered employee or worked at a covered facility | 5 |
| Difficulties establishing survivor eligibility | 6 |
| Difficulties establishing eligibility in a SEC class | 2 |
| Difficulties obtaining payment of a medical bill | 34 |
| Difficulties with use of medical benefits card | 13 |

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TABLE 1, cont'd.

| NATURE OF COMPLAINT | NUMBER OF COMPLAINTS |
|---|-----------------------------|
| Difficulties establishing diagnosed illness/consequential illness | 8 |
| Reopening/Reconsideration issues | 5 |
| Take home toxins | 1 |
| Miscellaneous | 26 |
| TOTAL | 344 |

TABLE 2

COMPLAINTS BY FACILITY

In order to assist claimants, it is not always necessary to identify the facility where the worker was employed. Moreover, even when identifying the facility is necessary, this does not suggest any fault on the part of the facility. Rather, the intent of the Table of Facilities is to illustrate the reach of this program and the need for more outreach. Claimants who worked at facilities all across this country contact us with complaints, grievances, and requests for assistance. Some of the facilities on this Table employed large numbers of employees, while others employed smaller numbers. Some operated as covered facilities for many years, while others engaged in covered employment for a relatively short period of time. Yet, regardless of the size of the facility or the number of years it operated as a covered facility, there are those who work, or once worked, at these facilities, who have questions and concerns that need to be addressed.

| FACILITY | LOCATION | NUMBER OF COMPLAINTS |
|--|-------------------------|----------------------|
| Amchitka Island Test Site | Amchitka Island, AK | 1 |
| Area IV of the Santa Susana Field Laboratory | Santa Susana, CA | 6 |
| Electro Metallurgical | Niagra Falls, NY | 1 |
| Feed Materials Production Center | Fernald, OH | 4 |
| General Electric Company | Cincinnati/Evendale, OH | 1 |
| Hanford | Richland, WA | 11 |
| Idaho National Laboratory | Scoville, ID | 5 |
| Kansas City Plant | Kansas City, MO | 1 |
| Kerr-McGee | Crescent, OK | 1 |
| Lake Ontario Ordnance Works | Niagara Falls, NY | 1 |
| Los Alamos National Laboratory | Los Alamos, NM | 2 |
| Nevada Test Site | Mercury, NV | 1 |
| Oak Ridge | Oak Ridge, TN | 1 |
| Oak Ridge Gaseous Diffusion Plant (K-25) | Oak Ridge, TN | 4 |
| Oak Ridge National Laboratory (X-10) | Oak Ridge, TN | 3 |
| Oak Ridge Y-12 Plant | Oak Ridge, TN | 4 |
| Ore Buying Station at Grants, NM | Grants, NM | 1 |
| Pacific Proving Ground | Marshall Islands | 1 |
| Paducah Gaseous Diffusion Plant | Paducah, KY | 7 |
| Pinellas Plant | Clearwater, FL | 1 |
| Portsmouth Gaseous Diffusion Plant | Piketon, OH | 6 |
| Rocky Flats Plant | Golden, CO | 3 |

table continued on next page

TABLE 2, cont'd.

| FACILITY | LOCATION | NUMBER OF COMPLAINTS |
|-------------------------|-------------------|-----------------------------|
| Savannah River Site | Aiken, SC | 8 |
| Simonds Saw & Steel Co. | Lockport, NY | 1 |
| Uranium Mines | Various Locations | 2 |
| TOTAL | | 77 |

CHAPTER I.

EEOICPA AWARENESS AND OUTREACH EFFORTS

For individuals who worked, or continue to work, in service of our nation's nuclear weapons program, awareness of the EEOICPA is contingent upon a variety of factors, including where they worked, when they worked, and whether they continue to live in the vicinity of the nuclear weapons facility/employer. A primary means of learning of the EEOICPA has been in-person outreach efforts conducted by DEEOIC, the Joint Outreach Task Group (JOTG)³, and associated federal agencies. Unfortunately, in 2021, the COVID-19 pandemic continued to prohibit all in-person outreach efforts. As in 2020, DEEOIC maintained a schedule of monthly webinars. In total, DEEOIC hosted ten webinars from January through October 2021, with the Offices of the Ombudsman for the EEOICP and NIOSH providing the content for one of the webinars. These webinars afforded attendees an opportunity to learn about specific EEOICPA-related topics and pose written questions to the panelists. However, it is unlikely those without reliable internet access learned of the webinars or were able to attend. This is particularly true for areas of the country where internet service is spotty or for those who cannot afford internet service or the devices necessary to participate in online events. Claimants of advanced age have also frequently informed our office that they do not own or use personal computers or other such devices.

In addition to the lack of in-person outreach events in 2021, DEEOIC Resource Centers were also closed to visitors through April, which prevented claimants and potential claimants from receiving in-person assistance. In approximately May of 2021, the Resource Centers reopened to visitors by appointment only and remained in that posture through the end of 2021. While necessary, such limitations undoubtedly impacted the ability of claimants and potential claimants who live in the vicinity of one of the eleven Resource Centers to stop in to speak with Resource Center staff and/or review documents with them. Thus, the unprecedented challenges of providing in-person contact in 2021 returned our attention to the ongoing need for alternative avenues of outreach to inform as many potential claimants as possible of the existence of the EEOICPA.

Regardless of the circumstances, one of the most effective ways for potential claimants to learn of the EEOICPA is to be notified directly. By way of background, since 2013 this office has reported about DOE employee rosters maintained by the Department of Energy's Former Worker Medical Screening Programs (FWP) that have been utilized to notify potential EEOICPA claimants of in-person outreach events.⁴ See Office of the Ombudsman 2013 Annual Report to Congress, p. 16 (August 12, 2014). Our office has consistently recommended that DEEOIC, the DOE and the DOE FWPs work together to more broadly utilize these rosters to directly inform any/all potential claimants of the existence of the EEOICPA, regardless of whether an outreach event has been scheduled near them.

To put the issue in context, beginning in 2014, DEEOIC seemingly refuted that updated DOE rosters existed, stating,

Unfortunately, neither DOL nor DOE has access to the current addresses of many employees who worked for the hundreds of contractors and subcontractors in the nuclear weapons complex starting in 1942. In fact, no such compilation of updated addresses is known to exist so direct outreach to potential claimants could not be done. See DOL's Response to the Ombudsman's 2014 Annual Report to Congress, p. 2 (October 14, 2016).

³ The Joint Outreach Task Group is comprised of DEEOIC, DOE, DOE FWPs, DOJ, NIOSH, the Office of the Ombudsman for the EEOICPA, and the Ombudsman for NIOSH.

⁴ The DOE employee rosters have primarily been used by the FWPs to communicate the opportunity for free medical screenings to former DOE workers.

DEEOIC's refutation was confusing in light of the 2014 DOE FWP Annual Report which stated,

To locate former workers who may be eligible to participate in the [FWP] program, EHSS works closely with DOE Headquarters program offices to obtain rosters of former workers from site contractors, as well as field and site offices. Rosters are lists of names, along with other identifying information, of former DOE workers that may be available from employers or DOE.

Invitations are sent by the FWP projects to employees on the rosters they receive from DOE, using the last known addresses. When addresses are found to be outdated or inaccurate, supplemental outreach methods are used by FWP projects; these include address-update services, such as credit bureaus, or Internal Revenue Service mailing services. [T]he availability of rosters varies greatly by site.

The FWP projects provided support for seven outreach events sponsored by DOL. The assistance included mailing invitations to former workers regarding the upcoming events, distributing outreach materials for the events in the local communities, locating facilities where the events could be held, as well as having FWP project staff attend the events to support DOL and provide information regarding the FWP. See Former Worker Medical Screening Program 2014 Annual Report, p. 5-6, 18.

Over the years, our office continued to recommend in each annual report to Congress that DEEOIC work in conjunction with DOE and the DOE FWPs to send notices and information regarding the EEOICPA directly to former workers. DEEOIC's responses to such recommendations have pointed to the other forms of outreach it conducted⁵; to its inability to use the mailing lists and rosters due to privacy concerns⁶; its reliance upon the FWP mailing lists when appropriate for an outreach event⁷; and to utilizing the mailing lists to send more than 54,300 invitations, letters and postcards⁸.

In their response to the Office of the Ombudsman's 2020 Annual Report to Congress, the Office of Workers' Compensation Programs (OWCP) and DEEOIC stated they would continue to look for ways to conduct more in-person outreach as the pandemic comes to a close and would work with the former worker programs to have targeted mailings advertising such outreach events in order to reach those without internet access. See OWCP Response to the Office of the Ombudsman's 2020 Annual Report to Congress, p. 2 (December 29, 2021). DEEOIC's intention to work with the FWPs to conduct targeted mailings for outreach events remains helpful but is insufficient when limited to advertising in-person outreach events which may not be feasible due to pandemic concerns or limited resources. Therefore, the Office of the Ombudsman again recommends coordination between DEEOIC and the DOE FWPs to provide notice and information directly to former workers (potential claimants) for whom the DOE FWPs have updated mailing lists and/or employee rosters.

It is important to note that the FWP 2014 Annual Report indicated that as of September 30, 2014, the FWP projects had attempted to contact over 800,000 potential FWP applicants. See Former Worker Medical Screening Program 2014 Annual Report, p. 6. On the other hand, DEEOIC customarily only sends invitations to individuals who have already filed a claim for benefits and the scale of such contacts on an annual basis is smaller than that reported by the FWPs. It is our belief that over the past two decades, had DEEOIC forged an agreement or understanding with the DOE FWPs to mail notices and information directly to all the former workers on its rosters, it is likely that far more individuals and/or their survivors would have learned of the EEOICPA.

⁵ See DOL's Response to the Office of the Ombudsman's 2015 and 2017 Annual Reports to Congress.

⁶ See DOL's Response to the Office of the Ombudsman's 2016 Annual Report to Congress.

⁷ See DOL's Response to the Office of the Ombudsman's 2018 Annual Report to Congress.

⁸ See DOL's Response to the Office of the Ombudsman's 2019 Annual Report to Congress.

Based upon the feedback and complaints received by our office, for those potential claimants who do not reside within the mailing radius to receive notice of an in-person outreach event, the effect is that they may never learn of the EEOICPA or may be delayed in learning of the EEOICPA. These individuals face a number of consequences as the result of delayed notification of the EEOICPA, including being unable to obtain medical and/or employment records that are necessary to prove their claim.⁹ Moreover, coverage for medical benefits under the EEOICPA does not begin until the date the claim for benefits is filed. Therefore, the longer it takes an individual to file a claim, the less medical benefits coverage that person is entitled to for an accepted medical condition. Finally, by virtue of statutory limitations, some children of former workers who filed claims for survivor benefits are ineligible for benefits under Part E, and such limitations would not have negatively impacted a claim filed by the former worker and/or their surviving spouse had they received prompt notice of the EEOICPA.

As in 2020, our recommendation is for DEEOIC to expand its efforts to directly contact those who do not live within the mailing radius for an in-person outreach event by contacting them directly utilizing the DOE FWP rosters. While contacting as many of the thousands of former workers as possible is the goal, it is one that can be achieved in stages with thoughtful planning and hopefully with the highest priority given to those areas where no outreach has been conducted to date. Given the challenges of the past two years it is imperative for DEEOIC to move beyond its previous efforts to provide timely notice of the EEOICPA to all workers and their families.

Unfortunately, the DOE does not have rosters for those who worked at Atomic Weapons Employer (AWE) facilities or for Beryllium Vendors. This means that DEEOIC cannot rely upon DOE for assistance in contacting the current and former workers of these 193 AWE facilities or 74 beryllium vendors.¹⁰ As such, our Office encourages DEEOIC to continue expanding its outreach efforts directly to those who worked for these employers.

