DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

FEDERAL ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT PROCEDURE MANUAL

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INTRODUCTION

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) was enacted in October 2000. Part B of the EEOICPA, effective on July 31, 2001, compensates current or former employees (or their survivors) of the Department of Energy (DOE), its predecessor agencies, and certain of its vendors, contractors and subcontractors, who were diagnosed with a radiogenic cancer, chronic beryllium disease (CBD), beryllium sensitivity, or chronic silicosis, as a result of exposure to radiation, beryllium, or silica while employed at covered facilities. The EEOICPA also provides compensation to individuals (or their eligible survivors) awarded benefits by the Department of Justice (DOJ) under Section 5 of the Radiation Exposure Compensation Act (RECA). Part E of the EEOICPA (enacted October 28, 2004) compensates DOE contractor and subcontractor employees, eligible survivors of such employees, and uranium miners, millers, and ore transporters as defined by RECA Section 5, for any occupational illnesses that are causally linked to toxic exposures in the DOE or mining work environment.

The following Procedure Manual (PM) is designed to provide an overview of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) program and guidance regarding the general policies and procedures used by DEEOIC claims staff in the processing and adjudication of claims. The PM is supplemented by EEOICPA Bulletins and Circulars and is updated periodically.

CHAPTER 1 - DEFINITIONS

1. Purpose and Scope. The purpose of this chapter is to define the most commonly used terms in the administration of the EEOICPA. The chapter also identifies the abbreviations and acronyms for those terms (Exhibit 1-1) and provides a listing of the forms used in the program (Exhibit 1-2).

2. Definitions. This section defines the principal terms used in the Federal EEOICPA PM.

a. Act or EEOICPA means the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 et seq.

b. Atomic Weapon means any device utilizing atomic energy, exclusive of the means for transporting or propelling the device (where such means is a separable and divisible part of the device), the principal purpose of which is for use as, or for development of, a weapon, a weapon prototype, or a weapon test device.

c. Atomic Weapons Employee (AWE) means:

(1) An individual employed by an AWE during a period when the employer was processing or producing, for the use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; or

(2) An individual employed:

(a) At a facility that the National Institute for Occupational Safety and Health (NIOSH), in its report dated February 2002 and titled "Report on Residual Radioactive and Beryllium Contamination at AWE Facilities and Beryllium Vendor Facilities," or any update, indicated had a potential for significant residual contamination outside of the period described in subparagraph (1) of this definition;

(b) By an AWE or subsequent owner or operator of a facility referenced in subparagraph (a) of this definition; and

(c) During a period reported by NIOSH, in its report dated February 2002 and titled "Report on Residual Radioactive and Beryllium Contamination at AWE Facilities and Beryllium Vendor Facilities," or any update to that report, to have a potential for significant residual radioactive contamination. This will be identified on the DOE facility database as the "residual contamination" period.

(d) AWE means any entity, other than the United States, that:

(i) 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

(ii) The Secretary of Energy has designated as an AWE for purposes of the Act.

d. AWE Facility means a facility, owned by an AWE, that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling.

e. Attorney General means the Attorney General of the United States or the United States DOJ.

f. Average Annual Wage (AAW) means four times the average quarterly wages of a covered Part E employee for the 12 quarters preceding the quarter during which the employee first experienced wage-loss due to exposure to a toxic substance at a DOE facility or RECA section 5 facility, excluding any quarters during which the employee was unemployed.

Being "retired" is not equivalent to being "unemployed"; therefore, quarters during which an employee had no wages because of retirement will be included in the AAW calculation.

g. Benefit or Compensation means the money the United States Department of Labor (DOL) pays to or on behalf of either a covered employee under Part B, or a covered DOE contractor employee under Part E, from the Energy Employees Occupational Illness Compensation Fund. These terms may also include any other amount paid out of the Fund for medical benefits including but not limited to medical treatment, monitoring, examinations, services, appliances and supplies.

h. Beryllium Sensitization or Sensitivity means that the individual is sensitized to beryllium as demonstrated by any of the following:

(1) An abnormal beryllium lymphocyte proliferation test (BeLPT) or an abnormal lymphocyte transformation test (BeLTT) on either blood or lung lavage cells as interpreted by a medical doctor, for Part B and Part E claims;

(2) A positive physician panel determination as specified in section 7385s-4(b), for Part E claims only; or

(3) A determination that it is at least as likely as not that exposure to beryllium at a DOE facility or a RECA section 5 facility was a significant factor in aggravating, contributing to, or causing the beryllium sensitization or sensitivity; and it is at least as likely as not that the

exposure to beryllium was related to employment at a DOE facility or a RECA section 5 facility as specified in sections 7385s-4(c) and 7385s-5(a), for Part E claims only.

i. Beryllium Vendor means any of the corporations and named predecessor corporations designated as beryllium vendors in section 7384l(6)(A)-(I) of the EEOICPA, or their corporate successors; and also those facilities designated as beryllium vendors in the list published in the Federal Register by the DOE.

j. Bioassay means the determination of the kind, quantity, concentration, or the location of radioactive material in the human body, whether by direct measurement or by analysis and the evaluation of radioactive material excreted, eliminated, or removed from the body.

k. Central Mail Room (CMR) is a centralized mail processing facility operated by contractor staff who are responsible for scanning and creating an electronic image of incoming hardcopy documentation. Once the CMR staff has imaged a paper document, he or she classifies the document based on a list of pre-chosen "index" categories. The CMR staff person then uploads the document into the OWCP Imaging System (OIS) and assigns it to the associated case file record.

l. Chronic silicosis means a non-malignant lung disease as demonstrated by any of the following:

(1) The initial occupational exposure to silica dust preceded the onset of silicosis by at least 10 years and a written diagnosis of silicosis is made by a medical doctor and is accompanied by:

(a) A chest radiograph, interpreted by an individual certified by the NIOSH as a B reader, classifying the existence of pneumoconiosis of category 1/0 or higher;

(b) Results from a computer assisted tomography or other imaging technique that are consistent with silicosis; or

(c) Lung biopsy findings consistent with silicosis.

This evidence holds true for Part B and Part E claims;

(2) A positive physician panel determination as specified in section 7385s-4(b), for Part E claims only; or

(3) A determination that it is at least as likely as not that exposure to silica at a DOE facility or a RECA section 5 facility was a significant factor in aggravating, contributing to, or causing the chronic silicosis; and it is at least as likely as not that the exposure to silica was related to employment at a DOE facility or a RECA section 5 facility as specified in sections 7385s-4(c) and 7385s-5(a), for Part E claims only.

m. Claim means a written assertion to the OWCP of an individual's entitlement to benefits under the EEOICPA, submitted in a manner authorized by the Act.

n. Claimant means an individual claiming compensation under the Act.

o. Compensation Fund or Fund means the fund established on the books of the Department of the Treasury for payment of benefits and compensation under EEOICPA.

p. Consequential Injury is any injury, illness, or impairment by a covered employee as a result of an occupational illness, or sustained by a covered DOE contractor employee as a result of a covered illness.

q. Contemporaneous Record means any document created at or around the time of the event that is recorded in the document.

r. A Contract Medical Consultant (CMC) is a contracted physician who conducts a review of case records to render opinions on medical questions.

s. Coordination of Benefits with State Workers' Compensation (SWC) is to be determined when a claimant has received benefits from a SWC program for the same covered illness (es) to which he or she is to be awarded compensation under Part E, resulting in a possible reduction in the Part E award.

t. Covered Child means, under Part E, a biological child, a stepchild who lived in a recognized parent-child relationship, or a legally adopted child of a covered DOE contractor employee, who at the time of the employee's death:

(1) Had not attained the age of 18 years;

(2) Had not attained the age of 23 years and was a full-time student who had been continuously enrolled as a full-time student in one or more educational institutions since attaining the age of 18 years; or

(3) Had been incapable of self-support at any age.

This term should only be used in reference to claims under Part E.

u. Covered DOE Contractor Employee means, under Part E, a DOE contractor or subcontractor employee, or a RECA section 5 uranium worker who has been determined by OWCP to have contracted a covered illness through exposure to a toxic substance at a DOE facility or a RECA section 5 facility, as appropriate. This term should only be used in reference to claims under Part E.

v. Covered Employee means, under Part B, a covered beryllium employee, a covered employee with cancer, a covered employee with chronic silicosis, or a covered uranium employee. This term should only be used in reference to claims under Part B.

w. Covered Illness means, under Part E, an illness or death resulting from exposure to a toxic substance from employment at a DOE facility or a RECA section 5 facility. This term should only be used in reference to claims under Part E.

x. Covered Uranium Employee means, under Part B, an individual who has been determined by the DOJ to be entitled to an award under section 5 of RECA, whether or not the individual was the employee or the deceased employee's survivor.

y. Department means the United States Department of Labor (DOL).

z. Department of Energy (DOE) includes the predecessor agencies of the DOE, such as the Atomic Energy Commission (AEC) and the Manhattan Engineer District.

aa. DOE Contractor Employee means any of the following:

(1) An individual who is or was in residence at a DOE facility as a researcher for one or more periods aggregating at least 24 months; or

(2) An individual who is or was employed at a DOE facility by:

(a) An entity that contracted with the DOE to provide management and operation, management and integration, or environmental remediation at the facility; or

(b) A contractor or subcontractor that provided services, including construction and maintenance, at the facility.

bb. DOE Facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located:

(1) In which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and

(2) With regard to which the DOE has or had:

(a) A proprietary interest; or

(b) Entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

cc. Disability means that OWCP has determined entitlement to payment of Part B benefits for the covered occupational illness of CBD, cancer or chronic silicosis. This term should only be used in reference to a claimant entitled to benefits under Part B.

dd. Dose Reconstruction (DR) is used to estimate the radiation doses to which individual workers or groups of workers have been exposed, particularly when radiation monitoring is unavailable, incomplete, or of poor quality. These methods are applied to translate exposure to radiation into quantified radiation doses at the specific organs or tissues relevant to the types of cancer occurring among the workers.

ee. Durable Medical Equipment (DME) means the appliances that a qualified physician prescribes or recommends for a covered occupational illness or a covered illness which OWCP considers necessary to treat the illness. Examples of DMEs include walkers, wheelchairs, or hospital beds.

ff. Equivalent Dose means the absorbed dose in a tissue or organ multiplied by a radiation weighting factor to account for differences in the effectiveness of the radiation in inducing cancer.

gg. External Dose means the portion of the equivalent dose that is received from radiation sources outside of the body.

hh. Final Decision (FD). After reviewing all evidence of record and the Recommended Decision (RD), the FAB issues a FD, which is an independent written decision addressing the appropriateness of the RD outcome, making findings of fact and conclusions of law that legally support the decision.

ii. The Freedom of Information Act (FOIA) means the law that generally provides for public access to documents maintained by the government. It requires the government to release those documents upon request, unless the request or documents fall within one of nine exceptions listed in the law.

The FOIA also requires the publication of indexes of specified agency documents and records; provides time limitations for responding to requests; establishes a system of penalties for non-compliance with the time limitations; requires identification of persons responsible for granting or denying requests; provides for court review of denials, including classified materials; and provides for the levying of charges for searching and copying requested materials.

jj. Gaseous Diffusion means a uranium enrichment process based on the difference in rates at which uranium isotopes in the form of gaseous uranium hexafluoride diffuse through a porous barrier.

kk. Impairment means a loss, loss of use, or derangement of any body part, organ system or organ functionality as it affects the whole body, as a result of the covered illness. An impairment rating is performed once the employee has reached Maximum Medical Improvement (MMI) or is terminal This term should only be used in reference to claims under Part E.

ll. Incapable of Self-Support means the inability to obtain or retain employment, or engage in self-employment that provides a sustained living wage as a consequence of a physical or mental condition, illness or disease.

mm. Internal Dose means the portion of the equivalent dose that is received from radioactive materials taken into the body.

nn. Mail and File (M&F) Staff are responsible for maintaining paper case files located at the DO and FAB. They are also responsible for assisting with the physical movement of case files within the DO or FAB, including taking receipt of incoming files or transferring files to other district or FAB offices.

oo. Maximum Medical Improvement (MMI) is when the covered illness is stabilized and is unlikely to improve with or without additional medical treatment.

pp. Occupational Illness means, under Part B, a covered beryllium illness, cancer sustained in the performance of duty, specified cancer, chronic silicosis, or an illness for which DOJ has awarded compensation under section 5 of RECA. This term should only be used in reference to an individual(s) entitled to benefits under Part B.

qq. Offset is a reduction of the claimant's benefits under the Act. This is required if any person receives funds pursuant to a final judgment or settlement for the same accepted exposure that led to the accepted covered illness. Benefits that are excluded from an offset include:

(1) Workers' compensation benefits;

(2) Insurance policies; and

(3) A claim for loss of consortium filed by an individual other than the covered Part B or Part E employee.

rr. OWCP Medical Fee Schedule is a schedule of maximum allowable fees as determined by OWCP for the payment of medical and other health services furnished by physicians, hospitals, and other providers for an accepted occupational illness(es) and an accepted covered illness(es). The payment of fee for such service shall not exceed the maximum allowable charge with the exception of the following:

(1) Does not apply to charges for services provided in nursing homes; this does not include those charges for treatment furnished by a physician or other medical professionals in a nursing home; or

(2) Does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

ss. Physician means surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners within the scope of their practice as defined by state law.

The term "physician" includes chiropractors only to the extent that their reimbursable services are limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist.

tt. The Privacy Act means the statute governing a citizen's right to confidentiality of personal information, including financial and medical history, in records filed in a system of records under the individual's own name. This law sets forth the government's responsibility to properly maintain and restrict access to these records.

uu. Probability of Causation (PoC) means the probability or likelihood that a cancer was caused by radiation exposure incurred by a covered employee in the performance of duty. In statistical terms, it is the cancer risk attributable to radiation exposure divided by the sum of the baseline cancer risk (the risk to the general population) plus the cancer risk attributable to the radiation exposure. Other terms for this concept include "assigned share" and "attributable risk percent."

vv. Point of Contact (POC) means the individual or individuals serving within an agency or department who act as coordinator for the activity.

ww. Radiation means ionizing radiation in the form of alpha particles, beta particles, neutrons, gamma rays, X-rays, or accelerated ions or subatomic particles from accelerator machines.

xx. Radiation Exposure Compensation Act (RECA) of 1990, as amended, 42 U.S.C. § 2210 (noteTE), is a federal statute implemented by DOJ that provides monetary compensation to individuals who contracted certain cancers and a number of other specified diseases as a result of defined on-site/downwind exposure to radiation released during above-ground nuclear weapons tests or as a result of their exposure to radiation during employment as uranium miners, millers, or ore transporters.

(1) Section 4 of RECA provides benefits for individuals with cancer who were either proximate to atomic tests at the Nevada Test Site (downwinder) or participated at the site of an atmospheric atomic weapon test (onsite participant).

(2) Section 5 of RECA provides benefits for individuals who have contracted a covered illness through exposure to a toxic substance during covered employment at a section 5 facility as a uranium miner, uranium mill worker, or as a uranium ore transporter.

yy. Recommended Decision (RD). A RD is a written decision made by the CE regarding the eligibility of a claimant to receive compensation benefits available under the EEOICPA. As a recommendation, it does not represent the final program determination on claim compensability. It is a preliminary determination made by the CE that is subject to challenge by any claimant party to the decision.

zz. Referee Opinion is an impartial physician review in cases where the weight of medical evidence is equal between the opinion of the treating doctor and that of a CMC or Second Opinion physician.

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

bbb. Special Exposure Cohort (SEC) means the classes of employees designated by the EEOICPA, or by the Secretary of Health and Human Services (HHS), who when diagnosed with a specified cancer receive a presumption of causation that employment at a covered facility caused the specified cancer, without the need of a radiation dose reconstruction.

ccc. Specified Cancers. The following are specified cancers in accordance with 20 CFR § 30.5(gg):

(1) Leukemia. [Chronic lymphocytic leukemia (CLL) is excluded]. The onset is to have occurred at least two years after initial exposure at any covered facility during a covered time period.

(2) Primary or Secondary Lung Cancer. [In situ lung cancer that is discovered during or after a post-mortem exam is excluded.] The trachea and bronchi are included as part of the lungs. Sarcoma of the lung is a lung cancer. The pleura and lung are separate organs, so cancer of the pleura, such as mesothelioma, is not a specified cancer.

(3) Primary or Secondary Bone Cancer. This includes myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, essential thrombocytosis or essential thrombocythemia, and primary polycythemia vera [also called polycythemia rubra vera, P. vera, primary polycythemia, proliferative polycythemia, spent-phase polycythemia, or primary erythremia]. A diagnosis of polycythemia vera (and the listed a/k/a nomenclature) is sufficient by itself to be classified as a malignancy of the bone marrow. Leukocytosis and thrombocytosis are supplemental descriptors of polycythemia vera. The bone type of solitary plasmacytoma (a/k/a solitary myeloma) is a form of cancer consistent with bone cancer. The soft tissue type of solitary plasmacytoma is not a type of bone cancer or the specified cancer of multiple myeloma. (Note: Cancer of the hard palate is not bone cancer.)

(4) Primary or Secondary Renal Cancers.

(5) Other Diseases. For the following diseases, onset must have been at least five years after initial exposure at any covered facility during a covered time period:

(a) Multiple myeloma (a malignant tumor formed by the cells of the bone marrow);

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

(c) Primary cancer of the:

(i) Thyroid;

(ii) Male or female breast;

(iii) Esophagus;

(iv) Stomach;

(v) Pharynx – The pharynx has 3 parts - nasopharynx, oropharynx and hypopharynx. (The oropharynx includes the soft palate, the base of the tongue, and the tonsils);

(vi) Small intestine;

(vii) Pancreas;

(viii) Bile ducts (includes Ampulla of Vater, a/k/a hepatopancreatic ampulla);

(ix) Gallbladder;

(x) Salivary gland;

(xi) Urinary bladder;

(xii) Brain (malignancies only). The brain is the part of the central nervous system (CNS) contained within the skull, i.e., the intracranial part of the CNS consisting of the

cerebrum, cerebellum, brain stem, and diencephalon. (The intracranial endocrine glands and other parts of the CNS, benign and borderline tumors of the brain, and borderline astrocytoma are excluded);

(xiii) Colon (including the rectum);

(xiv) Ovary;

(xv) Liver (except if cirrhosis or hepatitis B is indicated);

(d) Carcinoid Tumors. These tumors are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer. A Carcinoid tumor of the organs listed above may be considered as a specified cancer.

Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute (NCI) under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature. The DEEOIC will consult with NCI only on issues pertaining to the name or nomenclature of a disease diagnosed at an anatomic location for the purpose of determining whether it constitutes a cancer.

ddd. Site Exposure Matrices (SEM) is a relational database which acts as a repository of information related to toxic substances potentially present at covered DOE sites and has information regarding site investigations and occupational exposure to hazardous agents to assist in determining the existence of causal links between covered employment, exposure to toxic substances during such covered employment, and the resultant illnesses arising out of such exposure.

eee. Spouse of a covered employee or covered DOE contractor employee means a wife or husband of that employee who was married to that individual for at least one year immediately before the death of that individual.

fff. Survivor means:

(1) For claims under Part B, a surviving spouse, child, parent, grandchild and grandparent of a deceased covered employee; or

(2) For claims under Part E, a surviving spouse and covered child of a deceased covered DOE contractor employee.

ggg. Time of injury means:

(1) In regard to a claim arising out of exposure to beryllium or silica, the last date on which a covered Part B employee was exposed to such substance in the performance of duty as specified in sections 7384n(a) or 7384r(c); or

(2) In regard to a claim arising out of exposure to radiation under Part B, the last date on which a covered Part B employee was exposed to radiation in the performance of duty as specified in section 7384n(b); or

In the case of a member of the SEC under Part B, the last date on which the member of the SEC was employed at the DOE facility or the AWE facility at which the member was exposed to radiation; or

(3) In regard to a claim arising out of exposure to a toxic substance under Part E, the last date on which a covered Part E employee was employed at the DOE facility or RECA section 5 facility, as appropriate, at which the exposure took place.

hhh. Toxic substance means any material that has the potential to cause illness or death because of its radioactive, chemical, or biological nature.

iii. Uncertainty Distribution is a statistical term meaning a range of discrete or continuous values arrayed around a central estimate, where each value is assigned a probability of being correct.

jjj. Wage-Loss is based on the number of calendar years that the covered DOE contractor employee was unable to work or sustained a reduction in wages as a result of the covered illness. Wage-loss compensation is payable for the years of lost wages occurring prior to the covered DOE contractor employee's normal Social Security retirement age, as determined by his or her date of birth. This term should only be used in reference to claims under Part E.

kkk. Workday means a single work shift, whether or not it occurred on more than one calendar day.

lll. Worst-Case Assumption is a term used to describe a type of assumption used in certain instances for certain dose reconstructions. It assigns the highest reasonably possible value to a radiation dose of a covered employee based on reliable science, documented experience, and relevant data.

CHAPTER 2 – THE EEOICPA

1. Purpose and Scope. This chapter provides an overview of the EEOICPA program and the structure of the DEEOIC. It also addresses the relationships between DEEOIC and OWCP, the various components of the DEEOIC, and training for DEEOIC employees.

2. The EEOICPA. The EEOICPA, as amended, 42 U.S.C. § 7384 et seq., was enacted as Title XXXVI of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Public Law 106-398. The Act originally had two parts, Part B and Part D. On October 28, 2004, the President signed into law an amendment that repealed Part D of the EEOICPA and created a new program called Part E.

a. Part B. The purpose of Part B is to provide a lump-sum payment of $150,000 and medical benefits as compensation to covered employees suffering from occupational illnesses incurred as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the DOE and certain of its vendors, contractors and subcontractors.

The legislation also provides for the payment of compensation to certain survivors of these covered employees, as well as for payment of a smaller lump-sum of $50,000 to individuals or their survivors who were determined to be eligible for compensation under Section 5 of RECA. Compensation for individuals with beryllium sensitivity is limited to medical monitoring and medical benefits.

b. Part E. The purpose of Part E is to provide variable amounts of compensation to DOE contractor employees or to their survivor(s) where it is at least as likely as not that exposure to a toxic substance while employed at a covered facility was a significant factor in aggravating, contributing to or causing the employee's illness or death. Variable amounts of compensation up to an aggregate total of $250,000 (for the employee and any survivors) are determined based on causation, wage-loss, and impairment.

3. Organization. This paragraph describes the structure and authority of the National and District Offices (DOs). OWCP has six divisions, of which DEEOIC is one. The others are the Division of Federal Employees' Compensation (DFEC); the Division of Longshore and Harbor Workers' Compensation (DLHWC); the Division of Coal Mine Workers' Compensation (DCMWC); the Division of Administration and Operations, and the Division of Financial Administration.

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

4. Responsibilities. This paragraph describes the roles of the various components within the DEEOIC.

a. DOs. Within each DO there are a variety of roles:

(1) Claims Functions. Supervisory Claims Examiners (SCEs) manage units of Senior Claims Examiners (SrCEs) and Claims Examiners (CEs). Staff in these units adjudicate claims, authorize compensation, respond to inquiries from interested parties, and maintain case files.

(2) Fiscal Operations. Fiscal Officers (FOs) are designated for each DO. The primary responsibility of these individuals is to ensure the integrity of the compensation payment process. The FO is also responsible for monitoring financial management records and serves as the DO point of contact for medical billing issues.

(3) Medical Referrals. DEEOIC uses the services of a contractor to assist in obtaining medical opinions on a range of issues including causation, impairment, wage-loss, etc. The contractor is also responsible for the scheduling of second opinion medical examinations. Within each DO, a designated District Claims Assistant (CA) is responsible for coordinating case referrals with the contractor.

(4) M&F. Contract personnel in this area open, sort and place mail, compile case files, retire case records according to established schedules, image case files and documents, and transfer case files in and out of the DO. The CMR is the central location for incoming mail. The contract staff is responsible for opening mail, prepping the mail for scanning, scanning the mail, and assigning the digital image of the mail to the proper case in the OIS.

(5) Contact and Technical Assistance. Customer Service Representatives are responsible for answering phones, referring calls within the DO and responding to general inquiries. Technical assistants are responsible for providing technical guidance and assistance to DO personnel and maintaining liaison with organizations outside the DO.

b. National Office (NO). The Director of DEEOIC has final authority to manage and administer the program. With the exception of the Final Adjudication Branch (FAB) Chief, who reports directly to the Director, the Deputy Director supervises the DEEOIC Branch Chiefs and serves as the Acting Director in the Director's absence. Under the immediate jurisdiction of the Director and Deputy Director are the:

(1) Policy Branch. Personnel in the Policy Branch consist of the Policy, Regulations and Procedures Unit (PRPU) and the Medical, Health & Science Unit (MHSU).

(a) The PRPU is responsible for working with the Office of the Director and the SOL in the research, determination and writing of all program policies, regulations and procedures, as well as

providing consultative services regarding those policies, regulations and procedures to various DEEOIC staff.

(b) The MHSU conducts and oversees scientific and nursing-related consultative services for DEEOIC staff. This can include industrial hygiene, health physicist, toxicological and nursing-related advice and consulting services. Additionally, these staff provide specific medical and scientific research, reporting and advice in the development of policies, regulations and procedures that involve scientific and/or medical issues.