⁹ It is our understanding that most hospital and medical providers follow record retention laws set by the state and many of these laws do not require retention of records beyond 5-7 years.

¹⁰ The DOE created a Facility List database to provide public access to summaries of information collected on the facilities listed in the Federal Register. The summary for each facility includes the facility name, state, location, time period, facility type, and facility description. <https://ehss.energy.gov/Search/Facility/findfacility.aspx>.

CHAPTER II.

MEDICAL BILLING AND TREATMENT AUTHORIZATION ISSUES

Claimants appreciate and value the EEOICPA medical benefits coverage for accepted covered illnesses. Medical benefits coverage begins on the date a claim is filed for an illness that is later accepted under Part B or Part E and covers all related medical expenses without co-payments or deductibles. Unfortunately, over the past few years, claimants have begun to question the value of this benefit considering the growing list of hurdles they must sometimes overcome in order to receive authorization for medical treatment and/or payment of medical expenses. Claimants also question the value of DEEOIC medical benefits when they are unable to find a physician, hospital, home health care company, or other medical provider to treat them who will participate in DEEOIC medical benefits processes.¹¹ In addition, claimants, their family members, authorized representatives, and health care providers filed complaints with our office in 2021 regarding what was described by one as a byzantine struggle for information and assistance.

The EEOICPA states that a claimant with an accepted covered illness shall be furnished with the services, appliances, and supplies prescribed or recommended by a qualified physician for a covered illness that the President considers likely to give cure, relief, or reduce the degree or period of that illness. See 42 U.S.C. § 7384t(a). The EEOICPA also provides for necessary and reasonable transportation and expenses incident to the securing of such services, appliances, and supplies. See 42 U.S.C. § 7384t(c).

For the past ten years, claimants have complained of difficulties finding health care providers, as well as what some have characterized as a decline in the number of health care providers who accept payment for medical services from the DEEOIC.¹² As discussed in our 2020 Annual Report to Congress, the transition to a new medical bill processor for the payment of all non-pharmacy related medical bills resulted in confusion and significant delays in payments.¹³ Problems with the new medical bill processor for DEEOIC continued into 2021. And finally, for claimants and authorized representatives seeking assistance with obtaining authorization for medical treatment or payment of medical bills, our office received complaints regarding difficulties in identifying and communicating with those who could provide meaningful assistance.

A. Complaints Related to the New Medical Billing Contractor

In April 2020, DEEOIC transitioned to a new medical bill processing contractor, CNSI. As discussed in the 2020 Annual Report to Congress, the transition did not go quite as smoothly as planned and our office received complaints from various stakeholders. In 2021, a little over a year following the transition to CNSI, our office received a complaint from a large health care system comprised of multiple hospitals. The health care system's accounting office stated that their collective hospitals had almost \$20 million dollars in unpaid claims and that much of the unpaid amounts related directly to CNSI computer programming issues that had not been disclosed. Because the health care system had already engaged with CNSI in an effort to resolve the problems, a detailed description of their issues was provided to the Office of the Ombudsman as follows:

¹¹ Depending on the type of medical treatment recommended, the claimant and their physician may have to engage in a process to obtain authorization from DEEOIC for the claimant to receive the treatment.

¹² See 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, and 2020 Office of the Ombudsman Annual Reports to Congress. <https://www.dol.gov/agencies/ombudsman>

¹³ In April 2020, DEEOIC transitioned to a new medical bill processor, CNSI, but maintained its contract with Conduent for processing claims for prescription medication.

Our office received notification that we could begin submitting electronic claims to CNSI in August of 2020... After attempts to submit electronic claims for several months, we questioned why these claims were consistently rejected. In January 2021, we discovered through our claims clearing house vendor that no provider in the United States had successfully submitted and received payment on an electronic claim through CNSI.

In April [2021], CNSI representatives agreed to have regular calls (twice a week) to work through claims processing issues...In the interim, CNSI offered to implement a process to circumvent the issue that entailed CNSI manually adding information to electronic claims to force them through their system. This process has proved cumbersome and difficult to monitor.

Prior to getting CNSI's acknowledgment and workaround, any provider wishing to have claims processed and paid by CNSI was forced to revert to a paper claim and medical records submission. This process is extremely costly and time consuming in labor, paper, and postage. Many medical records are hundreds of pages, and we must send certified mail. We ended up submitting nearly a thousand claims via paper as we could not get electronic claims to process with CNSI. In addition, due to CNSI losing portions of multiple-page claims, their representatives advised our office to suspend submitting multiple-page claims. Multiple page claims inherently contain large volumes of services, representing greater charges for services. Stopping these claims meant providers had no claim submission alternative for those higher cost services.

The transition to CNSI has proven a significant undue burden on healthcare providers who are treating the employees covered under the DOL workers compensation program. (April 2021 email from health system executive.)

The complainant confirmed during a subsequent communication that EEOICPA claims represented a large portion of their outstanding claims, for example, of 709 outstanding claims between April 1 and April 29, 2021, 667 were EEOICPA claims.¹⁴ It was also shared that the number would be much larger if all outstanding claims prior to April 1, 2021, and all outstanding Conduent claims were included.

In addition to health care providers, authorized representatives and claimant advocates brought their concerns regarding payment of medical bills to OWCP, DEEOIC, and our office in 2021. Their perception was that DEEOIC views these issues one-at-a-time and suggested that instead it would be useful for DEEOIC and CNSI to audit bill processing performance, identify areas of wasted energy and repeatedly denied bills, and take affirmative action to get ahead of the issues rather than putting out individual fires. (May 20, 2021, letter from Alliance of Nuclear Worker Advocacy Groups (ANWAG) to the Director of OWCP.) They also provided examples of outstanding medical bills that had been referred to collection agencies despite the efforts of authorized representatives to resolve the issues with DEEOIC and CNSI. OWCP responded, in part, that "...neither DEEOIC nor OWCP can control a provider's decision to institute collections efforts against a claimant when bill payment is delayed. DEEOIC, DAO, and CNSI have been working diligently to resolve identified issues with the bill payment process and have been working one-on-one with many providers to help them resolve issues with their internal billing systems and protocols." (July 13, 2021, correspondence from OWCP to ANWAG.) OWCP further stated, "Under DEEOIC regulations, OWCP is the first biller for medical services related to an accepted clam. Neither OWCP nor CNSI are able to address billing issues that stem from a provider's decision to bill other carriers rather than the primary payer on accepted cases." (July 13, 2021, correspondence from OWCP to ANWAG.) While the responses

¹⁴ CNSI, Inc. is the medical bill processing contractor for all OWCP programs, which includes the Federal Employees' Compensation Act (FECA) Program, the Longshore and Harbor Workers' Compensation Act Program, and the Black Lung Benefits Program.

from OWCP are accurate, claimants and authorized representatives reported that it would nonetheless be helpful to receive additional assistance from DEEOIC and CNSI when their outstanding medical bills were referred to Medicare, private insurance, or collections.

Another institutional provider contacted our office for assistance when they began to see an increasing number of medical bill claims denied as “procedures not related” to a covered illness. The provider noted,

We appeal these without success showing the eligibility or CPT/Crosswalk and have called repeatedly but the customer service representatives will not send claims back for review saying we must complete an online adjustment even when there is not an adjustment to make. They do not have many answers to our questions. Processing of claims has changed completely with the change to CNSI, and not in a good way unfortunately, and we would appreciate some information about how we can help the difficulties with getting these claims processed that are supposed to be processed by the DOL. (May 19, 2021, email from health care provider.)

A physical therapy provider reached out to complain after receiving authorization to provide treatment for multiple claimants from an MBE but later learned that the bills for treatment had been denied by CNSI. The provider indicated that when they were able to reach someone at CNSI, they were informed that the claims had been escalated, only to find out later that they had not. In contacting our office, the provider conveyed that it was most frustrating not knowing who to contact outside of CNSI for help. It seemed to this provider that CNSI was not familiar with DEEOIC policies and procedures. While continuing to provide services to claimants with authorization for physical therapy, the associated delays in payment had an impact on the provider’s ability to meet payroll. The provider also alluded to software problems with CNSI and inquired if our office was aware of any such problems.

Later in 2021, an authorized representative contacted our office with over \$15,000 in unpaid, out-of-pocket nursing home expenses and seeking assistance to determine why CNSI was taking so long to pay the bills. The authorized representative relayed that he/she had made numerous telephone calls to CNSI and to the DEEOIC MBE and that while the MBE was able to assist him/her with some previous bills, the MBE was now no longer responsive. Moreover, CNSI repeatedly informed the authorized representative that the paperwork submitted with the medical bills was correct and that the bills were “in process.” However, the payments were not received by the claimant, and the authorized representative found that the CNSI personnel who answered customer service questions were unable to provide an explanation regarding his/her specific billing issues. The CNSI personnel purportedly described their role as “simply a call center” and unable to provide more in-depth assistance. It was the authorized representative’s observation that the only input CNSI had into the process was to refer a bill back to another office for review and to repeatedly delay payment to the person entitled to DEEOIC benefits. (September 8, 2021, email from authorized representative.) With the permission of the authorized representative, our office sought assistance from DEEOIC. It is our understanding that the outstanding bills were ultimately paid, but we were not informed of the exact nature of the problems nor the process by which they were resolved.

And finally, an authorized representative for a claimant with neuropathy contacted us after three of his/her medical bills were rejected by CNSI. According to the Workers’ Compensation Medical Bill Process (WCMBP) online portal the claimant’s approval codes were accurate but the billing codes for services rendered were rejected, and the provider was allegedly unable to speak with anyone at CNSI who could assist them. The provider had informed the authorized representative that the claimant’s family would have to pay out-of-pocket if payment were not received from DEEOIC prior to the next billing cycle. It was unclear why CNSI was not able to directly assist the provider and/or authorized representative. It was also unclear whether CNSI had contacted DEEOIC for assistance or clarification of any relevant billing information.

B. Inadequate Assistance with Medical Bill Coding Issues

Medical bill coding issues are some of the more complex problems for claimants to understand, let alone resolve. However, when a claimant's name is on the medical bill and it remains unpaid, regardless of the reason, they are held responsible for payment. In 2021, we received complaints regarding coding issues in a variety of cases with the following general scenarios:

- the health care provider made an error in the medical bill coding.
- the health care provider used an ICD-10 code for a covered illness that had been accepted under an ICD-9 code.
- complete and accurate coding was not entered into the DEEOIC database.
- the transition from Conduent to CNSI impacted the codes appearing as accepted.
- CNSI programming rejected all codes submitted electronically for a period of time.

For some claimants, more than one of the scenarios listed above were at play in their claim, and for all claimants, assistance was necessary to resolve the problem. One claimant had two identical procedures performed on the same day for two accepted cancers. The bills were rejected by DEEOIC/CNSI and ultimately referred for collection. Claimant's authorized representative was unable to determine the specific reason for the denial and later received detailed information from DEEOIC to relay to the health care provider. Unfortunately, the health care provider had already referred the outstanding bills to Medicare, which added another level of complexity to the requirements set forth to resolve the problem.

Another claimant had a number of billing issues related to ICD coding problems. The claimant believed the problems had been resolved until they began to receive collection notices. It appeared the problem stemmed from both the conversion/migration to CNSI as well as the provider using an incorrect ICD code. In two other cases outstanding medical bills were sent to collections by the health care providers. In one case, CNSI did not have the correct ICD-10 code assigned to the claim by DEEOIC. In the other case, the provider did not use the correct ICD-10 code for the accepted medical condition. The Resource Center was solicited to provide assistance with the coding issues in these cases and endeavored to bring DEEOIC, CNSI and the provider onto the same page in order to resolve the issues. The ultimate outcome of the Resource Center's efforts was not reported to our office.