(2) Branch of Outreach and Technical Assistance (BOTA). Personnel in the BOTA are responsible for technical assistance and outreach activities, including developing informational materials and maintaining the Web page. In particular, BOTA staff:

(a) Develop and conduct training for DEEOIC staff;

(b) Manage the program's priority correspondence activity, including FOIA requests; preparing responses for the Secretary of Labor; Office of Congressional and Intergovernmental Affairs; OWCP Director, and the Director of the DEEOIC;

(c) Facilitate development of comprehensive outreach plans; including local outreach by Resource Centers (RC); monitor and approve outreach expenses, conduct and arrange outreach events, and act as the POC on the Joint Outreach Task Force Group (JOTG). The JOTG is comprised of representatives from the DOE, the DOE Former Worker Program (FWP), the NIOSH, and the DOL and NIOSH offices of the Ombudsman. These agencies work together to conduct joint outreach to current and former workers of the DOE workforce; and

(d) Promote and maintain cooperative relations with individuals and groups having EEOICPA interests through technical assistance and public relations activities.

(3) Branch of Automated Data Processing Systems (BAS). Members of this Branch provide data processing and payment systems support services for the DEEOIC. In particular, the Branch is responsible for:

(a) Developing and maintaining activities related to the Energy Compensation System (ECS) and OIS;

(b) Providing statistical reports and data; and

(c) Providing overall computer services.

(4) Management Unit. Members of this unit support the efficient operations of the DEEOIC by providing the following functions:

(a) Oversee DEEOIC budget and ensure that budget limitations are not exceeded;

(b) Monitor and manage personnel and procurement actions; and

(c) Provide administrative support to the Director and the Deputy Director.

(5) Branch of Medical Benefits (BMB). Personnel in this branch are responsible for medical bill processing, adjudication of certain medical benefits that require pre-approval (like home health care related activities) for claimants who have accepted conditions, and program integrity.

(a) The Medical Bill Processing Unit (MBPU) oversees the medical bill processing systems, transactions and coding necessary to assure prompt and accurate payment for approved medical benefits, and works with OWCP and the Central Bill Processing contractor to develop and implement appropriate bill payment codes, procedures and resolutions to issues which arise.

(b) The Program Integrity Team provides analysis, investigations, audit and reporting regarding whether payments made to claimants or providers were accurate and appropriate, and align with necessary treatments for approved conditions. When potential billing inaccuracies or discrepancies are identified, they will work to provide training and/or implement bill adjustments, as appropriate and necessary.

(c) The Medical Benefits Adjudication Unit (MBAU) provides medical benefits adjudication and decisions regarding requests for medical care or equipment that requires preauthorization.

c. FAB. Personnel in this Branch are responsible for issuing all FDs under the EEOICPA, except for decisions on overpayments. The FAB also processes all objections by holding oral hearings or reviewing the written record. FAB representatives issue FDs that affirm, remand, or reverse RDs issued by the DEEOIC DOs.

A FAB Office is located in Washington, D.C., and a FAB unit is co-located with, but independent from, each of the four DOs. The manager of each FAB DO reports to the FAB Chief. (Exhibit 2-1 contains a list of addresses, telephone numbers, and fax numbers for the FAB units.)

(1) A separation must exist between the DOs and FAB to maintain impartiality in case adjudication functions. The designated CE assigned to

a case handles all necessary development on outstanding claim elements not related to the RD currently in front of the FAB for review, and may issue a RD whenever the case record contains enough evidence on file to support a RD on any of the outstanding claim elements. While the CE may concurrently work on a case assigned to FAB, the CE may not engage in any case adjudication activity relating to a claim under evaluation by FAB. Moreover, FAB may not seek CE assistance with regard to its evaluation or development of a claim under consideration for finalization.

5. Training. This paragraph describes the information new employees need and addresses the kinds of training OWCP provides to its employees.

a. Orientation. Orientation is provided to all new employees of the DO, FAB and NO. This orientation includes the following topics:

(1) Organization of the DO, the Regional Office, the FAB, the NO, and OWCP, as appropriate;

(2) Mission and objectives of the DEEOIC;

(3) General description of duties;

(4) Staffing pattern, chain of command;

(5) Floor plan/physical layout of office, unit locations, emergency procedures, office security, etc.;

(6) Mail handling, paper and case flow;

(7) Working hours, breaks, lunch hour, sick and annual leave arrangements, flextime, telephone use, overtime authorization, etc.;

(8) Introduction to staff;

(9) Reference materials; and

(10) Role of partner agencies, e.g. NIOSH, DOE, DOJ, RCs, etc.

b. Courses. Three formal training courses have been developed for the DEEIOC staff. These include:

(1) All Staff Members Orientation. This is a course designed by each DO, FAB, and the NO to explain the basic concepts of the EEOICPA.

(2) CE Course. CEs, Senior CEs, Supervisors, and FAB Representatives take this course.

It is delivered in a classroom or through self-instructional format. A resource person is available to respond to questions if the self-instructional format is used.

The course, which requires about two weeks to complete, is designed to explain the claims adjudication process and to develop case management skills.

(3) Secondary Training. Additional training is provided to all claims personnel to address developing needs of the program (e.g., complex medical terminology/issues, facilities lists, exposure determination and SEM, precedent-setting decisions, RCs). This training may include advanced CE and FAB training. In addition, training on ECS is available.

6. Jurisdiction. Employee and survivor claims filed with the DEEOIC are assigned to a CE within one of the four DOs on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

7. Resources: DEEOIC district and FAB offices have full access to a range of reference materials and programmatic resources that are available through a publically accessible website. In addition, DEEOIC makes locally available other material that assists its staff in adjudicating claims. A list of programmatic references and resources available to staff can be seen in Exhibit 2-2.

CHAPTER 3 – GENERAL PROVISIONS

1. Purpose and Scope. This chapter summarizes the provisions and requirements of the EEOICPA and addresses its coverage.

2. Provisions of the EEOICPA.

a. Requirements for Part B Eligibility. A covered employee must satisfy criteria of eligibility for at least one of the following compensable categories under Part B:

(1) Beryllium sensitivity or CBD resulting from exposure to beryllium in the performance of duty.

(2) A specified cancer if the employee was a member of the SEC.

(3) A non-specified cancer if the employee incurred a cancer that is at least as likely as not related to radiation exposure from employment at a covered facility.

(4) Chronic silicosis resulting from exposure to silica from covered employment at a DOE facility in Nevada or Alaska, aggregating at least 250 work days during the mining of tunnels for tests or experiments related to atomic weapons.

(5) The U.S. Attorney General has determined entitlement to an award of $100,000 under RECA Section 5.

b. Requirements for Part E Eligibility. A covered employee must establish that it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness, and that it is at least as likely as not that the exposure to such toxic substance was related to employment at a DOE facility.

c. Medical Care. An employee who meets the statutory conditions of coverage is entitled to medical care consisting of services, appliances, and supplies prescribed or recommended by a qualified physician considered likely to cure, give relief, or reduce the degree or the period of that condition, and which DEEOIC considers likely to cure, give relief, or reduce the degree or the period of that illness.

Provider charges associated with the treatment of an accepted medical condition are paid from the compensation fund and are subject to a fee schedule.

d. Monetary Compensation under Part B. An eligible employee or survivor is entitled to receive a lump-sum payment of $150,000, if found eligible under Part B of the EEOICPA. An eligible uranium worker or survivor is eligible for a lump-sum payment of $50,000.

e. Monetary Compensation under Part E. Maximum compensation up to $250,000 is determined based on causation, wage-loss, and impairment.

(1) Employee Benefits: Covered employee is eligible for compensation up to $250,000 based on wage-loss and/or impairment.

(a) Wage-loss is based on the number of calendar years that the employee sustained a reduction in wages as a result of the covered illness. Wage-loss compensation is payable for qualifying years occurring prior to the employee's normal Social Security retirement age, determined by the employee's date of birth.

(b) Impairment is a loss, loss of use, or derangement of any body part, organ system or organ functionality as it affects the whole body, as a result of the covered illness. An impairment rating is performed once the employee has reached MMI (i.e., the covered illness is stabilized and is unlikely to improve with or without additional medical treatment).

(2) Survivor Benefits: The survivor is eligible for compensation in the amount of up to $125,000 if the covered illness aggravated, contributed to, or caused the employee's death.

(a) Wage-Loss: The survivor may be entitled up to an additional $25,000 or $50,000 depending upon the amount of calendar years over 10 years that the deceased covered employee experienced compensable wage-loss prior to his or her normal Social Security retirement age.

(b) Impairment: In general, the survivor is not entitled to impairment benefits under Part E.

f. Survivor Eligibility under Part B. In the event of the death of an eligible employee, the Act provides for the disbursement of compensation in order of precedence and in proportion to the number of eligible survivors. The order of precedence is spouse, child, parent, grandchild, then grandparent.

g. Survivor Eligibility under Part E. The only survivors eligible for benefits are the spouse, or children of the covered employee who are under the age of 18 years at the time of the employee's death, or under the age of 23 years and a full time student at the time of the employee's death, or any age and incapable of self-support at the time of the employee's death. In limited circumstances, a spouse may elect to receive the compensation to which an employee would have been eligible prior to death.

h. Third Party Liability. With the exceptions listed below, where an employee's compensable illness or death results from circumstances creating a legal liability

on some party other than the United States, the cost of compensation and other benefits paid by the

OWCP must be offset to reflect any settlement obtained. Exceptions include the following:

(1) Workers' compensation benefits are not offset under Part B; and

(2) Insurance policy payments made to an employee or eligible surviving beneficiary, where the employee or eligible surviving beneficiary has purchased the policy, are not offset.

i. Coordination of Benefits with SWC. When a claimant has received benefits from a SWC program for the same covered illness(es) to which he or she is to be awarded compensation under Part E, this requires a reduction in the award. Exceptions to this reduction include the following:

(1) Medical and vocational rehabilitation benefits received from SWC for the same covered illness(es) are not included in the reduction;

(2) The claimant has received SWC benefits for both a covered and a non-covered illness as a result of the same-work related incident; these benefits also will not be included in the reduction; and

(3) Reasonable costs in obtaining SWC benefits incurred by the claimant, such as but not limited to attorney's fees and specific itemized costs of suits, are not included in the reduction.

CHAPTER 4 – CUSTOMER SERVICE

1. Purpose and Scope. This chapter describes the commitment of the DEEOIC to serving its internal and external customers with excellence.

a. Internal Customers. These include but are not limited to NO staff, DO staff, and RC employees.

b. External Customers. These include, but are not limited to, authorized representatives (ARs), attorneys, advocacy groups, congressional officials, contractors, and other external agents who have a vested interest in the claims process.

2. DEEOIC Standards for Customer Service. The highest level of customer service is expected in all dealings with individuals conducting business with and within the DEEOIC. All staff are expected to be courteous, professional, flexible, honest and helpful. The program's Operational Plan includes standards for the performance, responsiveness and timeliness of customer service. DEEOIC's Customer Service Goals include the following:

a. Customers. DEEOIC customers are satisfied with our services;

b. Services. DEEOIC services are delivered to customers in a timely and accurate manner; and

c. Planning and Development. Customer needs are integrated into program planning and product development.

3. Telephone Communications. DEEOIC staff speak to claimants, ARs, health care providers, employer organizations, RC personnel, governmental organizations, and others on a daily basis.

a. Telephone Skills. Effective telephone skills are one of the keys to providing accurate, courteous, and timely information to callers. These skills include, but are not limited to, the following:

(1) Answer the telephone promptly;

(2) Identify the caller’s needs;

(3) Handle inquiries in a professional and pleasant (non-defensive) manner;

(4) Provide prompt, informative responses;

(5) Keep conversations brief but provide accurate, courteous, and timely information; and

(6) Give callers an accurate estimate of when a return call will be attempted, if necessary.

b. Inquiries Directed to RCs. RCs are situated in key geographic locations throughout the United States to provide assistance and information to the DEEOIC claimant community and other interested parties. The RCs play a limited but valuable role in the claims process and their duties include the following:

(1) Provide information on claims process and program procedures to the DEEOIC claimant community;

(2) Assist claimants in the completion of the necessary claim forms;

(3) Take initial employment verification steps for all new EEOICPA claims filed with the RC;

(4) Conduct occupational history development for certain employees;

(5) Provide case-specific information and clarification to claimants and ARs;

(6) Educate and assist the claimants regarding impairment and wage-loss benefits on cases with positive causation determinations; and

(7) Provide medical bill payment assistance to claimants.

For more information about the RCs, see Chapter 10 - Resource Centers.

c. Documenting Phone Calls. The Phone Calls Screen in ECS allows the ECS user to memorialize telephone conversations. The Phone Calls screen in ECS also provides a mechanism by which incoming and outgoing telephone contact on a given case file is tracked and maintained.

(1) The person who answers the phone must create the phone record in ECS, unless the call is immediately transferred to another person and that person picks up the phone and speaks with the caller. The second person then becomes responsible for creating the phone message record in ECS. A copy of the phone call note from ECS must be bronzed into OIS.

(2) The person transferring the call must ensure that the call is picked up so that the caller is not inadvertently dropped or transferred to a voicemail message.

(3) Callers may be transferred to voicemail only with the caller's explicit knowledge and consent.

4. Written Communications. DEEOIC staff must use good writing skills in all correspondence. Letters must be clear, concise, instructional, accurate, and tailored. Specific skills include:

a. Considering the Reader. Use language that the reader can understand and customize the correspondence accordingly, specifically for that reader. Avoid using abbreviations in the body of the correspondence, unless they have been written out at the beginning of the correspondence;

b. Checking for Errors. Review correspondence before issuance to eliminate grammatical, spelling, template or other technical errors;

c. Choosing the Mode of Expression. Use natural and non-adversarial wording. To the extent possible, write politely, conversationally and employ commonly used words;

d. Making Documents Visually Appealing. Present text in a way that highlights the main points to be communicated. Use bullets or numbered lists when providing instructions or identifying deficiencies. Avoid lengthy narrative explanations or too much usage of underlining or bolding of the text in the correspondence; and

e. Tailoring the Letter to the Issue at Hand. Do not use lengthy, "laundry list" template letters when only certain information is being requested or provided. Identify what evidence has been submitted and the additional information that is needed in order to proceed with the adjudication of the claim in a timely manner.

CHAPTER 5 – PROGRAM DIRECTIVES

1. Purpose and Scope. This chapter describes the communications and directives system used by the DEEOIC. It focuses on the structure of the PM governing claims under the EEOICPA, and addresses its relationship to the Program's other written directives.

2. Directives. The publications relating to the EEOICPA include both external and internal releases, as follows:

a. External Directives. These may consist of either legal or informational releases.

(1) The Federal Register contains "Notices" and "Rules" pertaining to new or revised policy.

(a) "Notices" in the Federal Register advise the public of proposed changes and invite comments on them.

(b) "Rules" in the Federal Register state the regulations adopted by the program.

(2) Pamphlets and notices inform the public of the availability of EEOICPA benefits.

b. Internal Directives. There are three categories of directives; they are permanent (unless superseded), time-limited, and informational.

(1) Permanent directives include the following:

(a) The Federal EEOICPA PM, which is updated by transmittals.

(b) Other guides, including the DOL Correspondence Guide (DLMS Handbook 1-2); the GPO Style Manual; Program Memoranda; OIS, and the ECS User's Manual which provides users and operators of the ECS with guidelines for interacting with the system.

(2) Time-limited directives are issued as Bulletins. They may involve changes to procedures, special reports, or pilot programs. A Bulletin is effective until it is superseded by the PM or an updated Bulletin.

(3) Informational directives are issued as Circulars and do not require specific action. They are used to meet the following objectives:

(a) To announce personnel changes, upcoming events or activities, or other items of informational value;

(b) To call attention to standing instructions or performance standards that may require compliance or improvement;

(c) To announce proposed plans or anticipated program changes; or

(d) To inform DOs of the activities and interests of the NO.

3. Procedure Manual. The EEOICPA PM is accessible to all interested parties within and outside of the DEEOIC.

4. Maintenance and Revision. EEOICPA Transmittals update the EEOICPA PM.

a. Citations to the PM. The EEOICPA PM has thirty-six chapters, which in turn are divided into paragraphs, subparagraphs, and sometimes sub-subparagraphs. The PM should be cited as follows:

Citation to a chapter: Federal (EEOICPA) PM Chapter 1 (Version X.X)
Citation to a paragraph: Federal (EEOICPA) PM Chapter 1.1(Version X.X)
Citation to a subparagraph: Federal (EEOICPA) PM Chapter 1.1a (Version X.X)
Citation to a sub-subparagraph: Federal (EEOICPA) PM Chapter 1.1a(1) (Version X.X)

CHAPTER 6 – PROCESSING MAIL

1. Purpose and Scope. This chapter identifies the different types of mail received by the DEEOIC and outlines mail-processing procedures. In addition, the chapter contains procedures for case mail association, outgoing mail processing and handling returned mail. Also provided is information regarding the handling of priority correspondence, including FOIA and Privacy Act requests, and the safeguarding of Personally Identifiable Information (PII) in the disclosure of claim records.

The work of staff related to mail and file is tied closely to ECS functionality in tracking cases, managing case status and record keeping. Specific instructions for using ECS are set forth in user guidance available to staff.

2. Types of Mail. Most mail received by a DEEOIC Office is through the U.S. Postal Service (USPS). However, some mail is received by private overnight mail service, facsimile transmission (fax), electronic mail (e-mail), or by hand. Mail is grouped as follows:

a. Priority Correspondence. DOL considers mail to and from the following parties as priority correspondence:

(1) The President and White House Staff;

(2) The Vice President and members of the Vice President's staff;

(3) The President Pro Tempore of the Senate;

(4) The Speaker of the House of Representatives;

(5) Other Members of Congress;

(6) Members of the Cabinet;

(7) Governors of States;

(8) Foreign government officials (e.g., Prime Ministers, Cabinet-level officers, Ambassadors, etc.);

(9) Directors/Managers of employee organizations;

(10) Directors/Managers of national and international labor organizations;

(11) Members of the press; and

(12) Requestors of data under FOIA and the Privacy Act.

b. Primary Claim Forms. These documents, which contain information on new claims, include:

(1) EE-1, Claim for Benefits under the EEOICPA;

(2) EE-2, Claim for Survivor Benefits under the EEOICPA; and

(3) Any letter or document containing "words of claim" under the EEOICPA. "Words of claim" simply means that the individual is requesting benefits under the EEOICPA.

c. Bills. Form OWCP-1500 is used to bill OWCP for medical services and supplies. Hospital bills are submitted on the Form OWCP-04. Form OWCP-915 is used for employee reimbursement of out-of-pocket medical expenses. Form OWCP-957 is used for employee reimbursement of medical travel expenses.

d. Fiscal Documents. Fiscal items may include an EN-20, payment transaction forms (PTF), payment cancellation forms, etc.

e. Routine Mail. Other types of mail typically received by the DEEOIC include:

(1) Documents from claimants and/or their AR, such as: medical records, employment records, exposure records, birth certificates, marriage certificates, death certificates, school records, affidavits, address changes, waivers, requests for an oral hearing, review of the written record, reconsideration, or reopening;

(2) Documents from the DOE, contractors, and/or subcontractors;

(3) Information from other agencies, such as HHS, NIOSH, DOJ, and the Social Security Administration (SSA);

(4) Medical reports from attending physicians;

(5) Mail from contractual sources, including reports from a CMC, Center for Construction Research and Training (CPWR), and second opinion and referee specialists;

(6) Occupational/Exposure reports from an IH and TOX;

(7) Requests for information from other Federal, state, and local government agencies; and

(8) Case-specific documents forwarded from other offices within DEEOIC, including a RC, for file association.

3. Electronic Recordkeeping. The DEEOIC maintains case file records in both paper and electronic form. Incoming paper mail is processed and scanned for electronic storage by a contractor at the CMR, located in London, Kentucky. The CMR date stamps the document(s) and its corresponding envelope, assesses the quality of the electronic image, and associates the

document(s) with the appropriate case record in OIS. The electronic document(s) is then indexed according to predetermined subjects and categories.

4. Unreviewed Mail Notification. Once the CMR has imaged a document and associated it with an existing case file record, an electronic notification is sent through OIS to the appropriate CE, notifying him/her that mail has been received in a case for which he/she is assigned. The assigned CE is to verify that the unreviewed mail has been associated with the appropriate case file, that the document was indexed correctly into the appropriate subject/category, and must review the entirety of the document and ensure that proper action is taken in response to the information provided. It is important that the CE check OIS for new mail on a daily basis.

5. Handling of Mail Received in a DEEOIC Office. While the CMR contractor handles the bulk of incoming mail for scanning and association with claim records, some mail and faxes will occasionally be received in DEEOIC offices. The M&F Clerk(s) in each office carefully inspect the contents of incoming envelopes to ensure that all contents are removed. For faxes, the M&F Clerk inspects the submission to make sure that it is complete and relates to a single claim. The envelope (or in case of fax, the top page of the document) must be date-stamped, indicating the DEEOIC office location in which the mail was received and the year, month, day, and time of receipt. Subsequently, the M&F Clerk forwards the faxes and mail to the CMR for incorporation into OIS.

The nature of some correspondence may require action at the DEEOIC DO level to image documents into OIS locally, at the office's discretion. Such documents may include, but are not limited to:

a. EE/EN-20 Acceptance of Payment Under the EEOICPA. At the time a payment is Authorized by the DD (or an approved person with the DD role), all documents associated with the payment (i.e. EN-20, PTF, Payment Memo, Screen Print, etc.) are to be bronzed and saved as a "payment packet" in OIS. Once the payment packet is bronzed, the documents will be labeled with a unique identifier and filed under the Category: Forms and Claims; Subject: PTF. The payment packet will be described using a unique identifier consisting of the letters "PMT" followed by the first 4 letters of the payee's last name, the last 4 numbers of the payee Social Security Number (SSN), and the Authorization Date as it appears on the PTF. For example, a payment to someone named Jones, with a "last 4" of 9876, and an Authorization Date of 01/01/2014 would be stored in OIS as follows:

Category:	Forms & Claims
Subject:	PTF
Description:	PMT JONE9876, 01-01-2014

b. SSA-581 Authorization to Obtain Earnings Data from the SSA. The SSA requires an original signed copy of the SSA-581. As such, a copy of the SSA-581 is to be bronzed into the appropriate case record in OIS, and the original is sent to SSA for processing.

c. Documents Pertaining to a Terminal Claimant. Because documents in terminal cases are time-sensitive and require swift action, mail of this kind received at a

DEEOIC office is directed to the assigned CE for immediate incorporation into OIS and appropriate handling.

d. Priority Correspondence. Priority correspondence generally refers to the request for information and/or status of a claim from the claimant or an authorized third party. Consequently, priority correspondence is time sensitive and requires careful attention in its review and response.

Of the priority correspondence listed in paragraph 2a above, the most common are FOIA requests, Privacy Act requests, and Congressional inquiries. In instances when a third party makes such a request (other than a FOIA request), a waiver signed by the claimant or AR must be included.

(1) FOIA Requests. FOIA requests allow third parties to request and gain access to existing Federal Government information, as outlined under 5 U.S.C. §552. FOIA requests are highly time sensitive and require careful attention as they involve the disclosure of specific documentation pertaining to the DEEOIC and/or its claimants. Each DEEOIC Office is to have a Point of Contact who can effectively identify FOIA requests and forward them to the DEEOIC National Office's Branch of Outreach and Technical Assistance.

Exhibit 6-1 shows a FOIA Process Flow Chart which identifies the steps to be taken in order to accurately and expeditiously process a FOIA request received in a DEEOIC office.

(2) Congressional Inquiries. On behalf of their constituents, Congresspersons submit requests for information pertaining to a claimant's EEOICPA claim. The responsible DO or FAB office is responsible for ensuring that these inquiries receive a comprehensive review and that a response is prepared in a timely manner.

(3) Privacy Act. The Privacy Act of 1974, 5 U.S.C. §552a, applies to an individual seeking information about him or herself. The law provides an individual the right to access records maintained in federal systems of record (e.g., claim files) that are retrievable by his or her name or other personal identifiers.

Examples of Privacy Act requests received by DEEOIC include requests for a copy of a case file or a specific document from a case file (e.g., CMC report, SSA records). Privacy Act requests may be submitted by claimants, an AR or authorized third parties.

(a) Handling document requests. In instances when a claimant, AR or authorized third party is seeking a copy of the entire case file record, or a specific document in a case file, the CE is to:

(i) Access ECS to determine if the case file has an imaged component.

(ii) Copy relevant documents from the paper case file and/or OIS.

(iii) Determine what information, if any, needs to be redacted.

(iv) Before copies are sent, the CE/FAB Hearing Representative (HR) reviews the case file and the redacted copies, and completes a Data Release Form (Exhibit 6-2). The CE/HR then provides a copy of the redacted case file to the appropriate Supervisory CE, Senior CE, or HR for review to ensure the documents are appropriately redacted. A cover letter outlining the claimant's appeal rights is to be included. The CE/HR is only permitted to release documents that have been reviewed, and whose release has been approved by the appropriate Disclosure Officer or his/her designee. The Data Release Form is to be bronzed into the appropriate case record in OIS.