One authorized representative brought to our attention the fact that while the Workers' Compensation Medical Bill Processing Portal permits claimants to view medical eligibility, authorization, case status and bill status, it appeared to him/her as if the system was not designed for claimants to self-diagnose billing issues. Likewise, the authorized representative conveyed that it did not seem as if the Resource Center staff, who always strive to be helpful, were trained to identify and address the specific coding issues that were at the root of some of the rejected medical bills. It was reported that while the Resource Center staff did provide information and direction for claimants when they spoke to their health care providers, MBEs, and/or CNSI, it would be helpful for a more systemic approach to be implemented with an eye towards more instruction and proactive involvement of the Resource Center or other relevant DEEOIC offices.

The problem of outstanding medical bills being referred to collection agencies was an issue that became more apparent in 2021. For claimants and their families who are navigating the health care system in order to receive timely and appropriate medical treatment for a covered illness, the appearance of a collection notice from one of their health care providers was a cause of immediate, added stress. While some may question why a claimant would consent to pay a deductible or co-payment to Medicare or a private insurance company for medical services that are covered 100% under the EEOICPA, the answer becomes a bit clearer when it is understood that the alternative may mean spending significant time and energy delving into the world of medical bill coding and/or frequent communication with the various offices that play a role in medical bill processing, not to mention the threat of ruined credit that has a broader impact on the claimant and their family.

C. Difficulties Obtaining Assistance with Medical Billing

Ultimately, each outstanding medical bill from a hospital, physician, or other medical provider represents an EEOICPA claimant whose medical bills are unpaid. The challenge for claimants and providers alike is determining how to resolve unpaid bills. It is our understanding that some health care providers worked directly with CNSI and Conduent regarding billing issues, yet others processed the outstanding bills through other insurance such as the claimant's private health insurance or Medicare. Other providers referred outstanding bills to collection agencies. It has been our experience that when claimants learn of outstanding medical bills that they believe should have been paid by DEEOIC, they are uncertain who to contact for assistance. Some claimants contact their claims examiner or medical benefits examiner. Others may contact a Resource Center or CNSI/Conduent directly. And others contact our office when they do not know who to contact or feel they have been given the run-around.

In 2021, claimants continued to report feeling that they were "getting the run-around" because they were unable to speak to someone who could promptly resolve their problem, or they were informed that they needed to speak to another person or another office. Frequently claimants who contacted our office had been informed to have another party take action to resolve the problem, but upon contacting that party were informed that the party did not have all the information needed to address the problem or did not know how to address it.

Another point made to our office was, "...many claimants and medical providers decide to [submit] medical bills through Medicare or private insurance rather than dealing with DEEOIC's bureaucracy. They would rather pay their Medicare/private insurance deductible and co-pay than deal with the often, lengthy process with DEEOIC." May 20, 2021, letter from Alliance of Nuclear Worker Advocacy Groups (ANWAG) to the Director of OWCP.

At least two claimants who contacted our office seeking assistance in 2021 had received letters from Medicare regarding medical bills paid by Medicare for treatment that Medicare believed was related to their accepted covered illnesses under the EEOICPA. The claimants were somewhat relieved when we informed them of Circular 21-01, Reimbursement Letter to Government Entities or Insurance Carriers (August 4, 2021). Upon receiving correspondence from a claimant, this circular instructs the payment systems manager of the DEEOIC Medical Bill Processing Unit to send a letter to the government entity (e.g., Medicare) or the private insurance carrier instructing them to submit all reimbursable charges, including a copy of the original bill and proof of payment, to the bill-processing contractor (CNSI). This letter should allow for DEEOIC to obtain the necessary documentation to reimburse the government entity or insurance carrier for any medical bills related to claimant's accepted covered illness(es). However, since informing the claimants of this circular we have yet to learn whether DEEOIC has written such letters to a government entity or private insurance carrier, or whether DEEOIC has reimbursed Medicare and any other private insurance company for payments related to accepted covered illnesses.

A claimant with a consequential illness that resulted in the complete loss of his/her teeth contacted us when the completion of the dental restoration procedures was cancelled due to the amount of unpaid invoices for prior treatment. The claimant indicated he/she was unable to eat properly, and that his/her nutrition and health status was impacted by the delayed treatment. After the claimant's authorized representative contacted our office for assistance the provider was informed by DEEOIC that the issue involved the type of form the provider had used to submit the medical expenses. It is unclear how many patients with DEEOIC medical benefits coverage are treated by this provider, but it is apparent that the claimant, the claimant's authorized representative, and the provider were unable to identify the nature of this issue and find the solution absent DEEOIC's assistance.

We also heard from a claimant who in November 2020 received medical tests as part of the impairment evaluation process for his/her accepted illness. Our office was contacted in April 2021 after the claimant received a \$1,700 bill in the mail for those medical tests. The claimant explained that prior to obtaining the tests DEEOIC had specifically authorized them. However, unbeknownst to the claimant, the licensing information for the health care provider had expired and therefore CNSI denied payment for the bills. The next few months involved communication between the claimant, our office, the DEEOIC Medical Bill Processing Unit and the health care provider before the bill was eventually paid in mid-August 2021. Prior to contacting our office, the claimant had no understanding of the issue or how to get it resolved. We appreciate the efforts of the Medical Bill Processing Unit in this case and hope that similarly situated claimants receive assistance in resolving such issues.

The two common threads that developed in our discussions of medical billing and payment issues were, 1) a lack of communication and transparency for claimants and providers when systemic issues were impacting DEEOIC and its contractors' ability to provide timely service; and 2) the lack of a logical, streamlined process by which claimants and authorized representatives can understand who to contact for assistance and under what circumstances.

During the time period from April 2020 through December 2021, we are unaware of any information displayed on the DEEOIC homepage regarding systemic issues that were impacting DEEOIC or its medical bill processing agent's ability to provide timely service. Likewise, we are unaware of any information available to claimants other than the instruction to contact a Resource Center when they have medical billing questions or send an email to DEEOICbillinquiries@dol.gov.¹⁵ Unfortunately, while the Resource Center staff does what it can to assist claimants, in our experience it is not uncommon for the resolution of medical billing issues to also involve assistance from MBEs, Medical Bill Processing Unit managers, CNSI staff, Conduent staff, and/or the medical provider's billing staff. The claimant is the least experienced person in this equation yet suffers the consequences when those involved do not assist in resolving the problem in a timely manner.

D. Difficulties Finding and Keeping Health Care Providers

The matter of finding a health care provider who can provide timely, competent care is of paramount importance to those with illnesses accepted under the EEOICPA. Most claimants had access to some level of health care in order to receive the diagnosis of an illness, however, fewer already have relationships with the specialty health care providers required to treat their illness. And an even smaller percentage already have relationships with home health care provides, durable medical equipment providers, and/or nursing homes. Claimants may access a portal on the DEEOIC website to see names of health care providers who have enrolled to receive payment from DEEOIC, and the Resource Centers have committed to directing claimants to this information on the DEEOIC website as well. However, some claimants were unsuccessful in searching the database and others were unsuccessful in finding the appropriate type of health care provider in the database. Despite the availability of this information on the DEEOIC website, our office received complaints from claimants and authorized representatives in 2021 who reported difficulties finding and keeping health care providers who accepted payment from DEEOIC.

¹⁵ This DEEOIC billing inquiries email address is not available on DEEOIC's website but was shared by DEEOIC during the question-and-answer session of the DEEOIC 2021 Stakeholder Update Webinar on July 14, 2021. It would be helpful to claimants and health care providers if this email address was displayed on DEEOIC's website as an additional contact/resource.

A claimant residing in Alaska reported a four-hour trip each way for medical care that was complicated when “no one wants to take the DEEOIC card.” The claimant described spending significant time on the telephone trying to reach various providers who accepted payment from DEEOIC. He/she also described providing the DEEOIC medical benefits card at hospitals only to be informed that the provider would instead bill Medicare or his/her private health insurance. Another claimant relocated from California to Texas and contacted our office when he/she did not know how to find medical facilities in the area that accepted payment from DEEOIC. And finally, a claimant contacted our office after unsuccessfully attempting to find a home health care provider in his/her area. When we directed claimant to the DEEOIC portal the claimant indicated the portal did not contain the names of any such providers in his/her area. In this situation we suggested the claimant contact the Resource Center or MBE for further assistance.

When claimant advocates and authorized representatives brought these issues to the attention of OWCP, they received the following response,

The OWCP Division of Administration and Operations (DAO) oversees the contractual requirements of the central bill processing vendor, CNSI. Contractual responsibilities include, but are not limited to, provider and claimant outreach activities. Although stakeholders have raised the topic of providers’ reluctance to register or accept the Medical Benefits Identification Card (MBIC) during DEEOIC presentations or outreach events, DAO has not received any communication from claimants or medical providers regarding the above-referenced issues. DEEOIC, CNSI, and DAO staff work closely to ensure that OWCP claimant and provider enrollment concerns are addressed in an efficient and effective manner. Claimants and providers who contact DEEOIC or the DEEOIC Resource Centers to request help will receive one-on-one assistance with the registration and billing problems they present. In addition, CNSI outreach staff conduct and report weekly on their analysis of issues encountered via the IVR call center and incoming provider/claimant email communications. Quality control measures have been instituted via DAO staff review of incoming email communications submitted to the CNSI outreach email.

With regard to recruitment of medical providers, CNSI and DAO are active in conducting general and targeted recruitment activities in areas identified as being deficient in access to medical providers/services. These areas are identified via the process referenced above and by the OWCP program reporting deficiency and need to DAO and/or CNSI. Additionally, CNSI outreach staff conduct enrollment reviews for potential “desert” areas of medical service coverage. (July 13, 2021, correspondence from OWCP to ANWAG.)

This acknowledgment of the issues by OWCP is constructive and following this correspondence the authorized representative and claimant community have expressed interest in learning more about the efforts undertaken by CNSI and DAO to address these issues.

E. Difficulties and Delays in Receiving Medical Care

As is often the case, when a claimant or their authorized representative contacts our office with what appears to be one question or concern, by the end of the conversation it is apparent that there are multiple issues. This is particularly true when we are contacted by those with questions or concerns regarding authorization for medical treatment. The following are examples of claimants who contacted our office in 2021 and had multiple questions and concerns regarding their receipt of medical benefits and requested assistance after their efforts to receive assistance elsewhere had fallen short.

A claimant with laryngeal cancer contacted our office after his/her electrolarynx broke, rendering him/her unable to speak. The claimant's claims examiner directed the claimant to work with a medical benefits examiner to obtain a replacement electrolarynx. Because the original electrolarynx had been covered by the claimant's EEOICPA medical benefits, the claimant expressed frustration that it took months for him/her to secure a new one. The claimant explained that the supplier of the device contacted the MBE on his/her behalf and was informed the claimant's treating physician was required to write a letter of medical necessity before authorization for the replacement would be granted. This process was confusing and frustrating for the claimant whose efforts to assist in providing the requested documentation to DEEOIC were further hampered by his/her lack of a printer or fax machine.¹⁶ Although not the initial reason for contacting our office, the claimant also shared that he/she had requested home health care benefits on August 3, 2021, and had not received a response by September 28, 2021. On October 4, 2021, after an inquiry was submitted by our office the claimant's home health care benefits were approved.

In mid-July 2021, a claimant's spouse contacted our office for assistance with home health care benefits for a claimant who had lung cancer with metastasis to the brain. The claim for home health care benefits had been filed on June 11, 2021, and the claimant's condition was terminal. The claimant's spouse had already experienced frustration in speaking with the claimant's MBE and a supervisor in the Medical Benefits Adjudication unit, in part, because the claimant had an authorized representative who was not involved with the claim for home health care benefits and therefore the claimant's spouse was unable to obtain information from DEEOIC regarding the claim. The claimant's spouse relayed that he/she was informed the claim was under review but that no further specific information was shared. In seeking to assist this claimant our office explained that DEEOIC required we obtain a Privacy Act Waiver signed by either the claimant or his/her authorized representative. Rather than delay matters any further, the claimant's spouse assisted him/her in signing a Privacy Act Waiver for our office. Following our office's contact with DEEOIC, the claimant's home health care benefits were approved on July 22, 2021.

A claimant in need of an air purifier to aid in the treatment of his/her symptoms from chronic beryllium disease (CBD)¹⁷ contacted our office through his/her authorized representative after receiving a copy of the letter DEEOIC sent to his/her treating physician. The letter sent to the treating physician who prescribed the air purifier took issue with the physician's justification for the air purifier for the following reasons:

- You did not adequately explain the level of dust particles, nor did you identify "other contaminants that are found in the natural air" of the claimant's home.
- Lack of objective evidence showing that the level of dust particles are outside acceptable ranges.
- Lack of objective evidence showing that the air purifier is required based on current medical need and how it will treat the covered condition.

¹⁶ Claimant shared that their child had to print documents for them, and their child lived 10 miles away.

¹⁷ CBD is a chronic respiratory illness for which there is no cure, and the illness normally progresses and worsens over time, eventually leading to severe respiratory compromise.

The MBE instructed the physician to respond to the issues listed above as well as provide a certified air quality assessment of the air inside the claimant's home with the proper number of tests timed out appropriately. The physician was to then provide the reference range for each reading and identify which pollutants were out of range (beyond the "good" and "moderate" ranges), along with explanations as to how the out-of-range values were affecting the accepted conditions. The physician was asked to provide the requested information within 15 days of the date of the letter. The authorized representative took exception to the requests made by the MBE for unspecified air quality testing to be identified and performed, with the results made available to DEEOIC accompanied by an explanation of the findings within 15 days of the MBE's letter. The authorized representative further requested that DEEOIC issue a recommended decision denying the air purifier that included specific references based on scientific medical data that an air purifier would not likely give relief or reduce the degree of respiratory symptoms related to claimant's CBD.

This claim is an example of what some claimants and authorized representatives have characterized as DEEOIC seemingly "moving the goal posts" with respect to the medical evidence needed to support the treating physician's request for medical treatment and/or durable medical equipment. Chapter 29 of the Federal (EEOICPA) Procedure Manual (PM) addresses ancillary medical benefits, which includes durable medical equipment such as an air purifier. See Federal (EEOICPA) PM Chapter 29, Version 5.0 (April 2, 2021). The PM outlines the developmental steps the MBE is to take in determining whether to authorize the requested durable medical equipment (DME). For more costly and complex services and equipment, DEEOIC provides detailed instructions regarding the evidence necessary to approve the authorization. However, in the list of equipment and services outlined by DEEOIC, an air purifier is not included, nor is the air quality testing detailed in the MBE's letter to the physician in the example above.¹⁸ Claimants, authorized representatives, and physicians rarely seek out specific information in the 700+ page DEEOIC Procedure Manual, but instead they have an understanding of the type of medical evidence DEEOIC routinely seeks when determining whether to authorize particular services or equipment. In this case, both the claimant and the authorized representative complained that the nature of the evidence required by DEEOIC was beyond what was routinely sought for an item such as an air purifier.

It also is unclear from the letter sent to the physician why such in-depth air quality testing is required to authorize an air purifier. Similarly, the reasonableness of the expectation that the physician would be able to comply with the testing requirements and provide the results within 15 days from the date of the letter is questionable.

In another instance involving durable medical equipment, the MBE wrote to the claimant that the evidence had failed to present a clear and convincing argument as to why the DME was indicated for his/her accepted covered conditions. The EEOICPA Regulations at 20 C.F.R. § 30.111(a) state that the claimant bears the burden of proving, by a preponderance of evidence, the existence of all criteria necessary to establish eligibility under the EEOICPA, and that proof by a preponderance of the evidence means that it is more likely than not that the proposition to be proved is true. Thus, the requirement that claimant submit a clear and convincing argument appears to hold the claimant to a higher burden than required by the regulations. This is another example in which claimants and their authorized representatives believed that the goal posts had been moved with respect to the criteria by which DEEOIC reviews their claims.

Finally, our office was contacted by the authorized representative for a claimant with a terminal illness who was residing in a nursing home and wished to return home with home health care services. When we were contacted the request for home health services had been pending for 6 weeks and the authorized representative reported having contacted the claims examiner, the MBE, and the MBE's supervisor in an effort to obtain authorization.

¹⁸ Subsequent versions of the PM released on September 20, 2021, and April 4, 2022, also do not discuss the necessity for home air quality testing in order to authorize an air purifier. See Federal (EEOICPA) PM Version 5.1 (September 20, 2021) and Version 6.0 (April 4, 2022).

Unfortunately, the claimant passed away prior to our office being able to determine whether he/she was able to receive the requested home health care services.

Based upon the cases brought to our attention in 2021 we observed that medical benefits delayed were sometimes medical benefits denied, either because the treating physician had not responded to DEEOIC's multiple requests for additional evidence, or the claimant was held to a higher standard than required. The common themes in the requests for assistance we received illustrate the need for consistency and efficiency. When an authorized representative complains of receiving letters from different claims examiners and medical benefits examiners on different cases involving similar requests for medical treatment and the development letters from those claims examiners and medical benefits examiners are quite different, the lack of consistency is concerning. When claimants and authorized representatives continue to reach out to our office knowing that they need assistance, and not fully understanding why they have not heard back from their claims examiner or medical benefits examiner, the need for greater efficiency is apparent. Among the priorities involved with managing life while dealing with a work-related illness, the added time and energy required to obtain the medical benefits that claimants believe they are entitled to under the EEOICPA has become an unwelcome burden.

CHAPTER III.

DIFFICULTIES WITH PART E CLAIMS

As in 2020, the vast majority of the contacts received in 2021 were from individuals who connected with us via mail, telephone, or email.¹⁹ Many of these individuals contacted us with questions, complaints, or requests for assistance concerning an ongoing claim or a claim that had been denied. The complaints received involving Part E claims highlighted the need for better communication between DEEOIC and claimants, as well as increased consistency during the claims adjudication process. The cases brought to our attention involved the use of the SEM database, industrial hygiene reports, and consequential illnesses. Other claimants brought concerns involving the occupational history questionnaire and the Statement of Accepted Facts (SOAF) sent from claims examiners to DEEOIC experts.

A. Occupational History Questionnaire

The Occupational History Questionnaire (OHQ) is a form completed by Resource Center staff during an interview with a claimant who has filed a claim under Part E of the EEOICPA. According to the DEEOIC, Resource Center staff have 14 calendar days to complete the interview, which typically takes 2-3 hours to complete. The purpose of the OHQ is to collect relevant information from the claimant about the employee's work history involving atomic weapons, including the employee's work locations, job titles, work processes, and/or contact with specific toxic substances. See Federal (EEOICPA) PM Chapter 10.5(a)(1), Version 5.1 (September 20, 2021). During the initial interaction with the claimant to schedule an OHQ, the RC staff is to advise the claimant that an authorized representative may be present during the OHQ as long as the claimant has registered their designated authorized representative with the DEEOIC. See Federal (EEOICPA) PM Chapter 10.5(a)(2), Version 5.1 (September 20, 2021). The RC interviewer will record narrative information collected during the interview in an electronic format that will enable the interviewer to print a completed OHQ at the conclusion of the interview. The RC interviewer is to record narrative responses in as accurate a manner as possible based on the verbal responses provided by the claimant. See Federal (EEOICPA) PM Chapter 10.5(b), Version 5.1 (September 20, 2021). The following examples indicate the issues raised with our office regarding the OHQ:

An authorized representative shared a complaint with our office regarding inaccuracies in an OHQ as well as less than acceptable behavior by the RC staff who conducted the interview. The authorized representative described the unpleasant behavior by the RC staff in detail and indicated it caused inaccuracies in the information provided by the claimant as a result of him/her feeling pressured, rushed, and belittled at times. The authorized representative also pointed out a significant number of inaccuracies in the information recorded by the RC staff, some of which coincided with statements made by the RC staff discrediting the information provided by the claimant.

As a result of the authorized representative contacting the office manager of the Resource Center and the DEEOIC National Office, an immediate response was provided to address the concerns raised involving the RC staff and the OHQ. However, the authorized representative noted,

¹⁹ The COVID-19 pandemic safety precautions prevented the Office and other agencies involved with the EEOICPA from conducting any in-person outreach in 2021.

I appreciate everyone's efforts and quick response regarding this situation. Honestly, [claimant] is older and ill, [he/she] often cannot think of things "on the spot" and often will remember things after the fact. I am so thankful I was present when the interview happened, as well as being able to assist [him/her] with reviewing the OHQ when we received it in the mail. This is exactly why AR's, advocates, etc. should be allowed to assist with OHQs, because being ill and/or having cognitive issues may not always make for the best of recollections. I hope to see this issue as a whole addressed someday. (June 9, 2021, email from authorized representative.)

The OHQ is a document based entirely upon the claimant's recollection of his/her own work history at covered DOE facilities. It is used and relied upon by DEEOIC for many aspects of claims adjudication. DEEOIC assumes that the claimant will recall or have all of this information readily available to share during an interview that sometimes takes hours to complete. Almost all claimants are ill, many are elderly, and some have cognitive issues that may make it challenging for them to remember very specific facts regarding every aspect of the work they performed over the course of their DOE career. While claimants are informed in advance of the topics the OHQ will cover, it would be helpful for them to be provided a copy of the OHQ form prior to the interview, and as recommended by the ABTSWH, so that they could take notes and give their responses some thought ahead of time in order to respond fully and accurately to the questions. See ABTSWH Recommendations to Secretary of Labor, Recommendation No. 2 (April 20, 2020).²⁰ Having a copy of the OHQ form would also help the claimants understand the questions being posed. It has also been reported to our office that RC representatives have denied claimants a blank copy of the OHQ for the claimant to follow along with during his/her OHQ interview. Many of the claimants who have contacted our office over the years were not aware of how the OHQ would be used in the adjudication of their claim, nor did they know how important it was to provide additional information to their claims examiner should they think of it after the OHQ was completed.²¹ We recommend DEEOIC also advise claimants how the information they share during their OHQ interview will be used in the adjudication of their claim, and inform them that they can review and amend their responses at any time by contacting their claims examiner.²²

One source of information that would help claimants to refresh their recollection of their workplace exposures is the individual claimant's employment records that DEEOIC requests and obtains from DOE at the beginning of the claims adjudication process. One of the initial developmental steps taken by a claims examiner in a Part E claim is requesting documentation from DOE with respect to the claimant's employment, including medical records, personnel records, industrial hygiene records, incident and accident reports, and radiological and dose records. "The CE uses this evidence to establish any likely exposures the employee had to toxic substances. This evidence has very high probative value because it is documentation from DOE dated *at the time of employment/exposure*, (not documentation created years later or in conjunction with an EEOICPA claim)." (Emphasis supplied). Federal (EEOICPA) PM Chapter 15.5(c), Version 5.1 (September 20, 2021). We have found that most claimants are unaware that this evidence has been requested and obtained by DEEOIC and almost all express frustration when

²⁰ The Director of OWCP responded to this ABTSWH recommendation, stating, "DEEOIC agrees with the Board that providing claimants with better information about the OHQ process may also improve exposure data. Accordingly, DEEOIC will work to produce a notice or summary document to help claimants prepare for an OHQ. This process will be included in standard operating procedures for the Resource Centers this summer." See DOL Response to the Recommendations from the April 2020 meeting of the ABTSWH (June 19, 2020). Based upon this response and feedback received from claimants, it appears that DEEOIC has not changed its policy to provide claimant's a copy of the OHQ form prior to their interview.