6. Physical Evidence. Any documents or other physical evidence submitted by a claimant is to be retained by the Program as part of the case record. Program literature and other public notices are to include instruction to the claimants as to the appropriate types of evidence to submit in support of a claim. Claimants should not send original documents to the CMR (e.g., birth certificates, death certificates, marriage certificates). The CMR will scan these types of records, but it may not be possible to return them to the submitting claimant.

a. Portable Media. The types of documents and evidence received by the DEEOIC in support of EEOICPA claims is varied and can occasionally consist of physical evidence which cannot be imaged into OIS, such as portable media, X-rays, etc. In such instances, the DO is to incorporate this information with the paper case file, making a notation in the electronic OIS record that physical evidence exists in the case. If no paper case file exists, a new file is to be created in which to store the physical evidence and is maintained by the DO.

7. PII. PII is defined as information that can be used to distinguish or trace an individual's identity, such as his or her name, SSN, or biometric records, alone or when combined with other personal or identifying information that is linked or linkable to a specific individual, such as a date and place of birth or mother's maiden name.

During the adjudication process, the DEEOIC collects, maintains, and shares a large amount of data. It is of the utmost importance that all DEEOIC staff maintains the privacy of all claimants and safeguards PII contained within the case record from unauthorized and improper disclosure.

a. Protected PII. Protected PII is information, which if disclosed, can result in harm to the individual whose name or identity is linked to that information. Examples of Protected PII include, but are not limited: SSN, credit card number, bank

account number, biometric identifiers (e.g. image, fingerprint, and iris), date of birth, place of birth, mother's maiden name, criminal records, medical records, and financial records.

b. Non-Sensitive PII. Non-sensitive PII is information, which if disclosed, cannot reasonably be expected to result in personal harm to the individual the information is linked to. Examples of non-sensitive PII that can become Protected PII if linked with other Protected PII include, but are not limited to: first/last name, e-mail address, business address, business telephone, and general education credentials.

c. Categories of PII that Indirectly Identify an Individual.

(1) Any information where it is reasonably foreseeable that the information can be linked with other information to identify an individual;

(2) Documentation not containing a name or SSN but containing a place of birth and mother's maiden name, which when taken together, can identify a specific individual; and

(3) Documentation containing the name or names of other individuals (e.g., names of co-workers).

d. Information Pertaining to Deceased Individuals. An individual's right to privacy ends upon his or her death. Therefore, a deceased person's name, address or SSN is not considered PII. However, documentation referring to a deceased person can contain PII regarding other living individuals.

e. Information Pertaining to Living Individuals. All DEEOIC staff are to prevent the unauthorized release of PII contained in paper records, electronic records (e.g. e-mails), or any other material for any living individual. This includes materials received from NIOSH, DOE, CPWR, corporate verifiers, unions, or any other source.

(1) CDs from NIOSH and DOE may contain PII on other individuals. DEEOIC staff must thoroughly review all documents on a CD before releasing the information. If a document contains PII on an individual other than the claimant, the document is printed and the appropriate PII is redacted. A photocopy is then made of the newly redacted record to ensure that the redacted information cannot be detected. This redacted document is then scanned into OIS.

If the CD is identified as containing PII pertaining to individuals other than the claimant, DEEOIC staff will place a label on the CD that states:

NOTICE:

This CD and/or printed documents from the CD, includes confidential information on workers other than this employee. This information must be carefully reviewed and redacted before release, whether by electronic or printed version, pursuant to the Privacy Act. Monetary fines may be imposed on an individual government employee for release of confidential information or personally identifiable information.

f. E-Mail. All DEEOIC staff must comply with all prescribed OWCP concerning the use of e-mail containing PII.

(1) E-mails sent from one DEEOIC employee to another through the internal OWCP wide-area network (WAN) are considered secure. E-mails to and from contractors who use the OWCP network (OWCP owned and properly configured equipment, including remote laptops that access the WAN) are also considered secure. Central Bill Process "threads" provided through the secure website of the Bill Processing Agent (BPA) conform to this policy, as they are also secured within an accredited network.

DEEOIC staff are permitted to list the employee's name and case file ID in the body of an e-mail message. However, the subject portion of the e-mail may not contain both the employee's name, combined with any identifier considered Protected PII, outlined above.

(2) E-mails between DEEOIC employees and parties outside of the OWCP network (e.g., RCs, corporate verifiers, NIOSH, DOE) are not secure. As such, DEEOIC staff are not permitted to disclose any protected PII in any part of the e-mail message and any attachments containing protected PII must be password protected or encrypted.

Therefore an e-mail message can contain the last name and Case ID number in the text of the message, as long as the SSN, full name, or other PII is not listed anywhere in the e-mail message. Accordingly, development letters must be faxed or mailed to corporate verifiers.

(a) SSA Exception. Communications with the SSA are through digital fax, and as such, do not subject to the above restrictions.

(3) Case specific e-mails received from an outside party containing Protected PII are to be printed and uploaded into the OIS case file. DEEOIC staff are permitted to reply with an acknowledgement e-mail, removing any PII from the sender's message and also advising the sender (e.g., claimants, physicians, Congressional offices) that DEEOIC does not conduct claims

communication via e-mail, but only by telephone or letter, as e-mail cannot be considered secure.

In addition, DEEOIC staff are to remove protected PII in any e-mail message chain and their attachments prior to forwarding them outside of the OWCP network. However, if this is not possible, the documents should be faxed or sent via mail or courier. Packages containing extracts of multiple protected PII records (e.g. to CPWR, DOE, RC) sent via courier must be tracked (e.g., sent by Registered Mail, Return Receipt, FedEx).

(4) E-mail messages with the BPA concerning claimants may only include the claimant's Central Bill Process Member ID. Claimant names are not to be included in the e-mail, unless in an encrypted attachment.

g. Protected PII and Portable Media.

(1) Protected PII is only to be stored on portable media when absolutely necessary. Protected PII on portable media devices including laptops issued by DOL are to be protected with agency-approved encryption. All reasonable measures are to be taken to ensure that portable media containing protected PII are stored inside a safe or in a secured, locked cabinet, room, or area during periods when the media is not in transit or active use.

(2) Delivery of portable media containing protected PII, including CDs, DVDs, or other writable media is done through the USPS or other DOL authorized delivery service with the ability to track pickup, receipt, transfer, and delivery. The portable media must be encrypted according to DOL standards and then double-wrapped in an opaque package or container that is sufficiently sealed to prevent inadvertent opening or reveal signs of tampering. The decryption key is not included in the same package as the portable media, but instead sent in a separate package.

h. Disposal of Documents and Electronic Media Containing Protected PII. Hard copy documents and electronic media containing PII are not simply discarded in a wastebasket, but instead discarded in bins specifically designated for shredding or burning.

i. Improper Release of Protected PII. If protected PII is improperly released to an incorrect individual, or documentation sent to the correct individual contains protected PII of another individual that was not redacted, DEEOIC staff must notify their supervisor who will follow the standard department protocols for reporting PII violations.

8. Outgoing Mail. Outgoing mail is processed as follows:

a. Envelopes. All envelopes show the addressee's full mailing address, including the ZIP code. If the addressee provides a P.O. Box and a street address, both are listed on the envelope. Some post offices require a further separation of local mail, and such requirements are honored.

b. Postage. A postage meter is used to affix postage. Airmail letters for overseas delivery are bundled separately from regular mail.

c. Registered and Certified Mail. These types of mail are processed according to USPS regulations and specific procedures established in each DEEOIC office.

d. Overnight Express Mail. The services of the designated contractor are used at the discretion of the DEEOIC.

9. Returned Mail. Occasionally, mail sent out by the DEEOIC is returned by the USPS as undeliverable. The effective handling of claims depends heavily on ensuring that the claimant and/or AR receive the correspondence sent by a DEEOIC Office. Therefore, it is important that the DEEOIC maintain the current mailing address and phone number(s) of the claimant and/or AR.

a. Inaccurate or Unreadable Mailing Address. On occasion, printing errors occur in which the mailing address contains a typo, is transposed, or is incomplete, and is thus returned as undeliverable. In such instances, the mailing address on the correspondence is examined and compared to the mailing address on file. If it is determined that a mistake was made by the DEEOIC, a corrected correspondence, with a new effective date, is prepared and resent to the correct mailing address and the release date is updated in ECS.

b. Unknown Address. In such instances, sufficient attempts to obtain a correct address are made prior to administratively closing the claim.

(1) Check the Social Security Death Index to verify the recipient is alive. A print out of the search is to be imaged into the case record.

(2) Call the claimant or AR and request the current mailing address be verified in writing. This request is also memorialized in writing.

(3) Review the case file in its entirety to determine if any new/different contact information for the claimant or AR exists in any of the evidence;

(4) Contact the RC to see if they have contact information on the claimant or AR. In instances of multiple claimants, they may also be contacted in an attempt to obtain updated contact information on the claimant or AR;

(5) Send a letter to the USPS Postmaster. Exhibit 6-3 shows a sample USPS Postmaster Address Request Letter. Information regarding the appropriate

postmaster to which this letter is to be sent can be obtained at http://www.usps.com/ under "Locate a Post Office."

c. Administrative Closure of Claim. If all efforts are exhausted and no updated information is obtained, the claim is in posture for administrative closure. A memorandum is prepared outlining the unsuccessful efforts of obtaining a current address and that the claim is being administratively closed as a result.

CHAPTER 7 – CASE CREATION

1. Purpose and Scope. This chapter describes the role of the RC, CMR, DO, and FAB in the case creation process. In addition, the chapter covers the process of creating an EEOICPA case file electronically in OIS and ECS. The chapter contains instructions for deciding whether a new claim is considered filed under Part B and/or Part E of the EEOICPA. Finally, the chapter provides guidance regarding the proper handling of additional claims received during claim adjudication and the handling of withdrawn claims.

2. New Cases. A new case consists of a Claim for Benefits, Form EE-1 or EE-2, with the accompanying Form EE-3, Employment History for a Claim Under the EEOICPA. DEEOIC will create a new case upon receipt of a signed written communication from the claimant or a person acting on behalf of the claimant (e.g., a guardian or duly authorized Power of Attorney). DEEOIC will consider any of the following documents a claim for benefits:

a. Form EE-1, Employee's Claim for Benefits;

b. Form EE-2, Survivor's Claim for Benefits; or

c. Any letter or document containing "words of claim" under the EEOICPA. "Words of claim" means that the individual has communicated in writing his or her intent to seek benefits under the EEOICPA.

3. Receipt of a New Claim. Designated DEEOIC staff at the DO or RC take new claim documentation, including the postmarked enveloped used to mail a claim form, and affix an inked date stamp on all documents. The date stamp is to identify the receiving office location and received date. Once date stamped, CMR contract staff then make an electronic image of the documents and upload them into the Energy Document Portal (EDP), which goes directly into the Case Create Queue in OIS. The CMR then send a notification to the Centralized Case Create (CCC) office of their action. The EDP also allows claimants, their attorneys, AR, family members, etc. to upload claim documentation into OIS.

Case create clerks at the CCC are responsible for checking the Case Create Queue daily to identify new incoming claims. The CCC records the relevant demographic data relating to the claim into ECS, such as personal, medical, employment and other component data. Upon completion, a copy of the claim form is uploaded into OIS, which automatically generates a unique ECS Case Identification Number (Case ID number).

a. Terminal Claims. In instances where a claim form is received by the DEEOIC office or a RC from, or on behalf of, a terminal claimant, the claim form and all supporting documentation is date-stamped, scanned, converted to a PDF attachment and immediately sent via e-mail to zzOWCP-DEEOIC-Centralized Case Create Group.

The subject line for any e-mail concerning a terminal claim should include "Terminal Case Create" followed by the name of the office sending the email, the claimant's last name (or case number in case of an existing case). For example, a

subject line would read: Terminal Case Create DEN Smith; or Terminal Case Create JAC 50100000.

To comply with program procedure, DO staff prioritizes any claim with a terminal status. Should a DD or FAB Manager determine that even a short delay in processing the forms would adversely affect the claimant, they are to contact the OIS Coordinator or Cleveland DD by telephone.

(1) If a terminal claim is received in the RC, the RC uploads all claim documentation to the EDP.

(2) The DD or designee reviews the documentation to determine whether the medical records necessitate the claim be expedited. If the claim is to be expedited, the DO follows the procedure described above. If the claim documentation does not support a designation of terminal status, the DO forwards the claim documents to the CMR for processing.

c. Occupational History Development. For Part E causation claims, staff completes an Occupational History Questionnaire (OHQ) by interviewing claimants about their knowledge of employee exposure to toxic substances. The RC staff completes the OHQ interview either in-person or telephonically within 14 days of assignment or receipt of claim. If the OHQ interview cannot be completed within 14 days, the RC staff may request an extension with the jurisdictional DO. Once the OHQ interview is complete, the RC staff scans and uploads the completed OHQ interview to the case file, via the EDP along with the approved DEEOIC checklist. While the RC is generally the recipient of new incoming claims, occasionally the DO will receive new claim documentation. In these situations, the DO receiving the new claim coordinates with the appropriate RC to have it conduct an OHQ.

4. Assignment of Claims to a DO. The assignment of a claim to a particular DO occurs on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

5. Creating Cases in ECS. The CCC enters into ECS information reported by the claimant from the incoming claim form, such as personal, medical, employment and any other relevant claim data. Important demographic information from the claim form necessary to create a claim include the employee/survivor name, SSN, mailing address, phone number, date of birth, sex, etc. The CCC also enters information concerning the nature of the claim to include the medical conditions claimed as work-related, the employment history for the employee, and responses to the receipt of other award or other legal information. Once this information is entered and saved, ECS assigns a unique Case ID Number for the entire case file. In addition, each person who has filed a claim within a case is assigned a unique claimant identification number. If the CCC is processing a claim based on the submission of an unsigned EE-1 or 2, or a claimant-signed correspondence that contains words of claim, he or she is to enter as much information as possible to permit ECS to assign a Case and Claimant ID Number. At a minimum, ECS requires the entry of name and mailing address of the claimant (in the case of a survivor, it is necessary to name the employee) to permit the creation of a case. Once the CCC creates a claim under this

circumstance, the matter is referred to the assigned CE to notify the claimant of the need to submit a signed EE-1 or 2 to allow for claim adjudication.

Case adjudication requires submission of a claimant-signed EE-1 or EE-2, so that DEEOIC obtains information necessary to process the claim and to ensure that the claimant acknowledges his or her responsibilities when submitting a claim. CCC will create a claim based on the submission of an unsigned EE-1/2, or words of claim. However, it is then the responsibility of the assigned CE to validate that the form is signed by either the claimant, or a person with legal authority to act on the claimant's behalf, prior to the issuance of a RD. If, when the case is in posture for the issuance of a RD, the CE has not obtained a claim form which has been signed by a claimant, or a person with legal authority to act on the claimant's behalf, the CE is to administratively close the claim. The CE mails a notification to the submitter advising of the administrative closure and requesting that the claimant submit a signed claim form. Upon receipt of a properly signed form, adjudication may resume, and the date of filing remains the date the original unsigned claim, or words of claim, was received.

For a systematic guide to ECS case create procedures, refer to the Claim Form Entry and Initial Review (Red Pane Review) instructions located in the ECS Procedures folder available to DO staff on the shared drive.

a. Handling Alternative Filings. A non-covered spouse or child of a deceased DOE contractor employee or RECA Section 5 uranium worker may submit a written request for an informal evaluation of whether the employee contracted a covered illness as a result of employment at a covered facility. As no RDs or FDs are issued in these instances, an EE-2 is not required. Accordingly, alternative filing requests are entered into ECS as "Words of Claim" under the form EE-2. The alternative filing request will be processed in ECS as a survivor claim according to instructions provided in Chapter 13.13.

6. CE Review. Once a new claim is received from the CCC, but prior to initial development and adjudication, the assigned CE reviews the claim forms, any employment and/or medical evidence, the claimed employment and occupational history development conducted by the RC and ECS to ensure ECS contains accurate information. If the claim requires additional follow up action by the RC, the CE may assign additional tasks to the RC as necessary.

a. Missing Information. If a claim form or document with "words of claim" is missing vital information (e.g., a diagnosed condition, employment information), the assigned CE requests the omitted information and/or the appropriate claim form from the claimant, or the designated AR.

b. Acknowledgement Letter. Upon receipt of a new claim, the DO is responsible for sending the claimant a letter acknowledging the receipt of a new claim and providing the claimant with a Case ID number and contact information should the claimant have questions regarding his/her claim.

c. Corrective Action. In some instances, a CE or FAB CE/HR will identify a data entry error or receive information that warrants a revision to claimant demographic data recorded in ECS. ECS demographic data such as date of birth,

date of death, gender, relationship type, phone numbers, Power of Attorney (POA) and AR names are editable by the assigned CE or FAB CE/HR. However, in other instances, critical data relating to the claimant, such as address changes or corrections to name, SSN or other payee data, requires extra steps to process. For ECS data changes that the assigned CE or FAB CE/HR cannot perform on his or her own authority, the DEEOIC requires two individuals to process an ECS data change: The person who requests an ECS change and a person who makes the change. This ensures information security and accountability for critical data changes that has the potential to affect payee outcomes.

Should a CE or a FAB CE/HR identify a reason to modify ECS data that he or she cannot input on his or her own authority, they are to prepare an email with a subject line, "ECS Change Request – Case ID xxxx (insert Case ID Number)." In the body of the email, the requester will describe the nature of needed ECS change. In addition, he or she will reference the Document ID in OIS or attach as reference any document supporting the data change request (i.e. a claimant submitted signed address change request). The CE or FAB/CE forwards the email to the Payee Change Assistant (PCA) or other ECS data change agent designated with that functionality by the DD or FAB manager. The PCA or designated ECS data change agent is to process the ECS change request, unless there is some reason to seek clarification beforehand. Once completed, the PCA or designated ECS data change agent responds to the change request with an email confirming the data update. The receiving CE or FAB CE/HR confirms the change occurred as requested and then bronzes a copy of the email, along with any attachments, into OIS for recordkeeping.

7. Creating a Claim Under Part B vs. Part E, or Both. Identifying when a claim is to be adjudicated under Part B, Part E, or both, it is first necessary to identify the claimed conditions. Conditions covered under Part B include CBD, beryllium sensitivity, chronic silicosis and radiogenic cancers. Claims for any other illness not covered under Part B are created and adjudicated solely under Part E, which covers any illness found related to occupational toxic substance exposure.

a. Consideration of Employment. In addition to considering the claimed medical condition(s), claimed employment is also considered. Part B of the EEOICPA covers employees of the DOE, its contractors and subcontractors, beryllium vendors, AWEs and eligible survivors. Part E offers benefits to DOE contractors, subcontractors and their eligible survivors.

Upon receipt of a claim filed at the RC, the DO CE will perform all necessary actions to verify claimed employment, including review of the Oak Ridge Institute for Science and Education (ORISE) database information.

Example 1: If a claim identifies employment as a federal employee at a DOE facility and a Part B medical condition, the claim is adjudicated under Part B only, because a DOE federal employee is not a covered DOE contractor employee, as required under Part E.

Example 2: If a claim identifies employment at an AWE or a beryllium vendor and a Part B/E medical condition, the claim is adjudicated under Part B only, because working at an AWE or beryllium vendor is not covered employment under Part E. (The exception to this is if it is indicated that the employee worked at an AWE or beryllium vendor that was designated as a DOE facility for remediation.)

Example 3: If only Part B medical conditions are checked on the claim form (e.g., CBD, beryllium sensitivity, chronic silicosis, or radiogenic cancer) and DOE contractor employment is claimed, the claim will be adjudicated under both Part B and Part E.

Example 4: Some AWE and beryllium vendor facilities are designated as DOE facilities during periods of remediation. If the claimant from Example 1 instead claims employment with an AWE or beryllium vendor during a period of remediation or identifies the AWE or beryllium vendor as a DOE facility on Form EE-3, the claim is to be adjudicated under both Part B and Part E. In such a case, additional development to establish covered Part E employment would be required.

Example 5: To establish covered employment under Part E, the employee must have been a DOE contractor employee. If the claimant from Example 1 claims only employment as a DOE federal employee, the claim is adjudicated under only Part B.

Example 6: If a non-Part B medical condition (e.g., asbestosis) and DOE contractor employment are claimed, the claim is treated as a Part E claim only.

Example 7: If the claimant claims diabetes (a non-Part B medical condition) and employment with an AWE or beryllium vendor during a period in which remediation did not occur, or does not identify the

AWE or beryllium vendor as a DOE facility on the Form EE-3, the claim is adjudicated under only Part B, as the employee must be a DOE contractor employee to be covered under Part E.

Example 8: If an employee claims prostate cancer and DOE contractor employment, the claim is adjudicated under both Parts B and E. If the same employee claims both prostate cancer and asbestosis, the prostate cancer is treated as a Part B and Part E condition, while asbestosis is adjudicated under Part E only.

Example 9: If a claimant identifies chronic silicosis on the Form EE-2, the claim is evaluated under both Parts B and E only when the claimed employment was in underground tunnels in Nevada or Amchitka Island, Alaska. If the claimant employment is outside of these facilities, the claim is adjudicated under only Part E.

Example 10: All new RECA Section 5 claims are to be adjudicated under both Part B and Part E.

8. New Claims in Existing Cases. In situations where there is an existing case record, if a DO or RC receives a new claim for an additional medical condition, or new survivor, the new claim form is date-stamped and forwarded to the CMR for processing, as outlined in Item 3 above.

a. Case Assignments. New claims in existing cases are assigned to the appropriate DO and CE, as outlined above in Item 4. However, if the case is found to be currently outside of the jurisdictional office (i.e. at FAB or NO), the new claim will be assigned to the DO CE assigned to the case.

b. Medical Evidence Only. If the claimant submits medical evidence for an unclaimed condition (i.e., medical evidence indicating the presence of an illness which identified as being potentially work-related) without a claim form, or document with "words of claim" for a covered condition, the CE contacts the claimant to request the appropriate claim form. He or she can also forward the evidence to a RC for assistance in initiating a new claim.

c. Survivorship Evidence Only. If a new survivor submits survivorship evidence (e.g., birth certificate, marriage certificate, school records) without a claim form, the DO or RC contacts the claimant to request he or she complete Form EE-2.

d. Wage-Loss and Impairment Claims. In cases in which a claimant submits Form EE-10, Claim for Additional Wage-Loss and/or Impairment under the EEOICPA, the CMR does not submit the form into the Case Create Queue. Any EE-10 received in the CMR is scanned as regular mail and appears in the assigned CE's "Unreviewed Assigned" document queue, at which time the CE is responsible for reviewing the claim form, entering the appropriate information into ECS and completing appropriate development actions. This data entry process also applies when a claimant submits "words of claim" in lieu of Form EE-10 to requesting wage-loss and/or impairment benefits.

9. Withdrawal of a Claim. A claimant is able to withdraw his or her claim for benefits for any claimed condition(s), or wage-loss or impairment, prior to the issuance of a FD for the requested benefit(s). All requests to withdraw a claim for benefits must be in writing, signed by either the claimant or his or her AR, and specific in reference to what Part or Parts under the EEOICPA the claim is to be withdrawn.

a. To resume development on a withdrawn claim, the claimant must submit a signed letter to DEEOIC requesting the resumption of the withdrawn claim or submit a new signed EE-1 or EE-2 form for the same illness(es)/death previously under adjudication. DEEOIC will resume development by picking up where development left off at the time the claimant chose to withdraw. Therefore, if a RD concerning the claim in question was issued and the case forwarded to FAB, but then the claim was administratively closed while the case was at FAB due to claim withdrawal, a new RD should not be issued.

CHAPTER 8 – CASE MAINTENANCE

1. Purpose and Scope. This chapter describes how hard copy case files are managed, repaired, and transferred between locations within the DEEOIC when files are not fully imaged.

2. Case Assignee and Location Designation. As case file records can be transferred to different locations within an office for various reasons (i.e. case adjudication, fiscal processing, management review etc.), ECS must reflect the designated physical location corresponding with any ongoing action involving the claim. As hard copy case files move to different locations within the DEEOIC, the DO or FAB staff must update the case office location in ECS and annotate the file jackets accordingly.

a. Notations on Case Jackets. DEEOIC staff member lists the new location code on the grid sheet on the front of each case file folder, as well as dates and initials each folder. The DEEOIC staff member then hand carries the file to its next location or places the folder in the appropriate pick-up area for appropriate routing.

b. Replacement Grid Sheets. When the case file jacket has been completely filled, it is copied. This copy is placed on the inside cover of the left side of the case file. A gummed grid sheet with spaces to enter new routing locations is then placed on the front cover of the case file.

3. Physical Maintenance of Hard Copy Case Files. Hard copy case files must be housed either in a designated central file location or in other secure holding locations throughout the DEEOIC Office. The physical location of the case file must correspond to the location code assigned in ECS. The person assigned to manage the case is responsible for ensuring that any hard copy documentation maintained in the case file folder is affixed securely by spindling it.

a. 2 x 2 Terminal Digit Order. Hard copy case files are to be organized by staff using a 2x2 terminal digit system. Physical folders are grouped together and filed using the last four digits of the file number, hereafter referred to as "terminal digits". The files are first grouped together in numerical order by the last two terminal digits (from XX00 to XX99). The first two terminal digits of a file determine the order of files with the same final two digits (00XX to 99XX). For example, files with the terminal digits 0034, 0234, 1001, 1034, 1234, 2001, and 3489 are filed as follows:

Ending with 01:	1001, 2001
Ending with 34:	0034, 0234, 1034, 1234
Ending with 89:	3489

b. Labeling Files. The outside edge of each physical case file folder must be labeled with the last four digits of the claimant's file number (terminal digits). Each digit has a distinct, brightly colored background, allowing searchers to locate, retrieve and/or file the folders with greater ease and accuracy.