²¹ See Federal (EEOICPA) PM Chapter 15.5(e), Version 5.1 (September 20, 2021) for further information regarding the use of the OHQ in the claims adjudication process.

²² Following the interview, the OHQ is sent to the claims examiner assigned to the claim. Any further changes or amendments to the OHQ should be sent to the claims examiner for incorporation into the claim file.

informed by our office for the first time that they are entitled to a copy of this information at any time as long as they send a written request to their claims examiner. This highly probative evidence would assist claimants at the earliest stages in the adjudication of their claims to recall more specific information about their workplace history and exposures. Additionally, because some claimants do not know the names of the specific toxins they worked with or around, and may have never seen their DOE personnel records, it would be helpful for them to see what is, and is not, part of their DOE employment files. Also, with this documentation in hand, claimants could easily review their OHQ responses and provide any relevant updates to their claims examiner and/or treating physician.

B. Site Exposure Matrices (SEM) Database

Sometimes the loved ones of claimants reach out to our office with questions and in need of assistance following the passing of a claimant. For example, in 2021, the surviving spouse of a claimant reached out to our office with questions regarding what to do following the claimant's death. The claimant's claim for interstitial lung disease had previously been denied and his/her spouse was uncertain about filing a claim for survivor's benefits. Upon review of the recommended and final decisions it was apparent that the claims examiner relied, in part, upon the absence of any toxic substances associated with the interstitial lung disease in the SEM database. It was also apparent that the SEM database searches by the district office and final adjudication branch did not necessarily conform to the guidance in the Procedure Manual in two respects: one, the name of the illness searched in the SEM was inconsistent with PM guidance; and two, the scope of the search in the SEM was overly narrow according to PM guidance. The SEM database should not be solely relied upon to deny a claim for benefits, and where a toxic substance, disease or health effect, and labor category or work process overlap, the claim should usually be further developed.

With respect to the first concern, the claims examiner is to treat pneumoconiosis, pulmonary fibrosis, and interstitial lung disease as being equivalents for purposes of claims adjudication. For SEM searches, the appropriate search term for each of these is "pneumoconiosis, other." Federal (EEOICPA) PM Chapter 18.13, Version 5.1 (September 20, 2021). Here, both the district office and the final adjudication branch used the search term "interstitial lung disease" instead of "pneumoconiosis, other" and because interstitial lung disease is not in the SEM database no toxic substances were identified as causing this illness. With respect to the second concern, the district office and the final adjudication branch both only searched the claimant's "labor category" of machinist in the SEM and because this labor category is not in the SEM database for the DOE facility where the claimant worked, no toxic substances were identified. However, per the PM, the claims examiner (CE) is to utilize other filtering functions as a means to further refine the search as a way of honing in on those toxins most closely associated with work performed by the employee that are also linked to the diagnosed condition. Filtering by work processes and building(s) as part of this effort is encouraged when the facts of the case allow this level of detailed searching. See Federal (EEOICPA) PM Chapter 15.8(e)(1), Version 5.1 (September 20, 2021). In this case, when the work process "machining" is searched along with the health effect of "pneumoconiosis, other", two toxic substances are identified that the claimant was potentially exposed to during the course of his/her employment. Neither of these toxic substances were identified when the terms "interstitial lung disease" and "machinist" were searched by DEEOIC since as noted, neither of these terms are in the SEM database for the DOE facility involved in this case. Toxic substance results such as these should qualify as compelling facts that require additional development by a claims examiner.

The SEM database is a valuable tool in the adjudication process; however, it must be used as prescribed in the DEEOIC PM or the results may not be accurate. Moreover, SEM database searches that follow the guidance in the PM may reveal additional probative evidence that could impact the outcome of a claim. Consequently, we recommend DEEOIC's performance management branch consider compliance with the SEM database search guidance found in the PM as a topic for individual claim reviews.

Furthermore, when a specific illness or labor category is not listed in the database, it should be clear when the omission from the database is deliberate, i.e., it has been determined that the illness or toxic substance should not be listed in the database. This is different from a search of the SEM database that yields no results for a listed illness or toxic substance for other reasons. Claimants and authorized representatives should be made aware of this distinction in written correspondence and decisions from DEEOIC in order to fully understand the limitations of the SEM database, as well as narrow the focus of claimants and authorized representatives as they seek to obtain evidence to perfect their claims.

C. Industrial Hygienists Reliance Upon Language Similar to Rescinded Circular No. 15-06

An ongoing area of concern for claimants and their authorized representatives is the continued use of language by DEEOIC contracted industrial hygienists (IH) that is similar in form and intent to the language in rescinded Circular No. 15-06. The relevant language of rescinded Circular No. 15-06 is,

As a result, the claims examiner (CE) can accept the following: For employees diagnosed with an illness with a known health effect associated with any toxic substance present at a DOE facility after 1995, it is accepted that any potential exposures that they might have received would have been maintained within existing regulatory standards and/or guidelines." EEOICPA Circular No. 15-06, Post-1995 Occupational Toxic Exposure Guidance (December 17, 2014).

Following the recommendation of the Advisory Board on Toxic Substances and Worker Health (ABTSWH) in October 2016, Circular No. 15-06 was rescinded. The ABTSWH criticized Circular No. 15-06 because an empirical basis for the policy was not provided, nor did the ABTSWH think it was likely empirical support could be provided. Furthermore, the ABTSWH found it doubtful that sufficient industrial hygiene monitoring was performed throughout the DOE complex from 1995 to the present to substantiate a broad claim that all exposures were routinely kept below existing standards. The ABTSWH also noted that the last paragraph of Circular No. 15-06 acknowledged that even minimal exposure to some toxins may lead to illness, and in that case, the circular contradicts its own principal conclusion that post-1995 exposures are to be considered, as a rule, insignificant. See ABTSWH Recommendation #1 (Adopted at October 17-19, 2016, Meeting.)

Circular No. 17-04 not only rescinded Circular No. 15-06 and its corresponding Memorandum dated February 20, 2015, it stated that the potential for toxic substance exposure in all claims must be evaluated based upon established program procedure and the evidence presented in support of a claim. See EEOICPA Circular No. 17-04 (February 2, 2017).

Below is a sample of the language currently used by contract IHs in their expert opinion reports,

There is no available evidence (i.e., person and/or area industrial hygiene monitoring data) to support that, after the mid-1990s, [his/her] exposures would have exceeded existing regulatory standards.

DEEOIC routinely shares the IH reports with a claimant's physician or contract medical consultant (CMC) as part of the evidence to be relied upon when opining on whether the claimant has satisfied their burden of proof under Part E. Therefore, the continued use of this language can lead CMCs and treating physicians to believe that even if a claimant established they were exposed to a toxic substance at a DOE facility with a known link to the claimed illness, unless the claimant submitted documentation of an exposure beyond the undefined regulatory standards or guidelines, the claimant has not satisfied their burden of proof. For claimants with covered employment during the last approximately 30 years, this language, when relied upon by contract IHs can be as detrimental to claimants' claims as the language of rescinded Circular No. 15-06. It simply changes from being guidance provided by DEEOIC to its claims examiners to guidance followed by contract IHs, and the adoption of the language by IHs fails to address the underlying concerns raised by the ABTSWH. Some might argue that it is more damaging to claimant's ability to satisfy their burden of proof to establish toxic substance exposure when this language is relied upon by a DEEOIC expert versus a claims examiner.

For example, one of the complaints filed with our office in 2021 revealed an IH report that relied upon the above-referenced language to describe a claimant's exposure to each of the seven toxic substances²³ the IH was asked to evaluate. For this claimant, who was employed at a DOE covered facility from the Fall of 1983 through the Summer of 2020, the period from the mid-1990s through the Summer of 2020 accounted for approximately 25 of the 36+ years of covered DOE employment. Thus, because the claimant did not have access to personal or area industrial hygiene monitoring data to demonstrate that his/her exposures to those seven toxic substances exceeded the undefined regulatory standards of the time, it was assumed by the IH that the exposures were within normal limits. This opinion was then forwarded to a CMC who relied upon it, in part, to opine that it was not as least as likely as not that exposure to toxic substance at a DOE facility was a significant factor in causing, contributing to, or aggravating the claimed illness. While the IH and CMC reports were certainly not the only evidence analyzed by the claims examiners, they were heavily relied upon in the decisions to deny the claim.

Claimants and their authorized representatives have requested an explanation for the continued use of this language to include:

1. What specific regulatory standards are the IHs referring to for each toxic substance at each DOE facility during the time periods that claimants worked at such facilities?
2. Do the IHs have access to the industrial hygiene monitoring that was performed throughout the DOE complex from the mid-1990s to the present to substantiate the broad claim that all exposures did not exceed existing standards?

²³ While a search of the SEM database revealed 13 toxic substances linked to the claimant's labor category and the claimed medical condition, only seven toxic substances were referred to and considered by the IH. This is likely due to the PM guidance which states, "No more than seven (7) toxic substances should be identified. However, if the CE established more than seven (7) toxins during the exposure development, the CE would have consulted with the National Office IH to identify which toxins were most likely to have been encountered and which would likely have the greatest impact on the claimant's claim. Based on this consult, the CE will include as many of the toxins as necessary." See Federal (EEOICPA) PM Appendix 1 – Exhibit 15-5, Version 5.1 (September 20, 2021). It is unclear whether the CE consulted with the National Office IH when the decision was made to refer seven of the 13 toxic substances to the IH in this claim.

3. If IHs have access to the existing regulatory standard for each toxic substance, why isn't this information cited by the IHs in their expert opinion reports?
4. Can the claimant be advised and provided a copy of the existing regulatory standards for each toxic substance they were exposed to after the mid-1990s in order to attempt to obtain evidence to establish that their exposures exceeded the existing regulatory standards?

For the reasons previously articulated by the ABTSWH, we recommend IHs be instructed not to rely upon this language and instead assess all toxic substance exposures based upon established program procedure and the evidence presented in support of a claim. Where IHs do rely upon any known regulatory standards, the specific standards relied upon should be identified in their expert opinion reports.

D. Errors in Expert Opinion Reports

Expert opinion reports relied upon by DEEOIC may include those written by DEEOIC health physicists, and DEEOIC toxicologists, as well as contract IHs, and contract CMCs. When a claim is recommended for denial, the claims examiner is to include the expert opinion report(s) with the recommended decision when it is mailed to the claimant and their authorized representative. See Federal (EEOICPA) Chapter 24.7, Version 5.1 (September 20, 2021). These expert opinion reports are based upon information and evidence that the claims examiner sends to the expert, along with specific questions to be answered by the expert. When the expert opinion report is based on incorrect information, it can sometimes be traced back to the information and/or evidence provided to the expert. The information, evidence, and questions are presented to the expert in a document called a Statement of Accepted Facts (SOAF). DEEOIC has identified the format and content of the SOAF in various PM chapters.

When incorrect information is incorporated into an expert opinion report, the incorrect information may then be relied upon by subsequent experts, e.g., when an error in an IH report is later relied upon by a CMC, claims examiner, and hearing representative. Similarly, failure to provide relevant information or evidence to an expert can have the effect of producing a less than adequate expert opinion report. And finally, because a claimant's first opportunity to review an expert opinion report is when it accompanies a recommended decision to deny their claim, some claimants have expressed that it feels as if it is too late to challenge the opinion of the expert. Claimants do not always know how to challenge an expert's opinion and many doubt they have sufficient time to obtain the necessary evidence to refute the expert's opinion with an expert opinion of their own, since they must object to the recommended decision within 60 days of receipt.

In 2021, we received a number of complaints from claimants and authorized representatives who identified incorrect information in their expert opinion reports. More than one claimant contacted us to complain that the expert report incorrectly referred to their history of smoking. A claimant who had never smoked saw that the CMC wrote that he/she had been a smoker and thus his/her smoking habit played a role in the development of the claimed illness.²⁴ An authorized representative identified information that

²⁴ An individual's smoking history is irrelevant in the adjudication of Part E claims. Therefore, even had the claimant been a smoker, it would not have been appropriate for the CMC to consider the claimant's smoking history in opining whether it was at least as likely as not that exposure to a toxic substance at a covered DOE facility was a significant factor in causing, contributing to, or aggravating the claimed illness.

did not pertain to the claimant's claimed medical condition and was subsequently relied upon by more than one expert and the claims examiner when adjudicating the claim.

The concern expressed by one authorized representative was that each of the expert opinion reports were required to be reviewed for accuracy, and it was unclear why such factual errors had not been identified and corrected prior to being relied upon in a decision. A group of claimant advocates expressed concern to OWCP and DEEOIC over what they characterized as a lack of effort to provide standardization and training for consistency. The group pointed out that different CMCs reviewing the same medical files for a claimant sometimes reach opposite conclusions in response to causation questions, and IHs often use template reports with similar language. The OWCP responded to the concerns raised by stating,

The DEEOIC has procedures and guidelines in place outlining when and how each type of referral should be made to medical and scientific professionals. These professionals provide reports which become part of the case file evidence to be weighed by the DEEOIC claims examiners when they render a decision on a given case. DEEOIC trains all claims examiners how to weigh evidence (including professional reports), but DEEOIC cannot establish standards and dictate specific outcomes which would encompass all the variables of each case. Thus, although professional reports may seem similar, cases are decided differently due to the unique circumstances of each case. See July 13, 2021, OWCP response to ANWAG.

Undoubtedly, each claim should be examined based upon the individual facts of the case. However, it would be helpful for claimants to know that documents such as SOAFs and expert opinion reports are fact-checked prior to being relied upon. While it is understandable that errors will be made from time to time, greater consistency in the review of these reports would go a long way to ensuring those errors are caught early and not permitted to perpetuate through the claims adjudication process. Additionally, claimants should be given a copy of the expert report in order to respond to it to correct any errors before the recommended decision is made.

E. Consequential Illnesses

The effect of an accepted occupational illness under Part B and/or covered illness under Part E in causing, contributing to or aggravating an injury, illness, impairment, or disease is considered a consequential condition. A claims examiner is to accept as compensable any claimed consequential condition(s) that is documented properly by substantive, well-rationalized medical evidence. See Federal (EEOICPA) PM Chapter 23.2, Version 5.1 (September 20, 2021). The topic of consequential conditions has appeared in previous annual reports as a result of reported confusion surrounding how to file a claim for a consequential condition, as well as when to file and what evidence is necessary to prove the claim.²⁵ This continues to be an issue.

For example, a claimant who had filed a claim for cancer and consequential conditions resulting from the treatment for the cancer contacted our office to file a complaint and seek assistance. The claimed cancer had been accepted, as well as several of the claimed consequential medical conditions. However, because a claim for impairment benefits was accepted in the same decision that deferred other consequential conditions, and then the deferred consequential conditions were adjudicated in further separate decisions, it was challenging for the claimant to keep up with the adjudicatory status of his/

²⁵ See 2018, 2019, and 2020 Office of the Ombudsman Annual Reports to Congress.

her outstanding claimed consequential conditions. The claimant also complained that his/her claims examiner was discouraging him/her from filing claims for consequential conditions despite the fact that the treatment for the accepted cancer had been extensive. When the claimant submitted additional evidence regarding a consequential condition that had previously been denied, he/she was not advised that they were required to submit a request to have the denied claim reopened until after contacting our office. The claimant in this case expressed frustration that the claims examiner seemed to expect the claimant to have a more sophisticated understanding of the DEEOIC claims adjudication process than the claimant had.

In fact, it is not unusual for a claimant to describe their claim as being “settled” when they first speak to our office after having received a decision accepting their initial claim for benefits under the EEOICPA. Most claimants are not aware of the fact that they will be required to file a new claim form for each additional medical condition they wish to claim, for any additional compensation they wish to claim, and/or for any consequential conditions they wish to claim. Those seeking to claim a consequential condition must file a Worker’s Claim for Benefits Under the EEOICPA (Form EE-1). It is up to the claimant to write on the claim form that it is a “consequential condition”. If the claimant fails to specifically indicate on the Form EE-1 that the medical illness being claimed is a “consequential condition” the DEEOIC will adjudicate the claim as a primary illness which delays the claimant’s ability to potentially receive benefits. Claimants are further confused by the fact that different additional claim forms are required to be filed with DEEOIC depending upon the nature of the claim.²⁶

We suggest that DEEOIC further streamline its adjudication process and provide greater transparency to claimants regarding how and why certain medical conditions are being adjudicated separately from others. It would be helpful for claimants to have a separate claim form or a space on the existing Form EE-1 dedicated solely to claims for consequential conditions.

²⁶ For example, different types of claim forms must be submitted to DEEOIC in order to claim impairment benefits (Form EE/EN11-A), wage-loss benefits (Form EE/EN-11B), or Additional Wage-Loss and/or Impairment under the EEOICPA (Form EE-10).

CHAPTER IV.

DELAYS, CUSTOMER SERVICE, AND OTHER ADMINISTRATIVE ISSUES

In 2021, claimants and their authorized representatives reached out to our office when experiencing what they believed were delays in communication and/or progress in their claims. It was not unusual for claimants to ask us for assistance with determining the status of a claim, or to complain when they were unable to communicate with DEEOIC staff or a DEEOIC contractor. Some of the complaints pertained to the ongoing impact of the COVID-19 pandemic on agencies such as the DOE and SSA. Other complaints pertained to the Department of Health and Human Services, National Institute for Occupational Safety and Health's pause on performing radiation dose reconstructions for claimants with Part B claims. And finally, our office received complaints regarding delays in DEEOIC's processing of medical treatment authorizations, medical bill payments, processing compensation payments, and issuing decisions. We also received complaints from claimants and authorized representatives of insensitive and sometimes rude behavior by DEEOIC or DEEOIC contractor staff, and difficulties interacting and obtaining assistance with the online portals and databases provided by DEEOIC.

A. Delays

Generally speaking, under Part B of the EEOICPA, claims for all but 22 "specified" primary cancers are referred by DEEOIC to NIOSH for a radiation dose reconstruction.²⁷ Following NIOSH's completion and return of the radiation dose reconstruction to DEEOIC, a claims examiner uses the radiation dose reconstruction to calculate the probability of causation that the claimant's cancer was related to his/her covered employment. Should the probability of causation calculation equal 50% or higher, the claim will be accepted under Part B. See 20 C.F.R. § 30.213(b), and Federal (EEOICPA) PM Chapter 17.15, Version 5.1 (September 20, 2021).

On May 3, 2021, NIOSH announced that effective immediately it would place a hold on:

- receiving new or rework case referrals from DOL,
- returning completed dose reconstructions to DOL, and
- receiving individual and site-specific dosimetry information from DOE.

According to NIOSH, the pause was estimated to last two to four months. The effect of this announcement was that NIOSH dose reconstructions were halted for DEEOIC claimants with non-specified cancers. DEEOIC posted an announcement/link on its website entitled, "How NIOSH's Cybersecurity Modernization Initiative Affects You." The content stated that NIOSH had begun to update its cybersecurity, which delayed its ability to process dose reconstructions. It further stated that by law, DEEOIC could not make determinations for certain cancers under Part B of the Act until it received individual dose reconstructions from NIOSH. (https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/DEEOIC_Response_NIOSH_Cybersecurity_Modernization.pdf.)

²⁷ The list of 22 specified cancers can be found on DEEOIC's website at <https://www.dol.gov/agencies/owcp/energy/regs/compliance/law/SEC-Employees>.

It was brought to our attention that the title of the announcement on DEEOIC's website was unclear regarding the impact of NIOSH's inability to conduct radiation dose reconstructions for DEEOIC claimants. Essentially, claimants who experienced delays in the processing of their Part B cancer claims may not have known that this was why their claim was delayed and the title of DEEOIC's announcement would not necessarily have lead them to click on a link describing NIOSH's "cybersecurity modernization" efforts in order to find out why their cancer claim was delayed. It was also unclear if DEEOIC directly informed each claimant who required a NIOSH dose reconstruction and was impacted by NIOSH's pause that their claim was delayed, why it was delayed, and when they might expect it to proceed.

In response to an inquiry from our office to DEEOIC regarding whether any steps had been taken to notify claimants impacted by the NIOSH dose reconstruction pause, DEEOIC responded, "DOL and NIOSH are looking at options for communicating to claimants about the pause in the NIOSH dose reconstruction process. The best information I can provide now is the information available on the NIOSH website... We'll keep you updated as events unfold." (May 18, 2021, email from DEEOIC to the Office of the Ombudsman.) No further updates were provided to our office.

However, during the August 18, 2021, meeting of the NIOSH Advisory Board on Radiation and Worker Health, NIOSH reported that it was still manually processing dose reconstructions for cases referred by DOL with claimants who had been diagnosed with a terminal illness. See CDC NIOSH Advisory Board on Radiation and Worker Health 141st Meeting, pgs. 935-36 (August 18, 2021). The DOE reported that it was in weekly meetings with DOL and NIOSH to discuss NIOSH's IT modernization effort. The DOE further reported that DOL continued to send lists to DOE every two weeks with the cases they would have referred to NIOSH in order for DOE to gather records so when NIOSH came back online and started to make electronic requests for records from DOE, most of the records would be ready to send. See CDC NIOSH Advisory Board on Radiation and Worker Health 141st Meeting, pgs. 21-22 (August 18, 2021).

On September 3, 2021, NIOSH announced that it was testing new technology that allowed for secure data transfer between NIOSH, DEEOIC, and DOE. NIOSH anticipated claims processing would increase as new automation and data management capabilities were implemented through late January 2022, with the expectation that NIOSH would have full functionality by the end of June 2022. DEEOIC did not provide any additional updates to its website regarding this information.

On September 15, 2021, NIOSH announced,

NIOSH recognizes the hardship that a delay in radiation dose reconstructions and claims processing has placed on claimants and their families. We are working diligently to improve the processes needed to achieve steady-state production and timely claims processing.

While it was estimated to take two to four months, unforeseen challenges arose in aligning the DOL and CDC IT environments. NIOSH resolved these challenges and is now exchanging files with DOL within a secure workspace. We are making every effort to address the backlog of claims as quickly as possible by reassigning staff and adding additional resources. Dose reconstructions for claimants with terminal diagnoses continue even during the pause and remain our highest priority.

(NIOSH Cybersecurity Modernization homepage, <https://www.cdc.gov/niosh/ocas/headlines/hl-2021/hl-050321.html>.)

From May 2021 to date, no additional updates or announcements were posted on the DEEOIC website regarding the ongoing delays, and it is unclear if DEEOIC or NIOSH provided any written notification or updates to individual claimants regarding the extended period of time during which their dose reconstructions were potentially delayed.

When a sizable portion of DEEOIC claims were simultaneously impacted to the extent that dose reconstructions stopped being processed by NIOSH for a period of time, claimants and authorized representatives found it frustrating not to receive more case-specific, timely information from DEEOIC. It is our understanding that DEEOIC knew the details of the cases it had referred to NIOSH (or were pending referral) that were impacted by the pause, and therefore the question remains why more was not done to communicate this information directly to effected claimants.²⁸

Furthermore, as a result of the COVID-19 pandemic's impact on their agencies, both DOE and SSA experienced delays in providing information and/or documentation to DEEOIC. Our office heard from an authorized representative that DOE was unable to timely verify employment at some DOE facilities or provide DEEOIC documentation from individual claimant's employment files. Moreover, SSA also experienced difficulties in providing wage earning records to DEEOIC. These records are relied upon to verify employment and adjudicate wage-loss claims. It was reported to our office that it was taking over a year for DEEOIC to receive records from SSA. While DEEOIC cannot control the availability of records from other federal agencies, the concern raised by claimants and authorized representatives is that DEEOIC had continued to adjudicate claims without relevant evidence, and in doing so, had not fully informed claimants of the unavailability of records that are routinely provided to DEEOIC.