4. Labeling Cases with Multiple File Parts. In the past, when the contents of a case file became too thick to be contained in one folder, they were divided by Mail and File (M&F) staff using the following rules (now that all new documents are scanned into OIS, this is no longer necessary, but is important to note when reviewing older hard copy case files):

a. The M&F Clerk labeled the original case file with the letter "A" at the bottom of the front cover of and "B" at bottom of the front cover of the overflow folder.

b. If it became necessary to divide the case more than once, the new overflow folders were labeled "AA", "AAA", etc.

c. Part B was always the active folder and contains the most recent documents, the original Forms EE-1/2, DOE claim forms (formerly Part D), documents containing words of claim for benefits under the EEOICPA, Employment History Form EE-3, any documentation showing compensation paid, and all documents requiring further action.

5. Repairing Cases. The M&F Clerk or other DEEOIC staff member designated by the DD, FAB Manager, or Policy Branch Chief, repairs the case folders and their contents that have become worn or unreadable due to wear and tear.

a. Loose Documents. The M&F Clerk or other designated DEEOIC staff member repairs or strengthens documents that have torn loose from the spindle by using a gummed or self-adhesive reinforcement, transparent tape, or other method approved by the DD, FAB Manager, or Policy Branch Chief.

b. Damaged Documents. If torn or damaged documents cannot be mended, and there is the potential for further damage to occur, the M&F Clerk or other designated DEEOIC staff member photocopies the documents so that the file contains a readable copy. To protect from further damage, the torn or damaged documents are placed in a protective sleeve or envelope and placed in the case file.

6. Missing Files. If a physical case file cannot be located, a special search is required. This special search includes searching throughout the File Room (occasionally cases get misfiled), at DEEOIC staff workstations, the DEEOIC Office as a whole, and even other DEEOIC Offices. If the special search is unsuccessful, DEEOIC staff must reconstruct the file.

a. Reconstructing Cases. When a hard copy case is lost and every effort to locate it within that DEEOIC Office and the other DEEOIC Offices is unsuccessful, the DEEOIC staff must reconstruct the case file.

(1) Memo to the File. A Supervisory CE or Manager prepares a memorandum for the signature of the DD, FAB Branch Chief, or Policy Branch Chief, explaining the loss of the file and the necessity of seeking replacements for imaging into OIS. The memo and reconstructed case file are bronzed into OIS. There is no need to reconstruct a hard copy case file.

(2) Requests for Records. The assigned CE, FAB Representative, or NO Representative prepares correspondence to all the claimants and ARs associated with the case requesting a copy of any documents pertinent to the case file that existed before case documentation began to be imaged into OIS. The assigned CE, FAB Representative, or NO Representative also requests duplicate documents from medical providers, the NIOSH, DOE, and any other identifiable source (e.g., CPWR, SSA, RC). In the memo and the letters requesting the documentation, the DEEOIC staff member requests that any documentation be submitted to the CMR or uploaded via the Electronic Portal for processing as imaged documents.

7. National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007 (NIAA). The NICS is a computerized system designed to help determine if a person is disqualified from possessing or receiving firearms by conducting a search of available relevant records. Among its requirements, the NIAA mandates that federal departments and agencies provide relevant information to the Attorney General for the NICS. The databases used by the NICS in its searches contain records with information relevant to the various legal prohibitions against firearm possession and purchasing under both Federal and State law. There are ten categories of Federal firearm prohibitions. For each category of prohibition, there are relevant record types that should be reported to the NICS. During the administration of the EEOICPA, the DEEOIC takes possession of a variety of claim documentation including some that is reportable. Records that DEEOIC is obligated to report under the NIAA are those that it receives during the administration of claims that originate from State or Local agencies.

a. Under the NIAA, DEEOIC has the potential to have reportable records in several of the ten categories of Federal firearm prohibitions.

(1) Felons.

(a) This includes any person "who has been convicted in any court of a crime punishable by imprisonment for a term exceeding one year," (including general court-martial) regardless of whether or not that term of imprisonment was imposed.

(b) The term "offense punishable by imprisonment for a term exceeding one year" does not include:

(i) any federal or state offenses pertaining to antitrust violations, unfair trade practices, restraints of trade or other similar offenses relating to the regulation of business practices; or

(ii) any state offense classified by the laws of the state as a misdemeanor and punishable by a term of imprisonment of two years or less.

(c) What constitutes a conviction is determined in accordance with the law of the jurisdiction in which the proceedings were held. If a conviction has been expunged or set aside, or the person has been pardoned or had his/her civil rights restored, it is not considered a conviction unless it was provided in the expungement, pardon, or restoration that the person may not ship, transport, possess, or receive firearms.

Relevant records defined by DOJ: Judgment and commitment orders from the courts – only if the conviction is secured without collaborating with a U.S. Attorney's Office or other DOJ component.

Potential DEEOIC specific relevant records: Judgments in state court actions, usually received in conjunction with 42 U.S.C. § 7385i(a) which states that a person convicted of fraud in the application for or receipt of benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) or any other federal or SWC law forfeits any entitlement to the EEOICPA benefits for any injury, illness or death for which the time of injury was on or before the date of the conviction.

(2) Fugitives from justice.

(a) This includes any person who has fled from any State to avoid prosecution for a felony or a misdemeanor leaves the state to avoid giving testimony in any criminal proceeding, or who knows that misdemeanor or felony charges are pending against him/her and who leaves the state of prosecution.

Relevant records defined by DOJ: Misdemeanor and felony warrants and charging documents – only if obtained without collaborating with a U.S. Attorney's Office or other DOJ component.

Potential DEEOIC specific relevant records: None anticipated.

(3) Persons unlawfully using or addicted to any controlled substance.

(a) This includes any person who uses a controlled substance and has lost the power of self-control with reference to the use of the controlled substance or who is a current user of a controlled substance in a manner other than as prescribed by a licensed physician.

(b) Unlawful use need only to have occurred recently enough to indicate that the individual is actively engaged in such conduct, not necessarily at the precise time the person seeks to acquire a firearm.

(c) An inference of current use may be drawn from evidence of recent use or possession of a controlled substance, or a pattern of use or

possession that reasonably covers the present time (i.e., conviction for use or possession within the past year or multiple arrests for possession within the past five years if the most recent arrest occurred within the past year).

(d) For a current or former member of the Armed Forces, an inference of current use may be drawn from recent disciplinary or other administrative action based on confirmed drug use (i.e., discharged based on drug rehabilitation failure).

(e) The term "controlled substance" includes, but is not limited to, marijuana, depressants, stimulants, and narcotic drugs, but excludes distilled spirits, wine, malt beverages, and tobacco.

Relevant records defined by DOJ: Drug-related convictions, drug-related arrests, and disciplinary or other administrative actions in the Armed Forces based on confirmed drug use – only if obtained without collaborating with a U.S. Attorney's Office or other DOJ component. Therapeutic or medical records that are created in the course of treatment in hospitals, medical facilities, or analogous contexts that demonstrate drug use or addiction should not be submitted.

Potential DEEOIC specific relevant records: Judgments in state court actions, usually received in conjunction with 42 U.S.C. § 7385i(a).

(4) Persons "adjudicated as a mental defective" or "committed to a mental institution"

(a) This includes any person who has been determined by a court, board, commission, or other lawful authority as being a danger to himself/herself or others, or lacking the mental capacity to contract or manage his/her own affairs.

(b) A mental institution is a facility that provides diagnoses by licensed professionals of mental retardation or mental illness.

(c) "Mentally defective" does not include a person:

(i) who has been granted relief from the disability through a qualifying federal or state relief from disability program as authorized by the NIAA; or

(ii) whose adjudication or commitment was imposed by a federal department or agency and: the adjudication or commitment has been set aside or expunged; the individual has been fully released or discharged from all treatment, supervision or monitoring; the individual has been found by a court, board, commission or other lawful

authority to no longer suffer from the mental health condition that was the basis for the adjudication or commitment, or whose adjudication or commitment is based on a medical finding of disability, without an opportunity for a hearing by a court, board, commission, or other lawful authority and the person has not been "adjudicated as a mental defective" pursuant to 18 U.S.C. § 922(g)(4).

(d) Formal commitment of a person to a mental institution by a court, board, commission or other lawful authority includes commitment to a mental institution involuntarily, commitment for mental defectiveness or mental illness or commitment for other reasons, such as for drug use. It does not include a person in a mental institution for observation or a voluntary admission to a mental institution.

Relevant records defined by DOJ: Judgment and commitment orders, sentencing orders, and court or agency records of adjudications of an individual's inability to manage his or her own affairs if such adjudication is based on marked subnormal intelligence or mental illness, incompetency, or disease (including certain agency designations of representative or alternate payees for program beneficiaries).

Potential DEEOIC specific relevant records: Court ordered guardianship and conservatorship documents received during the course of claims adjudication.

(5) Illegal/unlawful aliens, and aliens admitted on a non-immigrant visa.

(a) This includes any person who is illegally or unlawfully in the United States or has been admitted to the United States under a non-immigrant visa.

This includes those persons who:

(i) unlawfully entered the United States without inspection and authorization by an immigrant officer and who have not been paroled into the United Stated under § 212(d)(5) of the INA;

(ii) are a non-immigrant and whose authorized period of stay has expired or who has violated the terms of the non-immigrant category in which he/she was admitted;

(iii) were paroled under INA § 212(d)(5) whose authorized period of parole has expired or whose parole status has been terminated, or;

(iv) are under an order of deportation, exclusion or removal, or voluntary departure, whether or not he/she has left the United States.

(b) Permanent resident aliens and aliens lawfully present in this country without a visa are not prohibited.

Relevant records defined by DOJ: Deportation orders, visa applications (including denials), and immigration papers.

Potential DEEOIC specific relevant records: None anticipated.

(6) Persons dishonorably discharged from the military.

(a) This includes any person whose separation from the U.S. Armed Forces was characterized as a dishonorable discharge or a dismissal adjudged by a general court-martial.

(b) Any person who was separated for any other discharge (for example, a bad conduct discharge) or whose dishonorable discharge or dismissal has been upgraded under the authority of a discharge review board or a board for the correction of military records is not prohibited.

Relevant records defined by DOJ: Discharge records, court-martial records, and disciplinary orders – only if no other federal agency would be submitting.

Potential DEEOIC specific relevant records: None anticipated.

(7) Citizen renunciates.

(a) This includes any person who having been a U.S. citizen renounced U.S. citizenship either before a diplomatic or consular office of the United States in a foreign state pursuant to 8 U.S.C. § 1481(a)(5) or before an officer designated by the Attorney General when the United States is in a state of war pursuant to 8 U.S.C. § 1481(a)(6).

(b) Any person whose renunciation of citizenship has been reversed as a result of administrative or judicial appeal is not prohibited.

Relevant records defined by DOJ: Form DS-4083, Certificates of Loss of Nationality.
Potential DEEOIC specific relevant records: None anticipated.

(8) Persons subject to a domestic violence restraining order.

(a) This includes any person subject to a domestic violence restraining order as long as the court order was:

(i) issued after a hearing of which such person received actual notice and had an opportunity to participate;

(ii) restrains such person from harassing, stalking, or threatening his/her intimate partner or his/her child with that intimate partner or person, or engaging in other conduct that would place the intimate partner in reasonable fear of bodily injury to the partner or child; and

(iii) includes a finding that such person represents a credible threat to the physical safety of the intimate partner or child or, by its terms, prohibits the use, attempted use or threatened use of physical force against the intimate partner or child that would reasonably be expected to cause bodily injury.

(b) The Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) has clarified that an "intimate partner" is defined as:

(i) the spouse of the person

(ii) a former spouse of the person

(iii) an individual who is a parent of a child of the person

(iv) an individual who cohabits or has cohabited with the person.

Relevant records defined by DOJ: Protective orders.

Potential DEEOIC specific relevant records: Protective orders potentially received in conjunction with child support orders.

(9) Persons convicted of a misdemeanor crime of domestic violence.

(a) This includes any person who meets all of the following criteria:

(i) has been convicted of a federal, state, local or tribal offense that is a misdemeanor, or in states that do not classify offenses as misdemeanors, is an offense punishable by imprisonment for a term of one year or less or only by a fine;

(ii) the offense has, as an element, the use or attempted use of physical force or the threatened use of a deadly weapon; and

(iii) the offense was committed by a current or former spouse, parent or guardian of the victim, by a person with whom the victim shares a child, by a person who is cohabitating with or has cohabited with the victim as a spouse, parent or guardian, or by a person similarly situated to a spouse, parent or guardian of the victim.

(b) If a conviction of a misdemeanor crime of domestic violence has been expunged or set aside, or the person has been pardoned or had his/her civil rights restored, it is not considered a conviction unless it was provided in the expungement, pardon, or restoration that the person may not ship, transport, possess, or receive firearms (and the person is not otherwise lawfully prohibited in the jurisdiction in which the proceedings were held).

Relevant records defined by DOJ: Convictions – only if obtained without collaborating with a U.S. Attorney's Office or other DOJ component.

Potential DEEOIC specific relevant records: Judgments in state court actions, usually received in conjunction with 42 U.S.C. § 7385i(a).

(10) Persons under indictment.

(a) This includes any person "who is under indictment for a crime punishable by imprisonment for a term exceeding one year."

(b) The ATF has clarified that this includes:

(i) a person under indictment or information in any court under which a crime punishable by imprisonment for a term exceeding one year may be prosecuted, or;

(ii) a military service member charged with any offense punishable by imprisonment for a term exceeding one year which has been referred to a general court-martial.

Relevant records defined by DOJ: Indictments and information – only if obtained without collaborating with a U.S. Attorney's Office or other DOJ component.

Potential DEEOIC relevant records: Indictments in state court actions – usually received in conjunction with 42 U.S.C. § 7385i(a).

b. DEEOIC Responsibilities. All DEEOIC staff is to familiarize themselves with the stipulations for reporting records under the NIAA. During the course of claim adjudication, should a DEEOIC staff person identify any reportable records, he or she is to notify the assigned CE and Supervisory CE by email that a potentially reportable document exists in a DEEOIC case file. Once notified, it becomes the responsibility of the assigned CE to then undertake closer scrutiny of the potentially reportable document to ascertain the proper action to be undertaken.

(1) The CE is to examine the document, informed by the guidance provided in this section of the Procedure Manual on the ten categories of reportable documents, to make a decision on whether the document is sufficient to identify the named individual as a potential prohibitor under NIAA. The CE is to prepare a draft Memo to File that provides a summary of the matter and explains the outcome of their analysis, including justification for action as a potentially reportable document under NIAA or closure of the matter with no further action necessary. The CE then will forward the draft Memo to File for the DD to review. The DD is to review the Memo and certify that it represents an accurate finding with regard to the CE's review of the available evidence. If certified, the CE will finalize the Memo to File, and upload it into the OIS case file record.

(2) If the Memo to File, certified by the DD, identifies a potentially reportable document, the case file is to be transferred to the National Office Policy Branch for further action.

(3) Once the Policy Branch receives the case file, a Policy Analyst will evaluate whether the further action is appropriate. If the assigned Policy Analyst concurs with the Memo to File, the case file will be transferred to the Office of the Solicitor for evaluation. If the Solicitor agrees that the document meets the NICS reporting requirement, it will notify the Policy Analyst. The Policy Analyst will then update the ECS case record with the completion of the NICS indicator, along with a note on the input screen about the reportable document, the identified prohibitor and the relevant NIAA category. DEEOIC will coordinate the reporting of all cases with a positive ECS NICS indicator to the proper DOJ point of contact. Once all actions are complete, the Policy Analyst will transfer the case file back to the originating DO with a brief memo describing the disposition of the NICS evaluation. If any future developments occur with regard to the reportable document, including changes that warrant removal of a reported document, the CE may contact the Policy Branch for guidance.

CHAPTER 9 – TRANSFERS AND LOANS

1. Purpose and Scope. This chapter describes the procedures for transferring fully scanned electronic case files and hybrid (a combination of paper and electronic records) case files between the various offices within the DEEOIC, including the DO, the FAB or the NO. This Chapter also addresses the NIOSH case referral process.

2. Responsibilities. M&F staff process all fully scanned and hybrid case files transferred temporarily or permanently among the DEEOIC Offices. The Chief of Operations, Supervisory CE, ADD, DD, FAB Manager, NO Representative, M&F Clerk, or other designee transfers electronic records in ECS on all temporary or permanent case file transfers. If a file has a paper component (hybrid case), the physical file is shipped in its entirety to the designated location. If DEEOIC staff identifies misrouted case files, he or she is responsible for ensuring it gets transferred to the appropriate DEEOIC Office (including the paper component of a hybrid file).

3. Transfers (Loans). Case files are transferred between DEEOIC Offices for a variety of reasons; including the review of a RD, a FD, a remand order, a request for reconsideration, a request for reopening, a DO pending action, a medical or scientific referral, or for a policy issue.

a. The Chief of Operations, FAB Manager, NO Unit Chief for Policies, Regulations and Procedures, DD, ADD, Supervisory CE, SrCE, or other designee must determine whether the case is in a posture for transfer to another DEEOIC Office (e.g., the DO issued an RD that needs to be sent to FAB for processing of the FD). He or she ensures that any pending action items, including outstanding phone calls or other time-sensitive actions, are completed. Once the case is cleared for transfer, the following occurs:

(1) The person processing the transfer completes a DEEOIC transfer sheet accurately. The transfer sheet includes information regarding the case file, the destination of the file, the initiating staff person's name and transfer date;

(2) The completed transfer sheet is uploaded to OIS with proper indexing labels; and

(3) The transfer to designated jurisdictional office is recorded in ECS effective the date of the completed transfer sheet.

b. All cases sent to the NO require the authorization of the DD, ADD, Chief of Operations, Supervisory CE, FAB Manager, or other designee. The NO Unit Chief for Policies, Regulations and Procedures or designee authorizes case transfers from the NO.

c. DOs may transfer case files to other jurisdictions permanently, based on management decisions regarding case allocations amongst the district or FAB offices.

4. Maintaining ECS. Maintaining accurate case location information in ECS is essential. Each time a staff person transfers a case file from one location to another within a DEEOIC Office, or from one DEEOIC Office to another, he or she must update ECS to show the current location of the entire case file and the date in which the change in location occurred.

   a. For any hybrid case, M&F staff mails the paper component to its destination by using the designated express mail service or through the USPS.

   b. The jurisdictional office in possession of a file, even on temporary basis, must handle all case management functions; including imaging of incoming mail and documentation, along with its review and indexing.

   c. When either a fully scanned or hybrid case file arrives in the DEEOIC Office, the M&F Clerk or other designated staff must ensure that the case is assigned in ECS to a person responsible for management of the case.

5. Referring Case Records to NIOSH. As part of the dose reconstruction process, NIOSH must review certain employee's medical and employment records. When referring cases to NIOSH for a dose reconstruction, the case file is electronically transmitted to NIOSH via the Secure Access Management Service (SAMS). Any paper component of a hybrid case file not yet uploaded to OIS must be scanned and compiled with the electronic record in OIS prior to transmitting to NIOSH. Upon receipt, NIOSH sends the DO an electronic confirmation of receipt for each NIOSH referral received via the SAMS portal.

   a. Schedule. Each DO typically send cases on designated days based on the following weekly schedule:

      Tuesday: Jacksonville
      Wednesday: Cleveland
      Thursday: Denver
      Friday: Seattle

      Occasionally, a terminal claim or a high volume of claims will necessitate the submission of additional NIOSH referrals outside of the schedule noted above.

   b. Following the receipt of the confirmation emails from NIOSH, the DO prepares a manifest of cases and the type of referrals (initial, amended, or supplemental) electronically transmitted that day to NIOSH. The manifest is uploaded to the SAMS portal in the same manner the NIOSH referrals were submitted. NIOSH uses this manifest to reconcile the receipt of each referral submitted via the SAMS portal. For any claims submitted outside of the schedule noted above, a new manifest is prepared and submitted electronically via the SAMS portal for NIOSH reconciliation purposes.

6. Referring Cases to the NO. When a DO or FAB office refers a case to the NO, the transfer sheet must clearly describe the circumstance for the case transfer; including for policy evaluation, legal analysis, reopening, or medical health science assessment.

CHAPTER 10 – RESOURCE CENTERS

1. Purpose and Scope. This chapter describes the policies and procedures governing the DEEOIC RCs.

2. RC Functions. The RCs are situated in key geographic locations throughout the United States to provide assistance and information to the EEOICPA claimant community and other interested parties. The RCs gather substantial information and documentation, but they do not perform adjudicatory functions. The RCs provide claim development support and program outreach as well as initial claim intake.

A contractor manages and staffs the RCs. Each RC has a manager who reports to the RC Contractor Project Manager, who in turn, reports to the DEEOIC RC Coordinator located at the NO. The RC Coordinator is responsible for supervising the activities of all RC staff, nationwide.

The RC functions include the following:

a. Claim Intake. Most new Forms EE-1/2 are filed directly with the RC located in the geographical area where the claimant(s) reside. Forms EE-1/2 received directly in the DO undergo employment verification at the DO and such claims are referred to the RC only if the DO determines that an OHQ is required.

Regardless of place of receipt, the date of filing for a claim is the earliest discernible date stamp or postmark of a claim form or words of claim. Words of claim are any written statements received without a claim form that indicate a claimant's intention to seek benefits under the EEOICPA.

Whether filing by telephone or in person, RC staff relays information about the program to the claimant. The RC explains the eligibility requirements, asks about conditions that the claimant has developed, and begins the process of gathering information for use in adjudication.

(1) Filing by Telephone. When a claimant files a claim telephonically with RCs, but then either refuses or fails to sign an actual claim form, the RCs must proceed as follows:

(a) One week after the claim intake call, the RC telephones the claimant, informing him or her that the claim form must be signed to complete the filing process. If a case exists in ECS, the contact is recorded in Phone Calls.

(b) Two weeks (14 days) after claim intake, the RC sends the claimant a letter advising him or her that a signed claim form is necessary to begin the claims process. The letter further advises that in the absence of a returned and signed claim form, the unsigned claim form will be sent to the DO, but that the DO CE will administratively close the claim because of the lack of a signed claim form.

(c) If a signed claim form is not received four weeks (28 days) after claim intake, the RC sends a final letter to the claimant telling him or her that the unsigned claim form will be forwarded to the DO assigned to adjudicate the claim, and that the DO CE will administratively close the claim because of the lack of a signed claim form. The RC then prepares a memo to the file documenting the times, dates, and manner of the efforts made to get the form signed, and of the warning that the claim will be closed administratively. The memo, unsigned claim forms, and copy of 14-day and 28-day letters to the claimant are uploaded to EDP for further action by the CE.

b. Phone Calls: RC staff will serve as the initial responder for incoming DEEOIC phone inquiries, regardless of case location/jurisdiction or request status. RC staff members will use all available program resources in responding to inquiries in the most efficient and expedient manner possible.

When RC's receive phone inquiries from a claimant or AR seeking a status of a claim or medical authorization request that requires further review/analysis by DEEOIC staff, they are to transfer the call to the appropriate adjudicatory DO CE, FAB HR, or assigned MBE. Calls transferred in this manner will be documented as a pending phone call in ECS until closed by RC or DEEOIC staff. In the event that a transferred phone call is not answered by the designated DEEOIC staff member, the caller will have the option to either leave a voice mail message with the intended call recipient or be returned back to the RC staff member who may then annotate ECS with a request for a returned phone call.

When RC's receive onsite inquiries from a claimant or AR seeking claim status that requires further review/analysis by DEEOIC staff, they initiate contact with the DO CE, FAB HR or assigned MBE. When referring a claimant or AR to a DO, FAB or assigned MBE, the RC will initiate a telephone call with the appropriate DEEOIC staff member, requesting assistance to address an incoming inquiry received at the RC. If the DEEOIC staff member is not available to take the call, an automated record of a pending phone call will be created in ECS.

c. Program Information. If a potential claimant calls for information and/or guidance and no claim is on file, the RC staff member informs the potential claimant of filing requirements and available benefits. No referral to a DO or FAB is necessary. As no claim exists, a note memorializing the telephone conversation cannot be entered into ECS.

Where a current claimant contacts the RC for guidance about the claims process (e.g., confirmation that a claim exists, questions about submitting new evidence or a new claim for benefits), the RC can provide guidance to the claimant as needed without referral to the DO or FAB. The telephone conversation is memorialized in ECS.

Also, RC staff may assist claimants in understanding the information being sought in DO development letters, explain the means by which such information may be obtained, and assist claimants in obtaining evidence. The RCs also assist claimants with medical bills/documentation and enroll/educate medical providers to join and navigate the automated medical bill pay system. Again, the telephone conversation is memorialized in ECS.

d. OHQ. RCs conduct occupational history development on all new Part E claims and some previously filed Part D/E claims, as discussed in section 5 below.

e. Any document or record generated or received by the RC relevant to an initial claim submission or to an existing claim must be uploaded to OIS via the central mailroom or the EDP.

3. ECS Usage in the RC. ECS access is granted to the RCs to record claimant interaction and obtain claim status updates. All such interactions are recorded in ECS. Some RC activity occurs prior to case creation in the DO, and ECS data input is unavailable. RCs make ECS entries only on created cases. Where the case is not yet created, the RC maintains a written account of all claim-related activity, including the date on which such activity took place.

a. ECS Notes. The ECS Notes field is used for all face-to-face contact with a claimant on a created case. For example, ECS notes are used when a claimant appears at the RC to submit evidence or claim forms, to make an inquiry or raise a concern, or to complete the OHQ interview.

The RC staff member records the claimant's visit in the notes field in ECS, providing a synopsis of the conversation and a description of any evidence or new claim filed during the visit. The Notes entry outlines the interaction with the claimant, including instructions or guidance the RC provides to the claimant. The RC discusses only information on a specific claim with the claimant in question.

b. Phone Calls. The Phone Calls field in ECS allows RC staff members to memorialize telephone conversations, access telephone messages for calls received in the RC, and provides a mechanism to track and maintain telephone contacts on given case files.

RC staff members receive incoming telephone calls, return calls and place calls to claimants and others regarding questions and concerns arising out of the claims process.

(1) RCs receive various kinds of direct calls. Generally, incoming calls are from claimants (or their AR) seeking claim status or guidance, or from potential claimants seeking program information and guidance regarding the claims process.

(2) A RC staff member returns a telephone call received in the RC within two business days of receipt regardless of the issue at hand. All calls related to claims must be returned and memorialized in ECS accordingly.

(3) Outgoing calls are those generated from the RC for a purpose other than returning a telephone call. Many RC outgoing calls are generated in the course of conducting occupational history development, and are memorialized in ECS only on created cases.

c. Calls from Claimants. Each telephone call to or from a claimant must be accurately recorded in ECS. If RC staff members conduct OHQ interviews (see below) by telephone, the OHQ interview must be memorialized in ECS Phone Calls.

The RC staff member handling the telephone call outlines the content of the discussion, the claimant request, if any, the guidance or solution offered, and the outcome of the call or resolution of the issue at hand. Entry of quality data is of the utmost importance, and the RC staff member strives to ensure accuracy and specificity of data input when telephone contact is noted in ECS.

d. ECS Entries. The RC ECS user may change ECS entries placed into the system by RC staff as needed to correct errors, or at the request of the RC manager upon his or her final review of claim file material before it is forwarded to the DO. However, the RC cannot delete ECS entries, so RC staff and managers must ensure that the data entered into ECS is of high quality and free of errors prior to saving the entries into the system.

Once an ECS record is input at the RC level, only NO DEEOIC staff may remove it. No capability to add or alter ECS has been granted to the RCs, and all coding operations related to RC activity on a case (aside from activities related to inputting phone calls or ECS Notes) are entered at the DO to correspond with the date of the activity, as noted on the RC memorandum that accompanies case file materials to the DO.

e. ECS Security. Security measures govern access to the system due to the sensitive nature of the records available in ECS and other claim file documents (e.g., employment history, payment information, disease history, Social Security Numbers, and addresses).

When a RC staff member is hired, and ECS access is required for that individual, access must be granted. Conversely, when an RC staff member's employment is terminated, that person's ECS access must be disabled.

(1) To give a new RC staff member ECS access, the RC manager prepares a memorandum to the RC Contract Project Manager requesting such access and providing all pertinent employee information. The RC Contract Project Manager sends a memorandum to the DEEOIC RC Coordinator at NO, who reviews the request and advises Energy Technical Support of the need to grant access to an incoming RC employee.

(2) Upon termination or resignation of an employee, the RC Manager prepares a memorandum to the RC Contract Project Manager. The

memorandum provides the former employee's name, title, employee number, and all other necessary information, including the date of the employee's termination or resignation. The memorandum requests that the former employee's access to ECS be terminated on a specified date (i.e., date of termination or resignation).

(3) The RC Contract Project Manager then prepares a memorandum notifying the DEEOIC RC Coordinator advising of the RC former employee's scheduled departure. The DEEOIC RC Coordinator advises Energy Technical Support of the need to delete ECS access to the outgoing RC former employee upon receipt of such notification.

4. Security, Privacy, Conflicts of Interest.

a. RC Staff Member with Interest in a Claim. A RC staff member may be a party to a claim under the EEOICPA or may have a personal or familial interest in the outcome of a claim.

(1) RCs must avoid conflicts of interest in processing claims and should avoid even the appearance of impropriety in their work. Their staffs must work without any bias or influence that would affect their ability to render impartial service to the government in carrying out their duties.

Therefore, RC staff cannot process claims or occupational histories for immediate family members (defined as spouses, children, siblings, grandparents, parents, or first or second cousins) or for any other individuals with whom they would have so close a relationship as to affect their judgment.

When a RC staff member has a claim of his or her own, or when the situation meets the definition of a conflict of interest due to a relationship as defined above the RC notifies the DEEOIC RC Coordinator at NO in writing via e-mail memorandum.

b. Security and Individual Privacy Concerns. When interacting with claimants and other interested parties (e.g., ARs) RC staff must remain aware of individual privacy concerns and maintain compliance with Privacy Act mandates. Except as discussed below, RC staff members may not provide information about an individual claim for benefits, or any other personal information, to anyone other than the identified claimant or his or her AR.

(1) For RC staff to release any information regarding a specific claim or claimant to an alleged AR of that claimant, the RC staff must verify that the AR is listed in ECS as the AR of record.

A claimant may authorize other third parties to receive claims information, but may not authorize multiple ARs.

(2) Where information is sought that exceeds the RC's ability to assist the claimant or AR (e.g., specific development questions regarding the relationship between toxic substances and illness), the RC staff refers the matter to the proper DO CE, FAB HR, or MBE denoted in ECS as the primary CE.

c. Multiple Worksites. In all instances involving multiple worksites, the RC closest to the residence of the claimant(s) performs the required development tasks. For instance, if employment is claimed at all three Gaseous Diffusion Plants (GDP), and the employee/claimant(s) reside in the Paducah, Kentucky area, the Paducah RC handles all required tasks with assistance from the other RCs as needed.

d. Multiple Claimant Locations. If claimants reside in different states and the claim as a whole can be better served by another RC, a RC will be assigned based upon the geographical locations of the claimants.

5. Occupational History Development. The RCs conduct initial occupational history development on Part E cases only for claims involving covered Part E employees and their eligible survivors. This is accomplished by conducting an interview with each claimant filing a Part E claim to complete an Occupational History Questionnaire). Exhibit 10-1 is a sample of a completed OHQ; however, reported information will vary depending on individual employment and responses.

a. Scheduling the OHQ interview. Upon receipt of a new claim, the RC will ascertain the claimant's schedule for completion of an OHQ interview. The RC may interact with the claimant in-person at a RC office or via a telephone call. OHQ interviews will occur only in those cases under Part E that involve a contractor or subcontractor employee seeking compensation or the survivor(s) of a deceased employee. Prior to any OHQ interview, the RC is to provide the claimant notice about the purpose of the OHQ and the claimant's right to have a designated AR present during the OHQ interview.

(1) The RC should explain to the claimant that the function of the OHQ interview is to collect relevant information from the claimant about the named employee's work history involving atomic weapons. Specifically, the OHQ interview will seek information that the claimant is knowledgeable about the employee's work locations, job titles, work processes or contact with specific toxic substances. OHQ interviews typically take 2-3 hours. The RC will prepare a narrative account of the information received during the interview in an OHQ document that the RC will upload to the case file to assist with development during case adjudication. The RC will provide a copy of the completed OHQ to the claimant once the interview is complete.

(2) During the initial interaction with the claimant on scheduling an OHQ, the RC is to advise the claimant that an AR may be present during the OHQ interview. If the claimant has a desire to have their AR present, the claimant must have a designated AR registered in their claim. The RC

will coordinate with the claimant on a mutually acceptable schedule for conducting the OHQ with the claimant and their AR in attendance.

(3) In certain multiple claimant survivor claims, claimants may identify one spokesperson that will conduct the OHQ. The RC is to advise the claimants that this is acceptable; however, each claimant must submit a written request naming the spokesperson to conduct the OHQ. Otherwise, the RC is obligated to interview each claimant.

Once the RC provides notice to the claimant on the purpose of the OHQ interview and their right to have an AR present, the RC will determine if the claimant is agreeable to proceed with the OHQ interview or whether the RC needs to schedule the interview on a later date. The RC has 14 calendar days to complete an OHQ. In any situation where the RC cannot complete the OHQ within 14 days, the RC advises the DO CE via email of the reasons for the delay and outlines the steps necessary to complete an OHQ. The CE is to notify the RC whether the CE will permit an extension of the period for completing the OHQ. The CE should apply discretion in allowing more time to obtain an OHQ when reasonable reasons exist for doing so. If the RC cannot complete an OHQ within 30 days of receipt of a claim, the RC is to suspend all further efforts. It is to send an email notice to the assigned CE that an OHQ has not occurred. The RC will upload the email to OIS. Depending on the circumstances, a CE may later direct the RC to schedule an OHQ, if appropriate and necessary.

b. Conduct of the OHQ interview. The RC OHQ interview occurs to collect information about an employee's work history that potentially brought them into contact with toxic substances. Claimants often have detailed insights into different aspects of an employee's work history that are extremely valuable in developing an employee's toxic substance profile. During the RC interview, the interviewer will follow a set series of questions, allowing for additional follow-up, where necessary, to obtain as accurate and informative response as the claimant can recall. 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.

c. Documenting the OHQ for the case file. Once the OHQ interview is complete and the OHQ document finalized for release, the RC will print out a final version of the OHQ for mailing to the claimant. The RC will complete the OHQ confirmation notice (Exhibit 10-2) verifying that the interview took place and its date. The RC will then upload a copy of the confirmation notice, along with a copy of the final OHQ, to OIS so that it becomes part of the official case record. The RC will also mail a copy of the confirmation notice and the completed OHQ to the claimant. If the claimant has any comments or corrections, the claimant must submit written feedback to the district office CE assigned to the case.

6. Transfer of Cases. Once all possible occupational history development actions are complete, the RC uploads to OIS all claim forms and associated documents, including a memorandum outlining RC activities to that point. Upon receipt of the initial submission, the case is created as set out in Chapter 7 – Case Creation. Once the case is created and the claim assigned to a CE, the CE reviews all claim file materials and occupational history development materials for ECS data input.

a. CE Review. The CE reviews the initial submission to determine whether additional tasks are necessary at the RC level. As noted above, the CE may return any part of the package to the RC, if they identify a deficiency or they feel an additional OHQ interview is necessary.

The CE uses the information obtained during the occupational development as a tool for establishing causation (based upon employment and the claimed covered illness) in the adjudication process. Also, the CE proceeds to develop the claim.

b. Receipt of Materials in the RC After Case Create. Any such materials are sent to the DO with the occupational history development package if they cannot be included with claims submission. All other materials received at the RC after all development is concluded (including ECS printouts) are submitted without a memo.

c. Receipt of Material in the DO Prior to Case Create. In some cases, the DO receives documentation from the RC prior to receipt/filing of a claim form. The DO maintains all such information in a dummy folder and retains it until the claim form is received. When the case is created, RC actions are entered into ECS to correspond with the day upon which they actually occurred, regardless of claim filing date.

7. RC File Retention. Depending upon the circumstances and the need for additional follow-up regarding a task described in this chapter, RCs retain or destroy file materials as necessary.

a. RC staff retains all claim forms and associated documents submitted to DOL (either through EDP or U.S. Mail, etc.) for a minimum of seven calendar days. This includes Forms EE-1/2/3 and any supporting documents associated with these forms at the time of submission.

The RC staff also retains original Birth Certificates, Marriage Certificates, and Death Certificates until a copy is scanned to OIS. Once the Birth Certificate, Marriage Certificate, and Death Certificate is confirmed to be uploaded to OIS, they are returned to the claimant. Originals of these documents are not destroyed.

b. During the retention period, all documents are kept in a secure/locked cabinet.

CHAPTER 11 – INITIAL DEVELOPMENT

1. Purpose and Scope. This chapter explains the procedures the CE uses for the initial development of a new Part B and/or Part E claim under the EEOICPA.

2. Review for Potential Development. Regardless of the type of claim (i.e., B only, E only, B and E), the CE conducts an initial screening of all material submitted with a new claim to gain a contextual understanding of the scope of the claim and to begin formulating an approach to development, if needed. In this analysis, the CE must apply the various program resources that provide guidance relating to the criteria necessary for proper claim outcomes. Moreover, it is important that the CE apply proper expertise in assessing evidence, principally that all documentation relating to a claim is examined to ascertain whether it serves to satisfy the necessary criteria leading to a positive claim outcome. Key initial factors the CE needs to assess include:

a. Medical Condition(s). The CE must assess whether the claimant has submitted medical evidence, including physician treatment records, hospital records, physical exams, medical notes, or other documentation from a medical source, that support a diagnosis for each claimed medical condition.

b. Employment History. The claimant must provide information as to the employee's work history, including locations and period(s) of specific employment for a qualifying AWE, the DOE or its contractors and subcontractors, or employment at covered locations under Section 5 of RECA. Initial review of the employee's work history will help the CE direct his or her development in verifying the claimed employment as accurate.

c. Survivorship Eligibility (When Appropriate). In survivor claims, initial screening of the case ensures that every potential survivor who may be eligible for benefits is identified. The CE must review each survivor claim presented so that each potential survivor is recorded properly as a party to the claim, and that any other potential survivor that is not party to the claim, is identified so that development occurs to obtain claims from non-filing survivors.

3. Sources of Evidence. Decisions are based on the written evidence of record. Evidence may include (but is not limited to) forms, reports, letters, notes, personal statements, and affidavits. Most of the evidence required under the EEOICPA may be obtained from the following sources:

a. Claimant. Any claimant filing for benefits under the EEOICPA must submit the necessary evidence required for the program to adjudicate the claim.

b. DOE. The DOE had contractual arrangements with employees, contractors, subcontractors, AWEs and Beryllium Vendors with respect to the United States Atomic Weapons Program. The EEOICPA requires DOE to produce evidence in its possession regarding the work history of employees for which a claim has been filed.

c. Corporate Verifiers. While it produced atomic weapons, the DOE maintained relationships with a wide variety of external corporate entities, such as contractors and subcontractors, Beryllium Vendors and AWEs. In certain situations, the CE must

contact the corporate or other private entities to obtain information about a claim for compensation.

d. ORISE. Oak Ridge maintains the ORISE database, which may be accessed via the Internet. The ORISE database, which contains information for over 400,000 employees from the 1940s until the early 1990s, is an effective source for verifying employment for individual claims. ORISE is accessible via ECS.

e. NIOSH. NIOSH is an agency within HHS that is responsible for estimating the radiation exposure to DOE employees, contractors, subcontractors and AWE employees during the production of atomic weapons. NIOSH researches site information for covered facilities and sends dose reconstruction reports to EEOICPA DOs. The DOs use the dose reconstruction reports to determine the PoC between a claimed cancer and exposure at a covered facility, based on the criteria established by NIOSH.

f. Medical Sources. These sources include reports from doctors and hospitals providing examination and/or treatment to covered employees. By signing Form EE-1 or EE-2, the claimant authorizes OWCP to collect medical documentation pertinent to his or her case.

g. Center for Construction Research and Training. The Center for Construction Research and Training was formerly known as the Center to Protect Workers' Rights and continues to utilize the acronym CPWR. CPWR is a research, development and training arm of the Building and Construction Trades Department (BCTD) of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). The DEEOIC has contracted with CPWR to maintain a database of contractor/subcontractor employers at certain DOE facilities. Access to this database, found at https://www.btcomp.org./ may prove helpful in linking the claimed employers to the claimed DOE facilities, when other records are insufficient in establishing the employer and DOE facility connection (see Chapter 13 - Establishing Covered Employment).

h. SEM. The SEM is a web-based tool designed to assist the CE in developing for exposure to a toxic substance. The SEM identifies the toxic substances that were commonly used in each DOE and RECA Section 5 facility, and contains two general categories of information that may be searched: chemical profiles and site-specific information tailored to the covered facility or site.

i. Medical Health Science Experts. The program can consult with medical health science experts to assist in evaluating claims, including experts in the fields of health physics, industrial hygiene and toxicology.

j. Other Sources. The DEEOIC may receive evidence from other sources, such as individuals completing employment affidavits, claimant representatives, SSA records, DAR records, or by utilizing the Employment Pathways Overview Document (EPOD), which is a document that the NO Policy Branch created to assist CEs in identifying facility-specific contact persons and resources to use in obtaining employment verification (see Chapter 13 - Establishing Covered Employment).

4. Advising the Claimant of Deficient Evidence. When the CE determines that additional development is required, he or she must advise the claimant of the deficiency and provide the claimant an opportunity to overcome the problem.

a. Initial 30-day Period. If the CE identifies a deficiency in the evidence that requires development, a letter is prepared which describes the deficiency and additional information necessary to overcome the problem. The CE thoroughly reviews the evidence in the file before writing the letter and tailors the letter to the individual case.

b. Extensions granted for submission of evidence. If the claimant does not submit the requested evidence within the initial 30-day period, the CE has the discretion to extend due dates for justifiable reasons. The CE may allow for an extension to the period allowed for submitting evidence when the claimant has committed to the submission of additional evidence within a reasonable period after the initial 30-day period, or the CE has received a justifiable explanation from the claimant as to any delay. When granting an extension, the CE must clearly communicate to the claimant the period which he or she is allowing for submission of evidence.

5. Requesting Evidence by Telephone. The CE may use the telephone to gather evidence. Person-to-person contact often succeeds in obtaining information, addressing specific concerns and defusing contentious situations. The CE must conduct himself or herself in a professional and courteous manner on a telephone call.

a. Documenting Phone Calls. CEs document each call in ECS, which in turn will be uploaded automatically as a document into OIS for recordkeeping. CEs must document the call with sufficient descriptive narrative to clearly explain the interaction with the caller.

6. Former Part D Claims. Former Part D claims, which were administered by the DOE, have been migrated into the DEEOIC claims process. The CE must examine any relevant Part D documentation when adjudicating a claim, as it could assist in the adjudication of the DEEOIC claim. Materials that can be included in the Part D claim includes:

a. Physician Panel Report. Part D case files may contain this report, which consists of the Office of Worker Assistance (OWA) physician's discussion, rationale, and conclusion as to whether a toxic substance aggravated, contributed to, or caused the claimed condition(s).

(1) DOE acceptance of Physician Panel recommendation. If a positive DOE Physician Panel finding is present in a Part D case file and the file contains a claim approval letter signed by a DOE official, DEEOIC considers the finding a positive determination from DOE. Generally, such claims are in posture for acceptance of causation under Part E, but further development of survivorship and potential coordination and offset issues may be required of the CE before issuing a RD.

b. Building Trades National Medical Screening Program Database. This database contains work history and medical test results for employees who worked at Amchitka

Island, Savannah River, Oak Ridge, and Hanford. The information also relates only to those employees who filed Part D claims with DOE from 2000-2004. DEEOIC maintains the database and it is accessible by claims staff. Employee information found by the CE in accessing this database is to be extracted and uploaded into OIS for reference during claim review. A letter from the Building Trades FWP Medical Director describing the information obtained in the database search and attesting to its validity is also available to staff. For any positive search result for which the CE finds information maintained in the database, the CE prints this letter and attaches it to the documents extracted from the database and they are uploaded to OIS.

7. DOE Former Worker Program (FWP). The FWP began in 1996 and DOE designed it to evaluate the effects of DOE's past operations on the health of workers employed at DOE facilities. The program documents medical conditions and workplace exposures that may help the CE develop and adjudicate claims. FWP records contain valuable information about medical conditions and can help the CE develop for a covered illness. During initial development, CEs should include any documentation originating from a FWP in their examination of the case. In those instances where there is an indication of FWP screening of the named employee, the CE must contact the relevant FWP for any medical or employment documentation in its possession.

a. Results of medical tests conducted by the FWP (e.g., pulmonary function tests, BeLPT, blood tests, X-rays with B reader interpretations, etc.) are valid when interpreted by a qualified physician. The CE may use such test results in evaluating records for a covered illness, provided a physician's interpretation of the test result is present in the case evidence.

b. Exposure Documentation. FWP medical screening includes an evaluation of former DOE workers for adverse health outcomes related to occupational exposures to substances such as beryllium, asbestos, silica, welding fumes, lead, cadmium, chromium, and solvents. In many instances, FWP screening collects information as to the nature, extent and duration of exposure to particular toxins. This evidence can be very useful to a CE when assessing a Part E claim because it provides exposure details that are unique to the employee.

c. Obtaining FWP Records. In those instances where claimant submitted documentation suggests that they have undergone screening by a FWP, the CE may request medical and employment records in possession of the FWP. DEEOIC will provide its staff with a listing of POCs for the different FWPs. The CE reviews the POC list to identify the appropriate POC. The CE prepares a package and a cover letter to the POC (Exhibit 11-1). The package includes a letter to the FWP, a cover memo, Form EE-1 or EE-2, and EE-3. Once completed the CE mails or faxes the packet to the designated POC.

8. Terminally Ill Claimants. DEEOIC strives to process claims fairly and expeditiously for all claimants. However, claimants who are end-stage terminally ill must have priority processing.

a. Claims Actions. DO and FAB CEs and HRs are instructed to watch for indicators of an end-stage terminally ill claimant any time they are reviewing a case file or preparing a decision. Indicators of end-stage terminally ill claimants include requests for hospice care, medical evidence stating that the claimant is at the end-stage of an illness, or

telephone calls or letters from RCs, congressional offices, ARs, family members, or medical providers regarding the claimant's illness. Upon receipt of information that an employee may be at a terminal stage of an illness, the DO or FAB CE must coordinate notification of the situation to the DD (or ADD) or FAB Manager (depending on where the file is located).

The DD/ADD or FAB Manager must use sound judgment in determining if priority handling needs to occur. If medical documents or other information indicate that the claimant is in the end-stage of his/her illness or that death is imminent, the DD/ADD or FAB Manager directs case action to occur in an expedited manner and ECS is updated to include the terminal indicator.

Priority handling for terminally ill claimants requires all DEEOIC staff to undertake claim adjudication activities in an expedited manner, wherever possible. If a case requires referral to the NO for reopening or policy clarification, the DO or FAB must identify the claimant as terminally ill in the memo to the Director. If the claimant's terminal medical status is unclear, the DD/ADD or FAB manager must initiate development to obtain medical evidence to establish the status of the claimant is at the end-stage of a disease or illness.

9. Correspondence Creation and Tracking System (CCAT.) CCAT is an internal form and correspondence generator within ECS that is used to generate certain standardized forms and correspondence letters. The system populates various fields with information already contained within ECS, such as names and addresses, while allowing the user to input other claim-specific information. In addition, CCAT also contains samples of these forms and letters.

a. Below, in alphabetical order, are the forms and letters currently available in CCAT:

(1) Alternative Filing Acknowledgement Letter

(2) AR Acknowledgement Letter

(3) Change of Address Acknowledgement Letter

(4) Claim Acknowledgement Letter

(5) DEEOIC Case Transfer Sheet

(6) DME Authorization Letter

(7) EE-8 and EN-8 Smoking History Questionnaire

(8) EE-9 and EN-9 Race/Ethnicity Questionnaire

(9) EE-10 and EN-10 Claim for Additional Wage-Loss and/or Impairment Benefits under the EEOICPA

(10) EE-11A and EN-11A Form (Impairment)

(11) EE-16 and EN-16 Form

(12) Hearing Request Acknowledgement Letter

(13) Hearing Transcript Letter

(14) HHC Authorization Letter

(15) Home Hospice Authorization Letter

(16) Letter to DOJ for RECA Award Confirmation

(17) Lump Sum Payment Acknowledgement Letter

(18) Medical Travel Reimbursement Authorization Letter

(19) Not Claiming Impairment and/or Wage-Loss Letter

(20) Physician Letter

(21) Rehabilitative Service Authorization Letter

(22) Residential Care Facility Authorization Letter

(23) Review of Written Record Acknowledgement Letter

(24) Untimely Hearing Request Letter

CHAPTER 12 – REPRESENTATIVE SERVICES

1. Purpose and Scope. This chapter contains a discussion regarding persons who represent the interests of claimants before the DEEOIC. It provides guidance to DO and FAB staff on the designation of a representative, the role and functions of a representative, and fees charged by representatives for their services.

2. Authority. Under 20 C.F.R. §§ 30.600 and 30.601, a claimant may authorize any person, not otherwise prohibited by law, to represent him or her. The authorization includes allowances for communicating with claims staff, accessing case file documentation, receiving copies of decisions, submitting objection(s), filing appeals, and seeking medical authorizations.

a. No Requirement for Representation. A claimant is not required to designate a representative to file a claim or receive any benefit available under the EEOICPA.

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

c. Authorization in Writing. Any representative appointment must in writing. The information that is necessary for a claimant to appoint a representative is the representative's name, mailing address, and telephone number. The claimant is to date and sign the request. The claimant may appoint a representative by filling out the "Authorization for Representation/Privacy Act Waiver" (Exhibit 12-1), but use of this is not required. If the appointing document does not contain the representative's full name, telephone number and address, the CE obtains that information. Upon receipt of an AR notification, the CE or FAB staff person must enter the AR's information into the ECS.

d. Removal of Representative. A claimant may elect to either remove or change a representative at any time and for any reason. When removing a representative, the claimant is to submit a signed and dated written request that identifies clearly the person removed as representative. When replacing a representative, the claimant must state in writing that he or she is removing the previous representative and replacing that person with another person. The claimant must name the previous representative and name the new representative, along with the new representative's mailing address and telephone number. Once the claimant removes a person from serving as his or her representative, the assigned CE or FAB staff person is no longer to interact with that individual in relation to the claimant's case file. A representative may also resign his or her appointment with a signed statement of such. The CE or FAB staff person will update ECS regarding removal and/or change of representative.