When a claim is being adjudicated and additional evidence is needed to establish an element of the claim, DEEOIC sends the claimant what is called a "development letter" informing the claimant that certain evidence must be submitted to prove their claim. See Federal (EEOICPA) PM Chapter 11.4, Version 5.1 (September 20, 2021). The complaint was that instead of providing notification to claimants in the development letter that DOE or SSA records were delayed or unavailable, DEEOIC simply shifted the burden to claimants to provide the evidence. Thus, claimants who were also unable to obtain documentation from the same agencies that DEEOIC was unable to obtain records from, were required to proceed with the adjudication of claims without knowing records from DOE and SSA were unavailable.

We recommend that DEEOIC inform all impacted claimants and their authorized representatives in writing, ideally in the development letter, when it is unable to obtain evidence from specific agencies. Such notification would prevent claimants from unknowingly spending time and resources requesting information from the agencies unable to provide the documentation and allow them to focus on other ways to potentially obtain evidence. Moreover, should DEEOIC proceed to issue a recommended decision to deny a claim based upon lack of evidence from DOE or SSA, the claimant should be advised by DEEOIC that it wasn't a matter of those agencies not possessing the evidence, but simply that the agencies were delayed in providing a response to DEEOIC.

²⁸ As noted above, while dose reconstructions were paused by NIOSH, DOL was still receiving claims and then compiling lists of claimants, along with their personally identifiable information and employer information, and forwarding that information to DOE. DOE then collected the information so that when the NIOSH turned the "valve" back on, there wouldn't be a delay from DOL and DOE. See Centers for Disease Control (CDC) NIOSH Advisory Board on Radiation and Worker Health 140th Meeting, pgs. 35-36 (June 23, 2021).

Another set of complaints involved the instructions accompanying final decisions awarding compensation benefits to claimants. After the PM was updated on September 20, 2021, the cover letter sent to claimants accompanying the final decision instructed them to return their signed Acceptance of Payment Form EN-20 to the DEEOIC central mail room in London, KY, instead of to their district office of record. See Federal (EEOICPA) PM Chapter 33.3, version 5.0 (April 2, 2021) and version 5.1 (September 20, 2021). We received concerns from claimants about sending a form containing their banking information to a third-party contractor instead of to the DEEOIC district office. In addition, we received a complaint that sending the EN-20 to DEEOIC central mail processing added a step to the payment process because the form then had to be scanned into the DEEOIC system and routed to the proper party, which delayed payment to claimants. We also received complaints of EN-20 forms getting lost at the central mail room and delaying payment of benefits to the claimant.

Other complaints brought to our office concerned delays in some claimants receiving their medical benefits cards following a final decision to accept an illness, as well as confusion surrounding whether a medical benefits examiner or CNSI could replace a medical benefits card. Ultimately it was determined that the medical benefits examiner orders replacement medical benefits cards. We also received complaints about improper delays in the process, for example, an authorized representative complained of instances where certain claims did not seem to be proceeding through the adjudication process, only to later learn that the individual adjudicating the claim had failed to take all of the necessary steps within DEEOIC's computer system to have the claim file documents sent to the claimant. In one case, the authorized representative indicated that a claimant had not received correspondence from DEEOIC from November 2020 through mid-June 2021.

The obvious concern in cases such as those described above is that compensation or medical benefits to which claimants were entitled was delayed without being based upon a written DEEOIC policy or procedure. DEEOIC claimants must submit evidence under specific deadlines. However, it appears to be entirely up to the claims examiner to determine what and when information about the timing of claims processing, including any delays, will be shared with claimants. We suggest DEEOIC consider sharing with claimants the timelines for the issuance of decisions and routinely update claimants regarding the status of their claims, particularly when there are delays in the adjudication process. This would give claimants an expectation regarding when they would receive a decision or move on to the next phase of their claims adjudication. Consequently, they could be more prepared for the next step in the claims process and less anxious regarding the status of their claim. Increased communication would create greater transparency and promote greater claimant understanding, as well as trust in the process.

B. Customer Service

In 2021, claimants and authorized representatives reported customer service issues that included difficulties communicating with DEEOIC staff, inappropriate or rude behavior by DEEOIC staff, difficulties finding the correct person to address their questions, and difficulties assisting claimants who had been diagnosed with a terminal medical condition.

Also, our office received complaints regarding difficulties being able to speak with a claims examiner or medical benefits examiner. We were informed of telephone messages left for claims examiners and medical benefits examiners that were not returned, as well as voicemail messages left for the claimant which usually involved the claimant calling back, leaving another message, and then waiting an additional two days before they were able to speak with DEEOIC staff. Additionally, claimants contacted our office when they did not hear back from DEEOIC staff who had said they would be responding to the claimant.

Some examples follow:

In the past when claimants or authorized representatives have expressed frustration with their interactions with DEEOIC staff, DEEOIC has instructed claimants to contact the supervisor of the DEEOIC staff person with whom they are experiencing difficulties. While most claimants are reluctant to do so out of fear of retaliation, a claimant in 2021 provided written comments to the supervisor as well as a voicemail message. According to the claimant, the supervisor did not respond, but instead delegated the responsibility for responding to the claimant to the DEEOIC staff member complained about. The claimant expressed frustration in “getting the run around in this complicated process” and asked why the supervisor did not respond directly to his/her voicemail and letter. (Email from claimant to Office of the Ombudsman, June 23, 2021).

Another claimant wrote to us,

The staff I am dealing with are rude, condescending, and clearly are obfuscating the process and any attempt I make to move my claim along to approval. I truly believe that the intention of this program, as approved by Congress is a good faith effort to support those of us impaired by working at government nuclear facilities. However, the Administrators of EEOICPA have lost focus on the program's intent. As a Claimant, I should not be required to hire a Personal Advocate or Attorney to usher my claims through the process. This program is to compensate the injured workers, not create another layer of representation who take large percentages of the compensation which is needed by those actually impaired.

(Email from claimant to Office of the Ombudsman, June 23, 2021).

In January 2021, a claimant contacted us and described his/her inability to get a response to their telephone calls after leaving messages for his/her claims examiner of record and then another claims examiner who was filling in for his/her claims examiner. The claimant then contacted our office after his/her unsuccessful efforts to speak with a second claims examiner. Another claimant reached out after “being shuffled” between a Resource Center and two district offices in an attempt to obtain reimbursement for travel-related medical expenses after having submitted a letter of medical necessity for his/her travel companion.

Claimants are entitled to copies of any/all records in their DEEOIC claim file. In order to obtain copies of any claim file information, the claimant must submit a written request for the records to DEEOIC.²⁹ There can be delays in provision of records and the process is not as clear as it should be. For example, in June 2021 a claimant reported that he/she had been waiting for over one year for his/her employment records from DEEOIC. To make matters more frustrating for the claimant, he/she stated that despite not receiving the requested documents, his/her claim had been unfavorably decided. The claimant further commented,

- ***To file my claim, I have expended over 5k, and have aged 2-3 years beyond my almost 75 years of age.***
- ***Ideally, a flowchart of the steps to filing a claim, and the check points that must be satisfied to move forward.***
- ***Otherwise, former workers should be discouraged from filing claims.***
- ***The difficulty obtaining medical evidence of cancer can represent a practical time limit where medical records are not available because they cannot be located or have been destroyed in the time between the onset of the cancer and the filing of the claim - a period that sometimes exceeds 30 years.***

(Email from claimant to the Office of the Ombudsman, June 29, 2021.)

²⁹ Claimants are still not informed by DEEOIC that they may request a copy of any/all of their claim file information. It is our continued suggestion that DEEOIC notify all claimants of their right to request any documentation in their file provided they send a letter to DEEOIC requesting the documents.

We concur with claimant's assessment that it would be helpful for claimants to have a flowchart of the steps to filing a claim and the evidentiary requirements that must be met as claimants move through the adjudication process. While DEEOIC sends development letters to claimants when evidence is needed to satisfy an element of a claim, the development letter only addresses the evidence necessary to satisfy specific element(s). What is missing is an overview of the process particular to the specific claimant.

The policies and procedures regarding expedited service for terminal illness should be clarified and made consistent. Claimants and authorized representatives expressed concerns to us about being told there were specific timeframes for prognosis that did not reflect a consistent policy. For example, an authorized representative informed our office that a claims examiner had informed him/her that a letter from the claimant's treating physician was required to state that the claimant had three months or less to live in order for the claim to be expedited. The authorized representative also relayed that approval for expedited processing now required two levels of review by DEEOIC, and he/she was informed that DEEOIC was overwhelmed by requests for expedited claims processing. It was suggested by the authorized representative that DEEOIC publish its policies and procedures regarding how such cases are reviewed in order for claimants and authorized representatives to better navigate this sensitive issue. Given the frequency with which this issue was raised by claimants' families and authorized representatives, additional information regarding how DEEOIC determines which claims qualify for expedited adjudication is needed. The PM does not indicate a life expectancy timeframe for the physician to include in their letter addressing the claimant's prognosis. Moreover, a letter from the claimant's treating physician is only required if the claimant's terminal medical status is unclear. See Federal (EEOICPA) PM Chapter 11.8(a), Version 5.1 (September 20, 2021). Thus, the type of evidence that may be accepted to establish a claimant's terminal diagnosis appears to be broader than the requirements reported to our office. In the event a more specific timeframe is required, it should be communicated broadly to claimants and authorized representatives, ideally in the PM and other written guidance.

In 2021, DEEOIC created a Customer Experience Team (CX) within the Branch of Outreach and Technical Assistance (BOTA) consisting of a Stakeholder Engagement Analyst and a Customer Experience Strategist. According to DEEOIC, the mission of this team includes soliciting feedback from stakeholders, conducting analysis of data, and making data-driven recommendations for programmatic and procedural improvements. See CX Survey Results and Recommendations, July 2021. An initial survey conducted by the team sought feedback from 2,000 claimants who received final decisions between March 2021 and May 2021. The recommendations the CX team drew from the survey results included:

- Editing the format of recommended and final decisions because "[s]ome claimants did not understand why they were denied because the letters were not clear, and the message was lost in the statement of the case."
- Plain Language Refresher training courses so that claimants could better understand letters from DEEOIC.
- Providing estimated processing times to claimants in order to set expectations and reduce the anxiety claimants feel when they go for an extended period without hearing anything about their claim.
- Verbal reminders to staff and ensuring that training stresses the need to clearly explain decisions or requests from DEEOIC in order to counter claimant's lack of trust and feelings of uneasiness.
- Develop phone call best practices such as informing claimant in a voicemail message when DEEOIC staff will call back so the person can plan to be available for the call.
- Take annual training on difficult conversations.
- Avoid discussing potential outcomes with claimants.

See CX Survey Results and Recommendations, July 2021. https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/public_reading_room/final_decision_survey_report072021.pdf

We commend DEEOIC for dedicating resources to improve stakeholder's interactions with the program. Consistent with our recommendations in this and previous annual reports to Congress, we encourage DEEOIC to create a single point of contact to receive complaints from stakeholders. Now that DEEOIC has implemented the CX Team, we suggest DEEOIC utilize the CX Team as that single point of contact. This team should, at a minimum, acknowledge receipt of complaints and provide the complainant with a response. In doing so, the single point of contact could help alleviate concerns of retaliation expressed by claimants and authorized representatives despite our assurances that DEEOIC is committed to hearing and addressing their complaints. A single point of contact could give claimants confidence that their complaints would be received, acknowledged, responded to, and kept in confidence.