3. Length of Appointment. DEEOIC recognizes the authority of a properly appointed AR throughout the entire claims process (including any hearing), unless or until the claimant removes the appointment, the representative withdraws, or the claimant dies.

a. Death of the claimant. In the case of a claimant's death, his or her DEEOIC representative appointment ceases. In addition, any appointment such as an attorney-in-fact under a POA or a conservator under a conservatorship ends.

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

5. Authority of an Attorney-in-Fact or Legal Conservator/Guardian. A person with POA to act in the name of the claimant is an "attorney-in-fact." There are also other types of legal designations that may exist such as a conservator or guardian. In any of these situations, a written instrument has to exist that grants legal authority for someone to act on behalf of another. The written instrument will include language that describes the specific authorities granted for one person to act on behalf of another, and can be different from one situation to another. A general POA authorizes one person to have complete authority to act on someone's behalf on all matters, including signing documents and forms. In a special or limited POA, the authority to act may be limited to particular topics. Therefore, if an individual claims to have POA or some other legal authority to act on behalf of a claimant, the CE or FAB staff person must obtain a copy of the document conferring such authority. He or she must carefully examine the document to determine the scope of the legal authority granted. The CE or FAB staff person is to recognize any POA or other legal appointment, if the document upon which that appointment is made, conveys broad powers for the appointee to act on behalf of the claimant. Once the CE or FAB staff person receives documentation supporting the claimant has a POA, they will then update ECS with the new POA information. In those situations where the CE or FAB staff person determines that the legal authority of a person to act on behalf of a claimant is limited to a particular function that does not allow for engagement on the DEEOIC claim, he or she sends a letter to the claimant. The letter is to communicate what the concern(s) are regarding the appointment and is to specify what communication between the DEEOIC and the attorney-in-fact (or court-appointed representative) will and/or will not occur. In those situations where the CE or FAB staff person is unsure of the authority granted to a person to serve on behalf of a

claimant or of the legal sufficiency of a document, he or she may consult with the Policy Branch for guidance.

a. Form EN-20. In any situation where a person other than the specified payee is signing Form EN-20, the CE must submit the documents purporting to grant such power for review by the SOL to ensure that they are valid under the applicable state law.

When preparing documents for review by the SOL, the referring CE or staff person is to include as part of the referral package, a routine or terminal memo for review by the SOL (Exhibit 12-2). The referring CE or staff person uploads the memo to OIS and also sends a notification via OIS to the designated NO staff person. Upon receiving the notification in OIS, the NO staff person verifies the information and refers a printed copy of the POA package to SOL. Once SOL processes the POA and returns the copy to the NO staff person, the NO staff person bronzes the Solicitor's response into OIS, indexing the document(s) as Category "Adjudication Documents." The Subject is "SOL opinion." The Description is "POA review memo from SOL for (payee name)." The document is to be left in an Unreviewed status in OIS for identification by the assigned CE.

6. Interaction with Representatives. After a claimant properly appoints a representative to handle his or her DEEOIC claim, the CE or FAB staff person contacts the representative by letter. In the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in the claims process. From that point forward, or until the claimant removes or changes the representative, the CE or FAB staff person will communicate with the designated representative and copy them on all written interactions intended for the claimant. The CE or FAB staff are permitted to communicate with employees of the designated representative, including legal assistants, administrative staff, paralegals, or other individuals in the employment of the representative.

7. Representative Conflict of Interest Guidance. Conflicts of interest can arise when a duly appointed AR has direct financial interests arising out of the acceptance of a claim, even if those interests are only potential in nature, aside from the representational fees permitted under EEOICPA. This is because those other financial interests may be more lucrative to an AR, and therefore may be more important, than the potential amount of the fee for representing a client with a claim before DEEOIC. These sorts of divided interests on the part of ARs might motivate representatives to act in a manner contrary to a claimant's best interests and are not allowed under this policy.

a. Upon receipt of a signed notice of the appointment of an AR, the CE or FAB staff person sends an acknowledgment letter accompanied by the DEEOIC Conflict of Interest Policy.

b. If during any interaction with an AR or in review of case evidence, the CE or FAB staff person ascertains that the AR may have a conflict of interest, the CE should take immediate action to address the matter. A conflict of interest may exist if there is evidence that the AR is receiving financial benefits associated with the claim aside from the authorized fee permitted under the law. An

incidence of conflict of interest includes evidence showing the AR works for or is contracted by an individual, organization or entity that concurrently receives monetary payment from DEEOIC for services, supplies or other resources affiliated with the claim. This includes a representative who is a family member or other relative of the claimant receiving a wage, contractual payment, or fee from a medical service provider that the DEEOIC has granted authorization to provide in-home health services for that claimant. In any instance where a CE or FAB staff person is unclear as to the existence of a conflict of interest, he or she may refer the matter via a policy referral to the NO Policy Branch. Upon receipt, the Policy Branch will work with the SOL to provide a written response.

(1) Upon receipt of credible evidence that a conflict of interest may exist, the CE or FAB staff person must prepare a notice to the designated AR, with a copy to the claimant (Exhibit 12-3). The notice is to include a descriptive explanation of the evidence that suggests that a conflict of interest may exist. The CE or FAB staff person is to request that the AR prepare a signed statement explaining his or her response to the evidence of a conflict of interest. Moreover, the CE is to state that if a conflict of interest does exist, the DEEOIC will no longer recognize the designation of the AR unless the conflict is eliminated. The letter is to include a statement allowing the AR 30 days to respond to the notice.

(2) When in receipt of the AR's response, the CE or FAB staff person must carefully evaluate the information provided, along with a review of the evidence of record, to determine whether a substantiated conflict of interest exists. If the AR acknowledges that a conflict of interest exists, he or she may resolve the conflict by either submitting a signed resignation as the AR, or submitting evidence of the relinquishment of whatever charges, position, job or duty creates a conflict with the role of AR. The claimant can also withdraw the authorization for that representative, in writing, and designate a new AR. Consent of the claimant will not remove a conflict of interest.

(3) If the AR contends that the circumstances identified do not constitute a conflict of interest under DEEOIC's policy, or no response is forthcoming within 30 days of the initial notification, the CE or FAB staff must carefully weigh the evidence of record. Should the AR provide sufficient rationale that absolves him or her of any conflict of interest, the CE or FAB staff person notifies the representative, in writing, with a copy to the claimant, that no further action is necessary. However, if it is determined that there is compelling evidence of a conflict of interest, the CE or FAB staff person should conclude that DEEOIC will no longer recognize the designated AR as serving the interest of the claimant. Under this circumstance, the claimant is to be notified in writing that DEEOIC will no longer interact with the designated AR due to a conflict of interest.

c. Once a CE or FAB staff person has determined that a conflict of interest exists that disqualifies a designated AR from representing the claimant and appropriate

notification of such has been reported to the claimant, no further interaction with or disclosure of information to the AR is permitted. The CE or FAB staff person is to remove the AR information from the ECS.

d. When a CE or FAB staff person removes a representative due to a conflict of interest, he or she should refer the name of the representative to the NO Policy Branch. Upon receipt, the NO Policy Branch will coordinate a review to determine if an additional investigation is required to assess potential conflict of interest in cases where the same representative exists.

8. Representative Fees. A representative may charge a claimant a fee for services associated with representation before DEEOIC. Under 20 C.F.R. § 30.602, the OWCP is not responsible for any fee charged by a representative of an EEOICPA claimant, nor will it reimburse the claimant for any fees paid to the representative. Other than issues relating to the allowable fee under the EEOICPA, disputes over payment of fees, the quality of services rendered, or collection of monies owed are a personal matter between the claimant and his or her AR.

a. Fee Limits. Under 20 C.F.R. § 30.603, for services rendered in connection with a claim pending before DEEOIC, a representative may not receive more than the following percentages of a lump-sum payment made to a claimant:

(1) 2% for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus

(2) 10% of the difference between the lump-sum payment made to the claimant and the amount proposed in the RD with respect to objections to a RD.

b. Limitations. These maximum fee limitations apply even if the claimant and representative have agreed to other amounts in a contract or otherwise. Any such representative who violates this section shall be fined up to but not more than $5,000. Pub. L. 106-398, Title XXXVI, § 3648; Pub. L. 107-107, § 3151(a)(6)

c. A CE or FAB representative will refer any complaint of a violation of the fee schedule to the NO Policy Branch who will work with the SOL to determine if a referral to the DOJ is appropriate.

9. Privacy Act Waivers. A Privacy Act waiver grants the DEEOIC permission to copy all documents from the case file and send them to a person of the claimant's choosing. This person may be anyone the claimant wishes to receive material from the case file. The designated person will have no authority to make requests for additional information or sign documents on behalf of the claimant, unless the claimant submits additional documentation showing that the designee has such authority.

CHAPTER 13 – ESTABLISHING COVERED EMPLOYMENT

1. Purpose and Scope. The EEOICPA lays out a set of employment criteria which must be satisfied before a claim can be considered for compensability. These criteria, taken together, form the basis of covered employment. This chapter provides guidance to CEs for gathering and evaluating evidence to determine whether the criteria for covered employment are satisfied under the EEOICPA.

a. OIS. DEEOIC employees responsible for claim management must image into OIS all documents received or created that relate to a claim. This guidance applies to all of the procedures described throughout this chapter.

b. ECS. ECS is a claim status database used to manage case adjudication activities of the DEEOIC. Development of any employee case requires information input into ECS by CEs or FAB staff to record component-level data on claimed and verified employment. DEEOIC staff is to access ECS user guides and training material available through shared resources.

2. Facility Coverage. The EEOICPA provides facility definitions that serve as the basis for determining covered employment. The following summaries provide a definition of each type of facility covered:

a. AWE Facilities. An AWE facility means a facility, owned by an AWE, that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling. Coverage at the facility may be extended after the period of processing or production of radioactive material for use in a weapon, if there is a finding in a NIOSH report on residual radioactive contamination that the potential exists for residual radioactive contamination at that facility. This is the "residual radiation period." DOE designates AWE facilities.

(1) Coverage extends only to the employees who worked directly for the AWE at the AWE facility. Contractor or subcontractor services provided on-site or off-site for an AWE facility are not covered. Additionally, coverage is not provided for those employees of wholly-owned subsidiaries of AWE employers.

(2) The Joint Employer Doctrine does not apply. Courts have held that where the evidence shows that two or more employers exert significant control over the same employee, by jointly exercising the authority to determine the essential terms and conditions of employment to that employee, they can be held to be joint employers. However, this "joint employer doctrine" usually only applies in the labor law context, and is incompatible with the explicit intent of Congress, as expressed in the language of EEOICPA itself, to only extend coverage to employees of particular designated employers. This means that the evidence must establish that the employee worked directly for the AWE. Evidence that an employee

worked for a parent company or other corporate entity somehow related to the AWE employee does not establish employment by the AWE.

(3) AWEs are covered under Part B of the EEOICPA for cancer only. No coverage is afforded these employees under Part E of the EEOICPA.

(4) Designating additional AWE facilities is the responsibility of DOE; however, applicable time frames for AWE production activities at a particular facility are determined by the DOL.

(5) Determinations as to whether an AWE facility has a period of residual radioactive contamination, and the length of that period, are the responsibility of NIOSH. Periodic reports are issued by NIOSH that list affected sites. Facilities with residual radioactive contamination are covered as AWE facilities even if there is a change in the owner or operator of the facility. During the period of residual radiation, employees of subsequent owners or operators of the AWE facility are also defined as AWE employees and are afforded the same coverage under the EEOICPA. If there is a question regarding subsequent owners or operators of AWE facilities, the CE must refer the matter to the NO for evaluation.

b. Beryllium Vendors. Beryllium Vendors are companies which are named in the Act, or DOE has determined processed or produced beryllium for sale to, or use by, DOE. The Act identifies some beryllium vendors by corporate name, and these are known as statutory beryllium vendors. Any employee of a statutory beryllium vendor who worked for the vendor during periods when the company was engaged in activities related to the production or processing of beryllium for sale to or use by DOE, has covered employment, regardless of work location. DOE, through publication in the Federal Register, designated other beryllium vendors, which are location-specific. DOE designated the final list of beryllium vendors on December 27, 2002.

(1) Beryllium vendor coverage extends to direct employees of the vendor, its contractors or subcontractors and to any Federal employee who may have been exposed to beryllium at a facility owned or operated by the vendor.

(2) Coverage for beryllium vendor employment is limited to those benefits available under Part B of the EEOICPA for beryllium sensitivity and CBD.

c. DOE Facilities. A DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located, in which operations are, or have been, conducted by, or on behalf of DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program), and with regard to which DOE has or had either (A) a proprietary interest; or (B) entered into a contract with an entity to provide management and

operation, management and integration, environmental remediation services, construction, or maintenance services.

(1) The extent of benefits available to those who worked at DOE facilities is dependent upon the type of employment, specifically whether the employee was a DOE federal employee or an employee of a DOE contractor or subcontractor. Under Part B, coverage extends to both DOE federal employees and contractor or subcontractor employees working at the site, while under Part E coverage extends only to contractor or subcontractor employees.

(2) The definition of DOE includes its predecessor agencies:

(a) Manhattan Engineer District (MED) (August 13, 1942-December 31, 1946)

(b) Atomic Energy Commission (AEC) (January 1, 1947 – January 18, 1975)

(c) Energy Research and Development Administration (ERDA) (January 19, 1975– September 30, 1977)

(d) DOE (October 1, 1977 – present)

(3) Designations of DOE facilities or changes in DOE facility timeframes are the responsibility of DOL. Further information regarding how DOL assesses claims for DOE facility status is discussed later in this chapter.

d. Remediation Employment. At many AWE facilities, there is a period of remediation designated sometime after the years of active processing ended. When a facility is designated as a DOE facility for remediation only, in order to have covered employment at that location, the contractor performing the remediation work must have employed the employee. Any such remediation workers are eligible for the full range of benefits under both Parts B and E of the EEOICPA.

e. Facilities with multiple designations. Many facilities covered under the EEOICPA have multiple designations. Numerous combinations of AWE, Beryllium Vendor, and DOE facility designations may exist at the same facility. For those instances in which an employee works at such a facility during periods separately designated for different facility types, the employee will have eligibility for every category for which he/she has verified employment.

f. RECA Section 5. This is a category of employment involving miners, millers and ore transporters at uranium mining facilities. For information regarding the handling of these claims, please refer to Chapter 19 – Eligibility Requirements for Certain Uranium Workers.

3. Comparing Initial Claimed Employment to the Covered Facilities Database. The first step the CE takes in assessing covered employment is determining which claimed employment listed on the EE-3 Employment History form corresponds with a covered AWE, Beryllium Vendor, or DOE facility. The CE does this by comparing what the claimant has communicated on the EE-3 with the facilities identified on the DOE EEOICPA Covered Facilities Database. The link to access this database can be found on the DEEOIC website. It can also be found in the EPOD which is referenced in paragraph 6 of this chapter.

When performing the comparison between the claimed employment and the facility database, the CE must be diligent in assessing the evidence. While in many instances employment at a particular location or facility will be obvious, in other situations it may not. The CE reviews evidence presented by a claimant against the information stored in the database to assist in determining the location(s) where employment occurred. The CE must be mindful that often the name of a facility is different from the employer name provided by the claimant because multiple different operating contractors could have worked at DOE facilities over the years. Given these realities, the CE must cross-reference the data provided by the claimant with the information in the facility database. This can involve searching by facility name, state, location, employer name or contractor name using the key word search field. The "Find this Keyword" search feature is the broadest possible way to look for potential covered employment based on claimant statements.

The CE screens out certain employers from the review process if it is clear that it does not constitute covered employment. For example, employment as a shoe store clerk or department store cashier would not require action on the part of the CE as part of the review for potentially covered employment.

4. Matching Claimed Employment. The outcome of the initial employment facility screening will result in either part or all of the claimed employment having possibly occurred at a covered facility, or none of the claimed employment being linked to a facility. In any instance where the CE links all claimed periods of employment to a location identified on the facility database, he or she is to proceed to employment verification as discussed later in this chapter. Alternatively, if the CE is only able to match a portion of the claimed employment to a facility listed in the facility database, or there is no match found, he or she must communicate the findings to the claimant. The CE will contact the claimant to notify him or her who claimed employment may form the basis of a claim, and which does not appear to be linked to a covered facility. As part of this interaction, the CE is to give the claimant an opportunity to provide clarifying evidence. Paragraphs 16 and 17 of this chapter provide more information on the topic. This development may occur concurrently with other actions the CE takes on the claim, such as requests for additional medical or factual evidence.

When there is sufficient evidence to conclude that employment might have occurred at a covered facility, the CE proceeds with verification of employment. If the claimant does not respond to the inquiry, or does not provide any type of clarifying evidence, the CE may proceed with adjudication of the claim based upon the evidence of record. If there is no match between any claimed employment and a covered facility, the CE denies the claim. The CE will describe the situation clearly in the "Explanation of Findings" section of the RD issued to the claimant.

5. Verification of Employment. Once the CE matches claimed employment and a covered facility, the next step is employment verification. Employment verification is the process by which the CE establishes the factual accuracy of the claimed employment history. The CE has to collect evidence to establish that:

a. The employer qualifies for consideration under the law as an AWE, Beryllium Vendor, DOE, or DOE contractor or subcontractor.

b. The employee worked for the claimed employer.

c. The employee performed services on the premises of the covered AWE, Beryllium Vendor or DOE facility.

The process of employment verification is a difficult and challenging hurdle in many cases. Because the atomic weapons program dates back to the early 1940s, and involves a large number of public and private organizations, locating pertinent individual employment records can be difficult. Moreover, records may be missing, degraded, lost, or destroyed.

As the statute allows latitude in the assessment of evidence, it is not necessary for the CE to collect evidence that establishes that the claimed employment is proven beyond a reasonable doubt, but merely that a reasoned basis exists to conclude that the employment occurred as alleged.

This ensures that the claimant receives favorable treatment during the employment verification process. Once the CE has conducted an examination of the available factual evidence in support of the claimed employment, he or she must decide whether a sufficient basis exists to verify that each of the three elements of covered employment (5a, b and c above) is satisfied.

Furthermore, in matching claimed employment to covered employment, the CE is to be mindful that there are numerous classes in the SEC, described in Chapter 14 – Establishing Special Exposure Cohort Status. A CE always consults the most current list of SEC classes so that he or she promptly processes claims that contain evidence meeting SEC class definitions.

6. EPOD. The EPOD is a document that the NO Policy Branch created to assist CEs in identifying facility-specific contact persons and resources to use in obtaining employment verification. The EPOD lists every facility published in the Federal Register as a covered facility under the Act (except RECA facilities) and provides an outline of the identified methods for verifying claimed employment at each location. DEEOIC staff access the EPOD through a shared employee directory.

The resources listed in the EPOD do not provide an exhaustive list of means for verifying employment at a facility, but represent what constitutes best practices for verifying employment given the programmatic experience gained since passage of the Act in 2000. Specifically, the EPOD identifies which methods, or combinations thereof, are appropriate to pursue for verification of covered employment in the most expeditious manner possible. If the EPOD is silent on verification at a facility, the CE is to utilize Social Security Records (Paragraph 10, below) and “other employment evidence” (Paragraph 12, below).

The facilities in the EPOD are listed alphabetically by state. On the first page of the EPOD, there is a list of states and, for those states with a large number of facilities; there are additional letters after the state name. These letters provide an index of the facilities in that state. The state names and letters allow the user to navigate through the document. For example, to navigate to South Carolina, the user places the cursor on South Carolina and presses "Ctrl + left click" at the same time and the utility will jump to South Carolina. Alternatively, if a user wants to view the S-50 Plant in Tennessee, the most expeditious method would be to move the cursor over the letter "S" after Tennessee and then press "Ctrl + left click" at the same time and the utility will jump to S-50.

7. Using the ORISE Database. ORISE (the institute) developed a database as part of its mission to study the health and mortality of the DOE contractor work force. The database formed an important component of health studies, as it identified a significant portion of the population participating in these health studies. This database is instrumental in verifying covered employment for some employees. A CE will consider the data in ORISE accurate and valid employment information, even if it only provides partial affirmation of claimed employment. For every EEOICPA-covered facility for which there is some employment data in ORISE, the EPOD will indicate "ORISE – yes." When this occurs, the CE conducts an ORISE search in ECS. If there is no mention of ORISE in the EPOD for the facility, the CE proceeds to the next recommended method for verifying employment noted in the facility description in the EPOD or in this chapter. In any case where a CE accesses ORISE to obtain evidence in a claim, he or she bronzes the output, whether negative or positive, into OIS.

a. ORISE categorizes information in two sections, Employee Name and Employment. The Employee Name section identifies the employee's last name, first name, and middle initial. The employment section contains five columns of information. The first column entitled "Facility" lists all the facilities or employers (for which data exists in ORISE) where the employee worked. The second column indicates whether the employee was hired or terminated, followed by columns showing the hire/termination date, Job Title, and Badge No. ORISE was not created for the purpose of adjudicating claims, so information may be incomplete.

b. When using ORISE to assist with the adjudication of claims, the CE must consider the context of the information. For example, there may be data in ORISE confirming that an employee worked at a facility in 1949, but the CE must ensure that the covered period for this facility includes 1949. Additionally, for many employees, the information in ORISE is incomplete. For example, for some employees the database may show the employee's name and facility, but does not include specific hire and termination dates. If this is the case, the CE develops hire and termination dates using alternate methods described in paragraphs 8 through 12 in this chapter.

Note: There may be instances when the ORISE database returns search results showing "SSA Records Only." The DOE used this as an indicator, in the early days of the epidemiologic studies, to identify facilities for which requests were sent to SSA for information. It has no impact on the processing of claims under the EEOICPA and is only a vestige of DOE use of the data in the mid- 1980s.

c. If the information from the ORISE database verifies any portion of employment, the CE bronzes a copy of the ORISE employment results into the OIS case file.

d. The absence of data from ORISE cannot be used as the basis for finding that an employee did NOT work at a given facility either for the entire period claimed or for portions of claimed employment.

e. Some non-covered employers and/or facilities are present in ORISE. The CE needs to review the ORISE results for non-covered employers. For example, the Puget Sound Shipyard, for which ORISE ascribed the acronym PSSY, is not covered under the EEOICPA. In the event that ORISE "confirms" non-covered employment, it does not render such employment as covered under the EEOICPA.

8. Contacting DOE and Using the Secure Electronic Record Transfer System (SERT). The CE transmits requests for employment verification electronically to DOE via the SERT system. The SERT is a DOE-hosted environment where DOL and NIOSH send and receive records and data in a secure manner.

When the CE cannot verify claimed employment through use of ORISE, the CE uses Form EE-5 to obtain employment information. To determine whether EE-5 referral to DOE is appropriate, the CE looks up the name of the facility(ies) and/or employers in the EPOD. If there is a notation in the EPOD indicating "EE-5 and DAR: SERT" for that facility, the CE proceeds with the EE-5 procedures specified in this paragraph.

a. EE-5. The CE completes the top portion of the EE-5 by providing the employee name, SSN, claimed employer, and name of the claimed facility (ies). Only one completed EE-5 form per claimant request for employment verification is necessary.

In some cases, employees traveled to other DOE facilities to work and are considered "visitors" on site. As such, employment records verifying that the employee worked for that facility may not exist. However, there may be records establishing that he/she was on site. It has been found that the DAR (the process by which the DO gathers DOE work records on specific employees) records have been useful in establishing that the employee was on site. Therefore, under these circumstances, it is appropriate to request DAR records without the need for the EE-5 employment verification process. Refer to paragraph 'i' below on requesting DAR records.

b. Submitting the request to DOE via the SERT. To prepare a request for employment verification, the CE scans and combines the EE-1 or EE-2, as appropriate, the EE-3, ORISE database search results and the EE-5 form as an Adobe PDF file and saves it to his/her computer. The CE then submits the completed package to DOE via the SERT. The SERT system contains a listing of the DOE POCs and DOE Operations Offices, which are managed and maintained in the SERT system.

The CE accesses the SERT, creates a record request for the employee, uploads the PDF package, and sends the request to the appropriate DOE Operations Office(s). The SERT has the functionality to allow for the selection of multiple operations offices in cases where requests go to multiple facilities. The CE (requester) may also enter additional information in the 'Comments' section of the SERT that may be useful to the recipient (DOE) of the request. The field is also used for DOE to respond directly back to the DOL in response to comments.

c. Once the request is sent through the SERT, the CE bronzes a copy of the request in the case file.

d. Subcontractor employment indicated. Where claim documentation indicates subcontractor employment, the CE reviews the EE-3 and makes a preliminary determination as to whether the employee is claiming DOE subcontractor employment. If so, the CE notes this in the 'Comments' section of the SERT and requests any information that DOE might have to help substantiate that the company was hired by DOE, or a DOE contractor, to provide a service on-site during the time period when the employment is claimed.

   Questions regarding subcontractor employment are referred to the same operations' office(s) as the EE-5 package.

e. Response from DOE. The CE will receive notification via email when DOE has the documents ready for download through SERT. The CE accesses the SERT, selects the applicable EE-5(s), downloads the file to his/her computer, and bronzes the response into OIS.

f. Upon receipt of an EE-5 from DOE via SERT, the CE reviews it for completeness. DOE is responsible for selecting one of three options provided on the form and attaching any relevant information. In addition, the DOE representative completing the form must certify its accuracy. The CE returns any form that does not meet these requirements to DOE for correction. The three options available to DOE and the appropriate procedural responses are as follows:

   (1) For any of the claimed employment in which DOE selects "Option 1 – Verified Employment," the CE accepts this period as verified and no further action needs is required.

   (2) If DOE selects "Option 2 – No verification is possible, but other pertinent evidence exists," this indicates that DOE has some information on the employee, generally suggesting that the individual was on site or somehow associated with the facility, but the information is insufficient for DOE to provide verification. The CE develops the case further for employment as outlined in this chapter.

   (3) If DOE selects "Option 3 – No evidence exists in regard to the claimed employment," it means that DOE has no evidence at all regarding the

claimed employment. The CE develops the case further for employment as outlined in this chapter.

g. Timeframes. If the CE does not receive a response from DOE within thirty (30) days of the initial submission, the CE accesses the SERT system, enters the claimant's information, locates and selects the request for employment verification, and sends a reminder to the DOE operations office, using the "reminder" button. A memo is not necessary, since the SERT system maintains the requestor's or CE's contact information and the initial request. The CE bronzes the notification in the case file. If DOE is ultimately unable to verify employment, the CE is to proceed with other available development actions.

h. No Response from DOE. If the CE does not receive a response from the DOE within 60 days from the initial request, additional development is necessary.

(1) Contact DOE by telephone. If no response is received, the CE contacts the appropriate Operations Office by telephone or emails the DOE POC and inquires about the request for employment verification. The CE asks the contact person whether a response to employment verification will be forthcoming. If DOE responds via telephone that they have no records to verify employment, the CE documents this in the case file with a memo outlining DOE's response. This serves as the "EE-5" for purposes of a DOE response.

(2) Contact the claimant. If, after 60 days there is no response from DOE, the CE contacts the claimant for additional employment information. In cases where a response from DOE is received indicating that no records are available, the CE may contact the claimant for additional employment information immediately. In this case, the CE does not wait for 60 days to lapse.

i. DAR Process. For cases involving DOE contractor employees, the CE makes a request to DOE for records useful for developing information regarding toxic exposures and other purposes. Although CEs use DAR records predominately in the adjudication of the toxic exposure component of Part E cases, DAR records can also contribute to the evidence of covered employment, especially in cases involving DOE subcontractor employment or employees who are on official travel from one DOE facility to another and considered by DOE to be "visiting" on site. DAR records can include site medical records, job descriptions, radiological records, incident or accident reports, and others. In the past, requests for DAR records were made of DOE once employment was confirmed. However, with the implementation of the SERT system, the CE initiates a DAR request at the same time as the EE-5, employment verification request. In situations where DAR records are needed, the assigned CE should include the request for those records in the EE-5 package that is submitted to DOE through the SERT system. For more details on the DAR process, refer to Chapter15 - Establishing Toxic Substance Exposure.

j. Dosimetry Records. It is general program policy for NIOSH to obtain dosimetry records from DOE as part of the dose reconstruction process. The dosimetry records become associated with the file when the DO receives NIOSH's final dose reconstruction report. Nevertheless, in cases where dose records may be useful for confirming that an individual was on-site, or was monitored for radiation exposure, the CE may request such records from DOE as part of employment development. Dosimetry records pertaining to different DOE facilities can represent different periods of site presence. If there is a question as to the dates of on-site presence represented by and employee's dosimetry records, the CE should seek clarification from the Policy Branch.

9. Contacting Corporate Verifiers. Private companies operate many of the facilities designated as AWE or beryllium vendor facilities under the EEOICPA. Neither DOE nor any of its predecessors have possession of these employment or personnel records. The DEEOIC refers to companies that have documentation pertaining to such covered facilities as corporate verifiers. Many of these companies are still in business, or have been bought by other companies that have retained records of past employees. Several of the companies retaining possession of relevant employee records have agreed to provide employment verification for purposes of adjudicating claims under the EEOICPA. For each facility that is identified as having a corporate verifier, the EPOD provides the name and contact information for the corporate verifier. The CE follows the instructions listed in the EPOD to obtain such employment information. General procedures for handling corporate verifiers include:

a. Contact the corporate verifier via EPOD instructions. This involves providing them with the information and/or forms they need to answer questions about the claimed employment. This can include providing them with copies of the EE-1 or EE-2 and/or a letter providing the employee's name, the case identification number (or the full SSN if required by the corporate verifier), date of birth, employer name, and the dates of claimed employment.

b. Upon receipt of a response from the corporate verifier, the CE reviews it to determine if it is sufficient to verify the claimed period of employment. If the corporate verifier affirms the entire period of claimed employment, the CE accepts the period as factual. The CE obtains the verification from corporate verifiers in writing. While employment verification can be initiated through a phone call, there must be documentation from the verifier in the case file to substantiate a finding of covered employment. In some instances, a corporate verifier can verify that the employee worked for a specific company, but not the location of that employment. If the corporate verifier is unable to substantiate the claimed period of employment, or can only substantiate a portion of it, or can only substantiate employment with the company, but not at a covered location, the CE will need to request additional information from other sources. The CE can proceed with a request to the SSA for information as described in paragraph 10 of this chapter, and should ask the claimant for additional information, as outlined in paragraph 12 of this chapter, as appropriate.

c. If verification is for beryllium sensitivity or CBD, the CE need not verify all employment, only enough employment sufficient to substantiate the exposure at

any time during a covered time period. For additional information regarding development of beryllium claims, refer to Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions.

d. Corporate verifiers sometimes change. If a CE learns of a change in contact information or locates new contact information, this information must be sent to the NO Employment Contact in the Policy Branch.

10. Verifying Employment Through the SSA. The SSA records provide a history of quarterly wages and earnings for each company the employee worked for during the course of his/her career. Absent confirmation of employment through ORISE, DOE, or a corporate verifier, the CE requests additional information from the SSA. Also, for those facilities for which the EPOD does not provide any suggested employment verification pathway, the CE requests records from the SSA by following the procedures outlined below:

a. SSA earnings records are received from the claimant, if available, or the CE digitally faxes a completed Form SSA-581 to SSA to obtain this information. The form is located on the shared drive in the Forms folder within the Policies and Procedures folder). The process to obtain earnings records using Form SSA-581 is as follows:

(1) The CE completes the top portion of the Number Holder's Information section on the SSA-581. This includes the following information: name; SSN; date of birth of the employee; date of death of the employee (if applicable); and other name(s) used. The CE completes the form with the years deemed necessary to verify employment and/or establish wage-loss on the "Year(s) Requested" line. In the box entitled, Signature of Organization Official, the CE types his or her name (signature is not required) and in the "Office" box, select the correct DO location from the drop down menu. The CE dates the form and lists his or her direct phone number, along with the DO fax number. The CE capitalizes all entries on the SSA-581.

(2) The completed SSA-581 must be digitally faxed to SSA using fax number 877-278-7067. A cover letter is not required with the SSA-581. The CE is responsible for bronzing into OIS the completed SSA-581 and fax receipt.

(3) If the faxed SSA-581 is deficient, the SSA contacts the CE directly to explain the deficiency, or the SSA emails the DEEOIC designated POC with a list of rejected SSA-581s for each DO. This email will include the name of the employee, the employee's SSN, and the reason(s) for the rejected SSA-581. The email list must be bronzed into OIS with redaction of names not related to the particular case.

(4) The POC forwards the email of a rejected SSA-581 to the assigned CE. After making the necessary corrections, the CE digitally faxes the corrected SSA-581 to FAX number 410-594-2054. Cover sheet is not

required for resubmission due to a reject. The CE is responsible for bronzing into OIS any document received or created in response to a rejected SSA-581.

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

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

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

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

(b) Name of your organization.

(c) A copy of the SSA-581 or earnings statement in question.

(d) The full SSN of the number holder (employee), or the control number from the earnings statement.

(8) Upon receipt of a completed SSA-L460, the CE documents receipt of the SSA response in ECS. Should the SSA fail to submit an SSA-L460 after following up within the established procedures, the CE proceeds with claim adjudication based upon the evidence contained in the case record.

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

a. Web-accessible database. To substantiate the existence of a contract between DOE and a contractor, CPWR created a web-accessible database, which the CE can use in identifying and confirming the existence of contractor or subcontractor employers at certain covered facilities. Facilities for which CPWR has contractor and subcontractor information are identified in the EPOD as "CPWR." If the CE

determines that the claimed employment involves subcontractor employment at a facility in which the EPOD indicates "CPWR has contractor/subcontractor information," the CE first reviews the EE-5, the Data Acquisition Request (DAR), and any material received from DOE. If this information is insufficient for a finding of covered employment, the CE reviews the CPWR database for any information linking the claimed employer to the claimed DOE facility, by following these instructions:

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

(2) Upon access to the web site, a disclaimer notes that the database is a general information resource tool. It does not contain all of the documents that relate to DOE contractors and/or subcontractors. However, the DEEOIC considers the information available in the database to be accurate and correct. Once the CE accepts the disclaimer, the database opens into basic search mode. The database allows various ways to search for information: by subcontractor name; by site; or by scrolling down the subcontractor master list.

(3) To search by contractor/subcontractor name, the CE enters the name of the company identified in the evidence from the case record. The company name may be the current recognized employer name, an acronym for the employer, or a previous version of the name. The CE searches the database using various combinations of spellings or any known aliases for the employer name. This increases the likelihood of a positive outcome and reduces the number of false negative results. For example, if a CE enters the name "Bowles Construction Company," the database returns a negative result. However, if the CE enters "Bowles" or "Bowles Construction," the employer appears in the return.

(4) To search by site, i.e., covered facility, the CE clicks on the list box labeled "by site" on the left hand side of the screen and selects the facility for which he or she is seeking contractor or subcontractor information. This returns all employers known by CPWR linked to that facility. It may be necessary for the CE to scroll down to view all named employers. To view detail for a named employer, the CE merely needs to access the "view" link under the options category. In some instances, a contractor or subcontractor name might be linked to multiple covered facilities. In these instances, the detailed return for the employer is separated into sections by covered site.

(5) The CE may also search the comprehensive listing (master list) of all contractor employers listed in the database which appears if no name or site search criteria are applied, or if the option "show all" is selected. A unique document identification (Doc Id) has been assigned to each contractual finding. CPWR uses the Doc Id as a means of tracking. The Doc Id can also be used to search BtComp, if it is known.

(6) After the CE has accessed the database and conducted appropriate research to locate a contractor/subcontractor, the CE documents the case file in OIS. In the case of a positive result, the CE prints a copy of the screen for OIS bronzing. The printout must show all the results of the database search, including the employer name; site name; contractual relationship indicator; dates verified; type of work performed; a description of evidence; document ID; and date of database update. Generally, this information must be printed using a "landscape" print mode setting. The printout should also list the date of the database search, the date of the latest update of a facility, and any of the pertinent facts. If no results are found from a database search, the CE completes a "Memorandum to the File," noting the lack of information in the database for the claimed contractor/subcontractor. The CE bronzes the completed memo into OIS.

(7) The sole purpose of the database is to establish a relationship between a DOE facility and a contractor or subcontractor employer. A positive result may return varying levels of information about an employer linked to a facility. For example, a database return may merely list that a contractor or subcontractor was linked to a particular facility, but not when. Furthermore, the existence of a contract between the company and the DOE could be for a wide range of items or services. Under the EEOICPA, only contracts for services performed on the premises of the DOE facility are covered. Once a CE establishes that a contract existed between a company and the DOE, it is still necessary to establish that the contract was for a covered service, per paragraph 13 of this chapter. In addition to the database results, additional development may be needed independent of the database to ensure that such evidentiary gaps are filled. The CE may contact the NO Policy Branch regarding questions or other matters relating to the use of subcontractor database.

(8) If the contractor or subcontractor is not listed in the database, additional development is necessary. The CE is not to assume that a search of the database that does not return any results establishes that the claimed employer was not a contractor or subcontractor.

b. Requests for contractual information. In those instances in which BtComp.org does not return a positive result on a contractor or subcontractor, the DO POC will send a request via email to the CPWR designated point of contact at CPWR to research documentation supporting a contractual relationship with a DOE facility. (Note: This search will be at a facility level and not at the employee level. There will be no searches conducted for employee records). The request should include the name of the contractor/subcontractor, the name of the trade, the DOE site, and the time period of contracted work. The CPWR will research its records and respond directly to the DO POC, via email, with its findings within 20 business days of receipt of the request.

c. Requests for supporting documentation. In cases where the CE conducts a search of BtComp, finds positive results, and needs a copy of the supporting documentation, the DOE POC sends the request to the to the NO, to submit the request to CPWR. In its request, the DO references the BtComp Document-ID number and the reason for the request. CEs request this documentation if it is being used to resolve a discrepancy in the case file, or if the documentation is needed for litigation purposes. The processing of this type of request will be at the discretion of the NO. The CPWR will respond with a copy of the documentation within 5 business days of the receipt of the request.

d. Forwarding of contractual information. If a CE obtains documentation during case development that substantiates a contractual relationship between a contractor and/or subcontractor and a DOE facility not already included in the database, he or she is to forward a copy of that documentation to CPWR. The documentation is to be sent by the DO POC via USPS to the current CPWR contact person at CPWR located at 8484 Georgia Avenue, Suite 1000, Silver Spring, Maryland 20910, or scanned and emailed to the POC at CPWR that maintains these records. The CPWR will review the documentation, update BtComp, and retain the documentation in their files.

12. Other Employment Evidence. Evidence of employment by DOE, a DOE contractor, beryllium vendor, or AWE may be made by the submission of any trustworthy contemporaneous records that on their face, or in conjunction with other such records, establish that the employee was so employed, along with the location and time period of such employment. No single document noted in this section is likely to provide all elements needed for a finding of covered employment, but rather each piece of evidence can contribute valuable elements needed to make a finding of covered employment.

Documentation from the following sources may be considered:

a. Records or documents created by any federal government agency (including verified information submitted for security clearance and dosimetry badging), any tribal government or any state, county, city or local government office, agency, department, board or other entity or other public agency or office.

b. Records or documents created as a byproduct of any regularly conducted business activity, or by an entity that acted as a contractor or subcontractor to DOE.

c. DEEOIC internal resources. The DEEOIC DOs each have gained experience with the facilities covered under this program. In the adjudication of claims, each office will accumulate documentation substantiating various subcontractor relationships. Once such a relationship has been established at a facility for a given time period, the CE can use this information in the adjudication of other cases in which the same subcontractor employment is claimed during the same time period. Therefore, as noted in paragraph 11, any such documentation accumulated during the course of adjudicating a claim that substantiates a contractual relationship with a covered DOE facility, must be forwarded to

CPWR. CPWR will then update the BtComp database based on information substantiated by this documentation.

d. Affidavits or other types of signed statements attesting to the accuracy of a claim. The CE requests that the claimant use the EE-4 Employment History Affidavit to collect statements from knowledgeable parties. Statements provided by way of an affidavit are considered in conjunction with other evidence submitted in support of a claim. Affidavits are particularly appropriate as a means of demonstrating that an employee worked at a particular location and are best used in concert other information, such as SSA records. Affidavits alone are usually insufficient to prove the existence of a contractual relationship between DOE and a company.

The CE has the discretion to assign probative weight to different affidavits. For example, the CE may find that an affidavit from a former CEO of an employer has significantly more probative value than that of one from a temporary worker who had no reason to be well-informed on his/her employer's contractual relationship with DOE or a DOE contractor. The CE must use his or her own judgment to ascertain what weight to give to any given piece of evidence, including affidavits. The CE is to assess the probative value of affidavits by applying these general parameters:

(1) Affiliation of affiant to employee (co-worker vs. family member). Affidavits from co-workers and managers carry more weight than those from family members, as they would be in a better position to provide details about work.

(2) Descriptive vs. vague employment information. More detailed affidavits carry more weight than vague, generalized statements because more specific information is more easily corroborated than that which is ambiguous.

(3) First-hand knowledge vs. second-hand knowledge. An affidavit not containing first-hand knowledge has very little probative value, as it is nothing more than hearsay.

(4) Compliments other evidence from file vs. contradictions. When documentation in the file supports portions of an affidavit, the probative value of the remainder of the content of that affidavit is high. In the alternative, when an affidavit is in conflict with other material in the file, its probative value is diminished.

13. Subcontractor Employment. Subcontractor employment at beryllium vendors and DOE facilities is covered under the Act, provided that certain developmental elements are met.

a. Definitions.

(1) Contractor. An entity engaged in a contractual business arrangement with DOE to provide services, produce material, or manage operations.

(2) Subcontractor. An entity engaged in a contracted business arrangement with a DOE contractor to provide a service on-site.

(3) Service. In order for an individual working for a subcontractor to be determined to have performed a "service" at a covered facility, the individual must have performed work or labor for the benefit of DOE within the boundaries of the facility. Examples of workers providing such services include janitors, construction, and maintenance workers. The delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, including workers involved in the delivery and loading or unloading of goods for construction and/or maintenance activities.

(4) Contract. An agreement to perform a service in exchange for compensation, usually memorialized by a memorandum of understanding, a cooperative agreement, an actual written contract, or any form of written or implied agreement, is considered a contract for the purpose of determining whether an entity is a "DOE contractor." Only employees who are employed by the company named in the contracting documentation are covered. Employees of parent companies or subsidiaries companies of the contracting company are not covered and the joint employer doctrine also does not apply.

b. Standard. Mere presence by the employee on the premises of a facility does not confer covered employment. There are three developmental components that must be met before a determination of covered subcontractor employment can be reached. These elements are:

(1) The claimed period of employment occurred during the covered time frame as alleged; and

(2) A contract to provide "covered services" existed between the claimed subcontractor and a DOE contractor at the facility or the identified vendor (during the covered time frame);

(3) The employment activities (work or labor) took place on the premises of the covered facility.

c. Subcontractor employment at beryllium vendor facilities. Under the Act, persons providing a service on the premises of beryllium vendors during covered time periods are entitled to the same benefits as employees of the beryllium vendor during those same covered time periods. For some beryllium vendors, the corporate verifier for the vendor at which the subcontractor performed work has records of subcontractor employees and, therefore, in verifying beryllium vendor sub-contractor employment the CE first contacts the corporate verifier for any information he or she has on the individual and his or her subcontractor employer. In those situations in which an employee is alleging beryllium sub-contractor

employment and the beryllium vendor is unable to confirm employment, the CE uses SSA records, affidavits and other evidence as described in this chapter.

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

e. Developing subcontractor employment. The CE will likely have to use an assortment of documentary evidence to make a finding of covered subcontractor employment. For example, SSA records may show that the employee worked for Sentell Brothers, thus establishing verified earnings. Documentation from CPWR may show that Sentell Brothers was a subcontractor during the period of verified earnings at K-25, X-20, Y-12 and Oak Ridge in general. The DOE may also provide documentation showing that the employee had a clearance to work at K-25 doing construction or dosimetry badging information specific to K-25. In this situation, the CE likely has sufficient documentation to make a determination that the employee worked as a K-25 subcontractor employee during the time period for which the earnings, the contractual information and the presence on the premises requirements are all met.

For all instances in which the CE is required to evaluate potential subcontractor employment, the CE writes a memo to the file delineating every period of claimed subcontractor employment and specifying the evidence in the case file that supports each of the following:

(1) the claimed subcontractor was in a contractual relationship with a DOE contractor,

(2) the subcontractor provided a service to DOE on the premises of the DOE facility, and

(3) the employee was engaged in providing that service on site, including the number of days the employee was engaged in that service.

The memo should also provide an explanation as to why the standard was or was not met (Exhibit 13-2) .

14. Researcher Employment at DOE Facilities. A DOE contractor employee is also defined as "An individual who is or was in residence at a DOE facility as a researcher for one or more periods aggregating at least 24 months." In order for an employee to meet the "researcher" provision under the Act, the following criteria must be met:

a. Research. There needs to be probative evidence in the file that the individual was actually performing research on the premises of the DOE facility. Visiting the site, obtaining medical tests on-site, or similar non-work related reasons that

people may have for being on-site at a DOE facility, does not qualify under this provision. Evidence useful in documenting that an individual was performing research on-site includes published journal articles, affidavits, or some other documentation affirming that the individual was engaged in research.

b. Living on-site not required. Although some DOE facilities provide dormitory-style accommodations which often house researchers, "in residence" can be satisfied by working "on the premises," and the individual need not have been living on the premises of the DOE facility.

c. Research can be unpaid. There is no requirement that the researcher is/was paid for the work.

15. Employees of Federal or State governments Other than DOE and its Predecessors. Employees of federal and state governments, (other than direct employees of DOE, ERDA, the AEC or MED) can be DOE contractor employees, as outlined in this paragraph.

a. Standard. A civilian employee of a state or federal government agency can be considered a "DOE contractor employee" if

(1) The government agency employing the individual is found to have entered into a contract with DOE for the accomplishment of one or more services on the premises of that DOE facility that such government agency was not statutorily obligated to perform, and

(2) DOE compensated the agency for that service.

b. Proof of contract. The DO contacts the federal or state agency directly in an effort to obtain the desired information. The DD is responsible for managing any necessary coordination with federal and state agencies. Any time documentation is obtained from these agencies, copies are to be provided to the NO. The CE should not pressure a state or federal agency to produce employment or contractual records.

c. If the evidence is unclear as to whether employment by a state or federal agency can be determined to be DOE contractor employment using the guidance in this paragraph, the CE obtains clarification from the claimant. The CE reviews any documentation submitted by the claimant and undertakes any additional development necessary to clarify the individual's employment status, including any needed input from the NO Policy Branch.

Upon finding that the employee does not meet the definition of a "DOE contractor employee" who worked for a state or federal agency, and where this is the sole employment listed on the Form EE-3, the CE issues a RD denying the claim on the basis that the employment by the state or federal agency does not qualify the claimant as a "DOE contractor employee" as defined in the EEOICPA.

d. Uniformed Members of the Military. A claimant cannot obtain EEOICPA benefits based upon service in the military. If the claimant provides information or identifies himself/herself as military personnel, the CE sends a letter to the claimant stating that uniformed military personnel are ineligible for benefits under the EEOICPA. Only civilian employees who performed services on the premises of DOE facilities, via contracts, are DOE contractor employees.

16. Evaluating Evidence to Verify Employment. Once the CE receives all available evidence, he or she has to determine if the evidence is sufficient to verify the three components of covered employment listed in paragraph 5 of this chapter. The CE evaluates all evidence carefully and uses discretion regarding documentation that reasonably establishes the presence of the employee at a particular facility during certain periods of time. Additionally, with regard to subcontractor employment, the evidence must reasonably satisfy all the components necessary to establish covered employment. If employment with other state or federal entities is claimed, then all the components discussed in paragraph 15 of this chapter must be fulfilled. In weighing the evidence submitted in support of covered employment, the CE considers the totality of the evidence and draws reasonable conclusions.

17. Developing Non-Covered Employment. There will be instances in which the CE is only able to match a portion of the claimed employment to a facility and/or employer listed in the facility database, or there may be no match found. In these instances, the CE communicates this to the claimant. The CE prepares a letter to the claimant explaining which employment is covered under the Act and which is not, including any pertinent dates. A description of what constitutes an AWE facility, Beryllium Vendor facility or a DOE facility should be included in the letter. In the event that the claimant believes some of this non-covered employment should be covered under the Act, the CE asks the claimant to supply any pertinent evidence substantiating the claim. Namely, the CE asks the claimant to provide evidence demonstrating that the claimed place of work met the definition of an AWE, Beryllium Vendor or DOE facility during the years the employee worked there. For example, a CE may ask the claimant to submit evidence such as contractual documents, business reports, internal memos, purchase orders, news articles, affidavits, etc. A period of 30 days is granted to the claimant to submit evidence in support of extending covered employment to additional facilities/employers and/or years.

After appropriate development, the CE decides whether any evidence submitted warrants a referral to the NO. If the claimant submits pertinent evidence supportive of adding a facility/employer and/or years of coverage, the CE prepares a brief memo to the file explaining the circumstances of the situation and requests a review of the case file by the NO. The CE submits a request to the NO to make a determination regarding the new evidence of an additional covered facility/employer or years.

18. Additions or Modifications to Facility Status. While the EEOICPA defines what constitutes an AWE facility, a Beryllium Vendor facility and a DOE facility, updates are periodically made to facility designations as new information becomes available. The NO Policy Branch is responsible for reviewing new evidence and deciding whether changes should occur to facility designations. As such, the Policy Branch is responsible for evaluating requests for changes to the covered facility listing or modification of facility designations, depending on the nature of facility evidence, the Policy Branch undertakes different actions.

a. AWE Facility. New designations are the responsibility of DOE. Accordingly, requests for new AWE designations are referred to DOE.

(1) Time frame changes relating to specific years of processing at an AWE facility are the responsibility of DOL. Evidence must be presented clearly demonstrating that the AWE processed or produced material that emitted radiation and was used in the production of an atomic weapon at the AWE facility.

b. Beryllium Vendor. The statutory deadline for adding additional Vendors was December 31, 2002, and therefore no additional Beryllium Vendors can be designated under the Act.