C. Other Administrative Issues

For the past few years, DEEOIC has provided claimants the option to upload documents to their claim files online by using the Electronic Document Portal (EDP). Once uploaded, the claims examiner associated with the case should have immediate access to the uploaded documents. In 2021, DEEOIC began permitting claimants to access their claim file information online via the Employees' Compensation Operations & Management Portal (ECOMP). Claimants were informed that ECOMP would permit them to access the status of their claims, including the status of their medical and pharmacy bills, as well as to view and download their case file documents. Unfortunately, our office received complaints from claimants that ECOMP did not function as described by DEEOIC.

Our office heard from multiple claimants and authorized representatives that the claim status page did not accurately reflect the status, nor did it contain any detail with respect to the claim status history. Other claimants reported that when they attempted to access pages in ECOMP they received the notice, "Page Not Found." Still others voiced concerns when the claimed medical conditions were not accurately identified as accepted or denied.

For example, a claimant experiencing problems with both the EDP and ECOMP reached out to us for assistance after uploading medical records and letters in the EDP that sought answers to questions posed to his/her claims examiner. The claimant notified our office that it took five weeks for him/her to be informed that the medical records uploaded to the EDP were unable to be opened by DEEOIC staff. Claimant also asked our office to assist in obtaining a response to his/her request for information from DEEOIC regarding the employee's delayed SSA records. The claimant described some of the technical and other issues as follows,

We have yet again entered items into the portal after this letter was received by the CE days ago, and whether received properly in the portal system is unknown. The portal could benefit the people submitting evidence by enabling submitters (us) to see the images of what was submitted, as it only allows the submitter to see the name of the file and see zero images. Seeing the file name only and whether it was received does not help the submitter to ever see the image presented in the system thus the quality of the image.

Coupled with the lack of communication (failure to return calls or respond to requests), the lack of respectful communication, refusal to answer oral and even written submitted questions makes for a beyond frustrating experience.

(Email from claimant to Office of the Ombudsman, February 17, 2021.)

After our office received a response from DEEOIC, the claimant contacted us again a couple of weeks later with additional complaints regarding lack of communication from the claims examiner and his/her inability to access the claim status in ECOMP.

Another claimant reported that when a document is uploaded to the EDP it is given a document control number (DCN) that is the only description of the document available to a claimant. When this particular claimant uploaded a document and then printed the page to confirm that the document had been processed, the printed page cut off the DCN, thus rendering the claimant unable to log back in to check the status of the document. The claimant expressed frustration that the EDP made it difficult to track documents and that our office could not access the EDP to determine if the document had been successfully uploaded.

The delays, customer service, and technology issues reported in 2021 were from those who had already spent time and resources attempting to find information, take action, or have their questions answered by a variety of people and resources. Almost every claimant who contacted us had already made efforts to speak with someone in DEEOIC or a DEEOIC contractor. Many had also spoken with health care providers, authorized representatives, and family members as they sought assistance. By the time most claimants reached us, they were in need of immediate information and assistance. And while we endeavored to provide that information and assistance in a timely fashion, we likewise had to inform them that our office does not have access to any of the online claim file databases or systems to which their claims examiner, medical benefits examiner, or DEEOIC contractor has access, and that in order for us to obtain any information from DEEOIC regarding their claim, they had to sign a Privacy Act waiver before DEEOIC would release any claim specific information. For some claimants the prospect of arranging for us to send them a Privacy Act waiver, sign it, and then return it to our office was a barrier to proceeding to obtain assistance - it was time consuming on top of everything else they felt needed to be done. Other claimants who initially seemed interested in obtaining assistance from our office likewise expressed hesitancy to complete additional paperwork. Finally, other claimants simply did not have the means to complete the task. Consistent with the mission and statutory duties of our office, we look forward to exploring ways we can work with DEEOIC to more efficiently serve this program's stakeholder community in 2022.

CHAPTER V.

ISSUES RELATED TO IMPAIRMENT CLAIMS

In 2021, claimants and their authorized representatives contacted our office with concerns and requests for assistance regarding delays in the processing of impairment claims as well as complaints regarding the adjudication process itself. By way of background, under Part E of the EEOICPA, once a physician has determined that a claimant's accepted covered illness has reached maximum medical improvement, the claimant may be entitled to impairment benefits.³⁰ The impairment evaluation must be performed by a qualified physician³¹ and must include the percentage of whole-person impairment for each accepted covered illness. The compensation payment is calculated by multiplying \$2,500 by each percentage of whole-person impairment. A claimant may file a claim for increased impairment compensation every two years, and benefits are payable only if the impairment evaluation concludes that the covered illness has worsened, as expressed by an increased impairment rating. In 2021, we received a number of complaints related to delays in the processing of impairment claims.

For example, an authorized representative reached out for assistance after submitting an impairment evaluation report to DEEOIC and not receiving a recommended decision for impairment benefits after three months. The reasons the claims examiners purportedly provided to the authorized representative for not issuing the recommended decision were: 1) the claims examiner had been pulled away to work on several other high priority cases, and 2) the Final Adjudication Branch was going to possibly issue a decision to accept a new medical condition, and if it did so prior to the recommended decision for impairment being issued, then the claimant would have to wait for an impairment evaluation on the new medical condition in order for both medical conditions to be adjudicated together. Prior to receiving a response from DEEOIC regarding the above-referenced concerns, the authorized representative received the final decision to accept the new medical condition. Shortly thereafter the authorized representative was further informed by the claims examiner that a new waiting period would begin in order for the new medical condition to be evaluated for permanent impairment. Given the delay in receiving an impairment decision for the first accepted illness, the authorized representative sought to know if there was a new policy of delaying a claimant's impairment compensation pending the acceptance of and an impairment evaluation for an additional medical condition. Our review of the PM did not result in the identification of such a policy.

Another authorized representative reached out to our office to share that the claimant became eligible for increased impairment benefits in October 2020 and despite submitting repeated requests for reevaluation of his/her impairment they had yet to receive the necessary documents from DEEOIC some four months later. The authorized representative wrote to us that he/she contacted the claims examiner in September 2020 and was assured that the impairment forms would be sent to the claimant immediately. Numerous unanswered voicemail messages were left for the claims examiner and the authorized representative was increasingly concerned due to the claimant's diagnosis of stage 4 cancer and COVID-19.

³⁰ A claimant must file a separate claim for impairment benefits using Form EE/EN-11A. While these forms are not available on the DEEOIC website, a claims examiner or Resource Center can provide them to claimants.

³¹ The claimant indicates on Form EE/EN-11A whether they wish to choose the physician to conduct their impairment evaluation or have the DEEOIC provide documents from their claim file to a CMC in order to provide an impairment evaluation. A primary difference between the two options is that the claimant's evaluation with their physician may be in-person, whereas the CMC will only review the documents provided to him/her by the CE.

In the 2020 Annual Report to Congress, we reported on a new subset of complaints regarding impairment evaluation reports that had been prepared by physicians of the claimant's choosing and then refuted by DEEOIC after the OWCP Medical Director provided his opinion. An authorized representative complained at the time that the Medical Director's involvement in specific impairment claims was evidence of DEEOIC National Office inserting itself into the claims adjudication process without the claimant being informed. The complaint was also made that claimants were not provided a copy of the Medical Director's written opinion, and the Medical Director's role in the impairment evaluation process was not mentioned in the EEOICP Procedure Manual. Subsequently, during testimony before the ABTSWH regarding updates to the DEEOIC PM, the Policy Branch Chief commented,

And so, what the procedures do now, is make it very clear that the Department of Labor is going to evaluate impairment ratings based solely, or very explicitly on what is the words in the AMA Guides[.]

The update also made it very clear that this is not going to be something that we will engage with our internal physician. We are no longer referring to our medical director, as a medical director. We're calling that individual now, just a medical officer. But that person, who will no longer have a role in the impairment process, if there would be development issues or concerns with the sufficiency of an impairment rating. We would give the rating physician the opportunity to clarify if that was an option. And then if that does not overcome whatever defect presents in the case file, that would be a standard referral to a contract medical consultant.

And so, the procedure is basically stipulating that our staff is really going to have to take a look at the words that are being presented by a rating physician to make sure that it conforms to the explicit instruction and guidance from the AMA Guides. (Emphasis added). (Advisory Board on Toxic Substances and Worker Health Videoconference Board Meeting, November 8, 2021, pgs. 53-55.)

In 2021, our office received complaints regarding a similar, but not identical, issue regarding the use of DEEOIC nurse consultants. For example, an authorized representative contacted our office after more than one impairment claim had been remanded following questions raised by a DEEOIC nurse consultant about a physician's impairment rating report. When we were asked whether a role for DEEOIC nurse consultants in the assessment of impairment ratings was documented in the PM, we were unable to provide an affirmative answer. The only instance of a DEEOIC nurse consultant referenced in the PM chapter on impairment ratings was found in the section regarding additional filings for increase impairment benefits where it says, "The CE may seek the input of a DEEOIC nurse consultant or CMC to assist in assessing whether a substantive basis exists for granting a waiver of the two-year rule." Federal (EEOICPA) PM Chapter 21.16(a)(1)(ii), Version 5.1 (September 20, 2021). This particular language narrowly addresses the situation where a claimant wishes to have an additional impairment rating prior to two years from the date of his/her last impairment award and does not address the concerns brought to our attention. Otherwise, nurse consultants are defined in the PM chapter on home and residential health care as those who function as subject matter experts in assessing medical evidence to ensure it reasonably correlates to the prescribed type, level, frequency, or duration of home health care, as prescribed by a qualified physician. See Federal (EEOICPA) PM Chapter 30.2(q), Version 5.1 (September 20, 2021). Thus, we were unable to offer any specific written support for a DEEOIC nurse consultant assessing the validity of a physician's evaluation in the impairment rating process.

Questions have been raised regarding the use of a nurse consultant to conduct reviews since a physician who wishes to provide an impairment rating for a DEEOIC claimant must submit credentials to DEEOIC that verify their qualifications to conduct an impairment rating consistent with the *AMA's Guides to the Evaluation of Permanent Impairment*, 5th edition. It would be helpful for the qualifications and role of the nurse consultants who review physician's impairment ratings to be included in the PM so that claimants and authorized representatives could have a better understanding of the purpose and scope of the review activity.

We are concerned that claimants and their authorized representatives may not be receiving notice that their claim has been reviewed by a nurse consultant and are not provided with copies of a nurse consultant's notes or guidance as part of the claims adjudication process. Absent the ability to read and potentially rebut the opinion of a nurse consultant, claimants appear to be at a disadvantage as they seek to understand the posture of their impairment claim. Claimants and their authorized representatives find it helpful to be aware of opinions and information that may impact their claim for benefits. Moreover, it is important for them to understand who provides information to CEs and be afforded an opportunity to review and respond to it prior to a decision being issued in their case.

APPENDIX 1**ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT**

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| ABTSWH | Advisory Board on Toxic Substances and Worker Health |
| AEC | Atomic Energy Commission |
| AR | Authorized Representative |
| AWE | Atomic Weapons Employer |
| BeLPT | Beryllium Lymphocyte Proliferation Test |
| CBD | Chronic Beryllium Disease |
| CE | Claims Examiner |
| CMC | Contract Medical Consultant (formerly known as District Medical Consultant) |
| CPWR | Center for Construction Research and Training |
| CX Team | Customer Experience Team |
| DCMWC | Division of Coal Mine Workers' Compensation |
| DEEOIC | Division of Energy Employees Occupational Illness Compensation |
| DFEC | Division of Federal Employees' Compensation |
| DLHWC | Division of Longshore and Harbor Workers' 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 |
| IH | Industrial Hygienist |
| JOTG | Joint Outreach Task Group |

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| 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 |



OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