(1) Time frame changes relating to Be Vendors are the responsibility of DOL. Evidence must be presented clearly demonstrating that the Beryllium Vendor had a contractual agreement involving beryllium with DOE, or its predecessors, and that the company is performing/or did perform those beryllium-related contractual tasks in the years to be added to coverage.

c. DOE Facility. Facility and/or time frame changes relating to DOE facility listings are the responsibility of DOL. Under the EEOICPA, a DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located in which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by

Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and with regard to which DOE has or had either (A) a proprietary interest; or (B) entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

Interpreting and applying the definition of a DOE facility is within the adjudicatory authority of the DEEOIC. To determine whether a facility is a DOE facility under the Act, certain parameters must be met.

(1) Operations. To show that operations were performed on behalf of DOE, the evidence must demonstrate that DOE paid for operations at that location. These operations are not limited to those involving radiation or weapons. Everyday operations such as providing library services in a technical library are sufficient to meet this statutory requirement.

(2) Proprietary Interest. To show that DOE had a proprietary interest, evidence that DOE owned the building, structure or premises, such as a deed or affirmative statement from DOE acknowledging ownership is required. Proprietary interest can also include instances in which DOE is contractually permitted a sufficient level of use and control over the property to support a determination that the property constituted a DOE

facility. DOE ownership of intellectual property or equipment, regardless of size, does not fulfill the proprietary interest definition. Moreover, DOE permitting, safety oversight, or licensing of work relating to use of radioactive material does not convey propriety interest.

(3) Contracts. To show that DOE entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services, the best possible evidence is to produce the contract. Typically, contracts with DOE or its predecessors identify the contract type on the first page, so in those cases in which contracts are located, it is generally not difficult to discern contract type. The contracts identified in this portion of the law are among the more common and significant contracts used throughout the DOE complex in the following ways:

(a) Management and Operation (M&O) contracts are those contracts that DOE often had with major companies to manage and operate large DOE facilities, such as Union Carbide and Carbon at K-25 and Y-12.

(b) Management and Integration (M&I) contracts were also used by DOE to run major DOE sites, but an M&I contractor generally had numerous smaller site contractors for which the M&I's job was to "integrate" the work of the smaller companies. The Idaho National Laboratory is an example of a DOE facility which has been run from time to time by M&I contract. Companies holding M&O and M&I contracts at DOE facilities are generally considered the "prime contractor" for that facility, though sometimes facilities will change from the M&O model to the M&I model.

(c) Contracts for environmental remediation services, construction, or maintenance services are also common throughout DOE, but are generally smaller in size than the major M&O's and M&I's. DOE used remediation contracts to clean up radiation at numerous AWE facilities. In these instances, the locations are designated as DOE facilities for the period of remediation under the DOE contract and the remediation workers are covered.

(d) Some common types of contracts issued by DOE that do not meet the statutory definition include research & development, output, and procurement.

19. Special Circumstances. There are some special circumstances regarding eligibility for benefits pertinent to the Naval Nuclear Propulsion Program and EEOICPA claims from citizens of the Republic of the Marshall Islands, as outlined below.

a. Naval Nuclear Propulsion. As noted in the section above, the statutory definition of a DOE facility specifically excludes, "buildings, structures, premises, grounds,

or operations covered by Executive Order No. 12344, dated February 1, 1982 (42 U.S. C. 7158 note) pertaining to the Naval Nuclear Propulsion Program." As a consequence of this exclusion, the DEEOIC is unable to find covered employment for those AEC employees and AEC contractors who worked at locations devoted to Naval Nuclear Propulsion operations.

b. Marshall Islands. The DEEOIC has received claims for compensation under the EEOICPA from citizens and nationals of the Republic of the Marshall Islands (RMI). The Marshallese base their claims on employment related exposure arising from the United States' nuclear weapons testing program conducted in the RMI. The DOE facility known as the Pacific Proving Ground was a weapons test site in the South Pacific from 1946 to 1962.

In 1986, the United States and the Marshall Islands terminated their trust territory relationship through enactment of the Compact of Free Association (Compact). The Compact is a comprehensive document encompassing a variety of agreements, including a number of socio-economic, agricultural, and monetary compensation programs. Under the Compact, the RMI became an independent sovereign nation and U.S. laws ceased to apply unless otherwise specified.

For purposes of the administration of the EEOICPA, this Compact has been interpreted as precluding coverage for RMI citizens and nationals. If the CE determines that a claim for benefits is from a citizen or nationals of the Marshall Islands, the CE explains, in the conclusions of law portion of the RD, that there is no provision under the EEOICPA for coverage of claims based upon employment in the RMI by citizens or nationals of the RMI. The CE inserts the following wording in the conclusions of law as a summary of the DEEOIC policy:

> *Since interpreting the EEOICPA to apply to claims by Republic of the Marshall Islands (RMI) citizens or Nationals based upon employment in the RMI would constitute an invasion of the sovereignty of the RMI, the presumption against applying a statute extraterritorially is invoked. Furthermore, there appears to be no contrary intent by Congress to rebut the presumption and, to the extent that Congress has expressed any intent, its approval of the Compact of Free Association between the United States and the RMI suggests that it did not intend for the EEOICPA to apply extraterritorially in this situation.*

CHAPTER 14 - ESTABLISHING SPECIAL EXPOSURE COHORT STATUS

1. Purpose and Scope. The EEOICPA established the SEC to compensate eligible members of the Cohort without the need for a radiation dose reconstruction and determination of the PoC. This means an employee who meets the necessary employment criteria to be included in a designated SEC class and is diagnosed with a specified cancer receives a presumption of causation that employment-related radiation caused the specified cancer. This chapter describes the procedures for establishing eligibility under the SEC.

a. OIS. DEEOIC employees responsible for claim management must image into OIS relevant documents received or created that relate to a claim. This guidance applies to all of the procedures described throughout this chapter.

b. ECS. ECS is a claim status database used to manage case adjudication activities of the DEEOIC. CEs or FAB staff record the various screening and development actions for all SEC related claim activities. CEs must pay particular attention to ECS coding requirements for screening of SEC claims and the SER/SEF coding in the SEC causation path. DEEOIC staff is to access ECS user guides and training material available through shared resources.

2. Identifying SEC Claims. The CE is to review the initial application forms carefully, including Form EE-3 - Employment History, to determine whether the potential exists for inclusion in one or more SEC classes. In addition, a claimant can identify employment at a covered worksite that may qualify for consideration for the SEC.

3. Determining SEC Eligibility. To be eligible for benefits under the SEC provision, an employee must belong to a SEC class. In establishing the SEC, Congress designated four statutory SEC classes. The EEOICPA also allows for addition of new SEC classes based on analysis and determination by HHS.

A SEC class can be based on a whole facility, limited to specific buildings in a facility, or even specific processes within a facility. In some cases, a SEC class may be limited to specific job titles or duties in a particular facility. In addition, each SEC class will have specific workday requirements that must be met; typically an employee has to have been employed for a number of workdays aggregating at least 250 workdays at one or more SEC worksites. The workday requirement at Amchitka, Alaska SEC class is met by any employee who spent any part of one workday at that facility, during which he or she was exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests. Finally, to be eligible under the SEC, medical evidence has to document the employee's diagnosis with at least one of twenty-two (22) specified cancers as listed under paragraph 7.

4. Statutory SEC Classes. The EEOICPA designated the following statutory SEC classes according to their respective covered facilities:

a. Gaseous Diffusion Plants (GDP) located in Paducah, Kentucky, Portsmouth, Ohio or Oak Ridge, Tennessee. A DOE employee, DOE contractor employee, or an employee of an AWE qualifies for inclusion in this SEC if he or she was:

(1) Employed for an aggregate of 250 workdays prior to February 1, 1992, at one or more of the above GDPs; and

(2) Monitored during such employment through the use of dosimetry badges for exposure to radiation, or worked in a job that had exposures comparable to a job that is or was monitored through the use of dosimetry badges.

(a) If the employee qualifies for possible inclusion in the SEC on the basis of work at a GDP, but Form EE-3 does not indicate whether a dosimeter was worn, the CE is to determine whether the employee had exposure during his or her employment that is comparable to a job that is or was monitored through the use of dosimetry badges.

In making this determination, the CE assumes that the employee had comparable radiation exposure if employment occurred during the following periods at the particular GDPs:

Paducah GDP: 7/52 – 2/1/92
Portsmouth GDP: 9/54 – 2/1/92
Oak Ridge GDP (K-25): 9/44 – 12/87(not 2/1/92)

Documentation shows the presence or active processing of materials that emitted radiation at the sites for these dates. 2/1/1992 represents the date that DOE implemented uniform radiation protection practices consistent with current industry practices and regulations. The 12/1987 date referenced for the Oak Ridge K-25 plant corresponds to the cessation of uranium processing operations.

b. Amchitka Island, Alaska. The EEOICPA grants SEC membership to DOE employees, DOE contractors or DOE subcontractors, who were employed prior to January 1, 1974 on Amchitka Island, Alaska, and were exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests. The CE considers the following factors in determining whether the employee was exposed to radiation in the performance of duty:

(1) Exposure to ionizing radiation from the Long Shot, Milrow, or Cannikin underground nuclear testing/explosions which occurred on Amchitka Island. The first detonation, Long Shot, occurred on October 29, 1965. The 80 kiloton underground nuclear explosion leaked radioactivity into the atmosphere. Radioactive contamination on Amchitka Island occurred as a result of activities related to the three underground nuclear tests and releases from Long Shot and Cannikin.

(2) As a result of these airborne radioactive releases, employees who worked on Amchitka Island could have been exposed to ionizing radiation from the Long Shot underground nuclear test. It is believed that such exposure began approximately one month after the detonation occurred. Thus, for purposes of determining SEC employment, the period from approximately December 1, 1965 to January 1, 1974 is to be used, unless the claimant can show that the employee was exposed during the month immediately following the detonation.

(3) In contrast to other SEC classes with the 250 workday requirement, this SEC class requires that the employee worked at Amchitka Island for any length of time during the period from approximately December 1, 1965 to January 1, 1974, and was exposed to ionizing radiation from underground nuclear tests.

5. Additional SEC Classes. HHS has authority to designate additional classes of employees to be added to the SEC. A class of employees may be included in the SEC if HHS determines that it is not feasible to estimate with sufficient accuracy the radiation dose members of the class received, and there is a reasonable likelihood that such radiation may have endangered the health of the members of the class. For a complete list of SEC designations, refer to Exhibit 14-1.

a. Overview of the SEC Designation Process. The designation process begins with a petition submitted to the NIOSH, Division of Compensation Analysis and Support (DCAS). The petitioner may include one or more DOE employees (including DOE contractor or subcontractor employees), or AWE employees, who would be included in the proposed class of employees, or their survivors. Individuals or entities authorized by these employees in writing or labor organizations representing or formerly having represented these employees may also submit a petition.

NIOSH may also initiate a petition if it determines that it cannot complete a dose reconstruction for a class of employees.

(1) NIOSH evaluates the petition for inclusion in the SEC to determine if it contains the minimal qualification to proceed with the SEC designation process in accordance with 42 CFR § 83.13 or § 83.14.

(2) If NIOSH determines that the minimum qualification for review and evaluation has been met, it forwards the petition to the Advisory Board on Radiation and Worker Health (Advisory Board) along with its evaluation. During one of its regular Board meetings, the Advisory Board reviews NIOSH's evaluation, hears from the petitioners if they choose and other interested parties. The Advisory Board also reviews any other information it determines to be appropriate for the petition.

(3) The Advisory Board submits a recommendation on a new SEC class to the Secretary of HHS within 30 calendar days of the Board meeting.

(4) The Secretary of HHS makes the final determination to add or deny a new class to the SEC based on the recommendation of the Advisory Board and the NIOSH evaluation. If the Secretary of HHS decides to add a new class to the SEC, he or she issues a designation letter to Congress with the definition of the class.

(5) A new SEC class becomes effective 30 calendar days after Congress receives the Secretary's designation letter, unless Congress objects or provides otherwise.

6. Workday Requirement. Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC worksites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are some cases where the employee worked for less than a year, and additional guidance is required to calculate the 250 workdays.

a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.

(1) If evidence exists establishing an employee's onsite presence at a designated SEC facility for 24 hours, including time spent working or living at the facility, the employee will be credited for 3 work shifts (i.e. 3 work days) towards the 250-work day requirement. In such instances, the 250-work day requirement will be satisfied if the evidence establishes the employee's onsite residential presence at a designated SEC facility for 83 days, which a CE may consider as the equivalent of 250 workdays.

b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workdays any infrequent periods of non-presence or non-work, like holidays, sick leave, strikes, layoffs, or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC worksite for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.

c. The period of 250 workdays starts with the worker's first day of employment at the SEC worksite. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC worksites.

d. Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension, dues, union local records, etc.), the following table may be used for conversion.

250 days =	50 five-day weeks, or
	42 six-day weeks, or
	12 months (five-day weeks), or
	10 months (six-day weeks), or
	2,000 hours
	24 hours per day of residential on-site presence for 83 days
One month =	21 days (if evidence indicates six-day weeks, 25 days

e. Where records of an employee's earnings are available, such as W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows: Divide the annual wages earned at the SEC worksite by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual employment. As such, this method should only be used when all primary employment data is lacking.

f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the NO Policy Unit may be required.

7. Specified Cancers. In addition to satisfying the employment criteria under a SEC class, the employee must have been diagnosed with a specified cancer to be eligible for compensation under the SEC provision. As with any cancer claim, the employee's occupational exposure to radiation must be before the initial date of diagnosis. For all specified cancers, first exposure can occur at any covered facility during a covered period, and does not need to be within a SEC covered period. The following are specified cancers in accordance with 20 CFR § 30.5(ff):

a. Leukemia. (CLL is excluded). The onset is to have occurred at least two years after initial exposure at any covered facility during a covered time period.

b. Primary or Secondary Lung Cancer. (In situ lung cancer that is discovered during or after a post-mortem exam is excluded.) The trachea and bronchi are included as part of the lungs. Sarcoma of the lung is a lung cancer. The pleura and lung are separate organs, so cancer of the pleura, such as mesothelioma, is not a specified cancer.

c. Primary of Secondary Bone Cancer. This includes myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, essential thrombocytosis or essential thrombocythemia, and primary polycythemia vera (also called polycythemia rubra vera, P. vera, primary polycythemia, proliferative polycythemia, spent-phase polycythemia, or primary erythremia). A diagnosis of polycythemia vera (and the listed a/k/a nomenclature) is sufficient by itself to be classified as a malignancy of

the bone marrow. Leukocytosis and thrombocytosis are blood abnormalities and are not to be considered cancer or, specifically, bone cancer. The bone type of solitary plasmacytoma (a/k/a solitary myeloma) is a form of cancer consistent with bone cancer. The soft tissue type of solitary plasmacytoma is not a type of bone cancer or the specified cancer of multiple myeloma. (Note: Cancer of the hard palate is not bone cancer.)

d. Primary or Secondary Renal Cancers.

e. Other Diseases. For the following diseases, onset must have been at least five years after initial exposure at any covered facility during a covered time period:

(1) Multiple myeloma (a malignant tumor formed by the cells of the bone marrow);

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

(3) Primary cancer of the:

(a) Thyroid;

(b) Male or female breast;

(c) Esophagus;

(d) Stomach;

(e) Pharynx – The pharynx has 3 parts - nasopharynx, oropharynx and hypopharynx. (The oropharynx includes the soft palate, the base of the tongue, and the tonsils);

(f) Small intestine;

(g) Pancreas;

(h) Bile ducts (includes Ampulla of Vater, a/k/a hepatopancreatic ampulla);

(i) Gallbladder;

(j) Salivary gland;

(k) Urinary bladder;

(l) Brain (malignancies only). The brain is the part of the central nervous system (CNS) contained within the skull, i.e., the intracranial part of the CNS consisting of the cerebrum, cerebellum, brain stem, and diencephalon. (The intracranial endocrine glands and other parts of the CNS, benign and borderline tumors of the brain, and borderline astrocytoma's are excluded);

(m) Colon (includes rectum and appendix);

(n) Ovary;

(o) Liver (except if cirrhosis or hepatitis B is indicated);

f. Carcinoid Tumors. These tumors are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer.

Carcinoid tumors should be recorded by the organ of the specified cancer. For example, the CE should use the ICD-10 code of C7A.010 for a malignant carcinoid tumor in the duodenum section of the small intestine.

Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

g. Names or Nomenclature. The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the NCI under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature. The DEEOIC will consult with NCI only on issues pertaining to the name or nomenclature of a disease diagnosed at an anatomic location for the purpose of determining whether it constitutes a cancer.

h. Identifying Specified Cancers. For cases where there is uncertainty as to whether a diagnosed cancer is a specified cancer, the CE is to refer the case file to PRPU for consideration. The examination of the record by PRPU will determine whether the diagnosed cancer originates within the anatomic structure of one of the listed "specified cancer" locations within the body, and conforms to the pertinent latency period, if any.

i. Spread of Cancer. Where cancer has spread to various sites (organs) it may be

difficult to identify the site of origin for the cancer. If the pathology report (or medical report) lists several alternatives and at least one site is considered a SEC cancer, the claim should be processed first as a SEC cancer claim.

8. Procedures for Processing SEC Claims. Processing SEC claims entails coordination between the PRPU and DO/FAB staff.

a. Role of the PRPU:

(1) Issues circulars with guidance on processing newly designated SEC classes. This will include specific instructions on how to evaluate evidence in the case file to determine SEC eligibility.

(2) Prepares a comprehensive list of all reported cases with claimed employment at a newly designated SEC worksite during the period of the SEC class. It will include pending cases, cases previously denied, and those at NIOSH. This comprehensive list will be provided to the DOs and FAB at the time of the issuance of the SEC circular.

(3) Unresolved questions on processing SEC claims, including questions on the definition of a SEC class, uncertainty as to whether a diagnosed cancer should be considered a specified cancer, or questions regarding calculation of the 250 workday requirement are referred to PRPU for guidance.

b. Role of the CE:

(1) Identifies a potential SEC claim by reviewing the information on the claim forms or other pertinent evidence in the case file to determine if there is sufficient evidence to suggest that an employee worked as a member of a named SEC class. For newly designated SEC classes, the CE is to review the comprehensive list provided by PRPU as noted in paragraph 8a(2).

(2) Reviews corresponding bulletins and circulars for designated SEC classes for procedures on evaluating evidence to determine if the SEC criteria are met.

(3) Completes an initial screening of cases on the comprehensive list provided by PRPU for a newly designated SEC class. A screening worksheet is to be completed for all cases on the comprehensive list. Upon completion, the worksheet is to be included in the case record.

Based upon the initial screening, the cases on the comprehensive list are grouped into three categories: those likely to be included in the SEC class; those unlikely to be included in the SEC class; and those for which development may be needed to determine whether the case can be accepted into the new SEC class.

The purpose of this initial screening is to prioritize handling of cases that are likely to be included in the newly designated SEC class. This screening step is only applicable to cases on the comprehensive list. It is not applicable to new claims submitted after the list is generated or when a comprehensive list is not generated. Once screening and prioritization is complete, a more detailed review of all the cases (priority given to cases that are likely to be included in the SEC class) and full development must take place to determine if a case is eligible for benefits under the SEC.

The SEC initial screening is a process to determine if cases on the comprehensive list meet the statutory requirements for inclusion in the SEC. If a claimant on the SEC comprehensive list is deceased, and the employment and medical criteria are met but survivorship development is needed, the CE will mark the initial screening worksheet "development needed".

(a) For cases on the comprehensive list at FAB, a FAB staff member is to conduct the initial screening and completion of the worksheet.

(4) Evaluates medical evidence in the case file of a potential SEC case to determine if the employee has been diagnosed with a specified cancer. If a deceased employee meets the employment criteria for SEC class membership, but an explicit specified cancer diagnosis and diagnosis date are not stated in the employee's medical records, a diagnosis and diagnosis date can be established based on the following:

(a) There is sufficient medical evidence for the employee that indicates a diagnosis of a specified cancer, but the diagnosis is not definitive, and

(b) An expert opinion is provided to support that the deceased employee did have a specified cancer. The medical opinion is to provide sufficient details and rationale based on accepted medical knowledge to support the specified cancer diagnosis and diagnosis date. The medical opinion can be provided by the employee's treating physician, a CMC, and/or an expert in a relevant medical field.

(5) If the employee has a specified cancer, the CE is to verify that the employee meets all employment criteria in the SEC class designation, including the workday requirement. In determining whether the employment history meets the workday requirement, the CE can consider employment at a single SEC class, or in combination with workdays at other SEC classes.

The CE also reviews any documentation that NIOSH may have acquired or generated during the dose reconstruction process to determine if the employee satisfies the employment criteria of a SEC class(es).

(a) NIOSH will identify and return dose reconstruction analysis records for cases with specified cancers that may qualify under a SEC class to the appropriate DO along with a CD for each case. The CD will contain all of the information generated to date, e.g., CATI report, correspondence, and dose information. The Correspondence Folder on the CD should include a copy of the NIOSH letter sent to each claimant informing the claimant of the new SEC class, and that his or her case is being returned to DOL for adjudication. The CE is to upload a copy of the NIOSH letter for each claimant into the case file.

(b) There may be some cases not identified by NIOSH that the CE determines may be included in the SEC class. If any such case qualifies under the SEC class and the case is with NIOSH for a dose reconstruction, the CE notifies the appropriate point of contact at NIOSH via e-mail to pend the dose reconstruction process and return dose reconstruction analysis records to the appropriate DO. The CE then uploads a copy of the "sent" e-mail into the case file (making sure the file copy documents the date it was sent). In addition, the CE is to write a letter to the claimant to advise that the case file has been withdrawn from NIOSH for evaluation under the SEC provision.

(6) Proceeds in the usual manner for a compensable claim and prepares a RD if the employee has a diagnosed specified cancer and meets the employment criteria of the SEC class. The CE notifies the appropriate POC at NIOSH via e-mail so that they may close their file. The CE then uploads a copy of the "sent" e-mail into the case file.

(a) If a Part B claim is accepted as a SEC claim based solely upon AWE employment, and the employee has some period of DOE contractor employment (it does not matter where or when), the accepted Part B cancer can be accepted under Part E, even though the SEC acceptance is based solely on AWE employment.

(7) Refers to NIOSH the SEC cases that were evaluated but do not qualify under the SEC provision, e.g. cases with non-specified cancers, specified cancers with insufficient latency period, or cases with insufficient SEC employment. NIOSH will conduct a full or partial dose reconstruction on the cases.

(a) For those cases which were previously submitted to NIOSH for dose reconstruction but were returned to the DO for consideration

in a SEC class, a new NIOSH Referral Summary Document (NRSD) is not required. Instead, the CE notifies the appropriate point of contact at NIOSH via e-mail to proceed with the dose reconstruction. The CE then uploads a copy of the "sent" e-mail into the case file. The e-mail should include a brief statement of why the case should proceed with dose reconstruction, e.g., non-specified cancer, insufficient latency period or does not meet the 250 workday requirement.

The CE also notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE is to send a copy of this letter to NIOSH.

(b) If the claim meets the SEC employment criteria and includes both a specified cancer and a non-specified cancer, medical benefits are only paid for the specified cancer(s), any non-specified cancer(s) that has a probability of causation of 50 percent or greater, and any secondary cancers that are metastases of a compensable cancer.

For the non-specified cancer, the CE prepares a NRSD for a dose reconstruction to determine eligibility for medical benefits. In these SEC cases, all primary cancers are to be listed on the NRSD, including the specified cancer(s).

(i) One exception to this rule is an accepted SEC claim where the specified cancer is a secondary cancer. Per regulation 20 CFR § 30.400(a), "In situations where the accepted occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer." However, "payment for medical treatment of the underlying primary cancer under these circumstances does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of EEOICPA." The CE is to send the claimant a letter with regard to payment of medical bills for the unaccepted condition (Exhibit 14-2.)

For instance, prostate cancer (non-specified cancer) metastasizes to secondary bone cancer. If secondary bone cancer is accepted as a specified cancer under the SEC provision, medical benefits are provided for both primary and secondary cancers (prostate and bone cancer) under Part B.

As such, it may be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E. In this case, only prostate cancer is included in the NIOSH NRSD for a dose reconstruction since the secondary bone cancer metastasized from the prostate cancer.

(8) If the CE determines that a case on the comprehensive list, which includes a FD, does not require any action, the CE writes a brief memo to the file indicating that the file was reviewed and noting the reason why no additional action is necessary. A case classified as not requiring any action is a case that does not meet the SEC criteria and there is no need to return it to NIOSH for dose reconstruction.

c. Role of the DD:

(1) The DDs have been delegated authority to sign a Director's Order to reopen a denied FD if the evidence of record establishes that the employee is diagnosed with a specified cancer and likely to be included in the SEC class. If the DD is unsure whether the SEC is applicable to a case, the case is to be referred to PRPU.

(2) Once a Director's Order is issued, the CE is responsible for issuing a new RD.

d. Role of the HR:

(1) Reviews cases pending a FD for possible inclusion under the SEC provision. If the employee qualifies under the SEC provision and the DO issued a RD to deny, the HR is to reverse the DOs RD and accept the case.

Every effort should be taken to avoid a remand of a potential SEC claim to the DO. However, if the HR determines that the case cannot be approved based on the SEC designation and that referral to NIOSH is appropriate or additional significant development is necessary, the HR is to remand the case for DO action.

(2) All cases on the comprehensive list provided by PRPU that are located at a FAB office are to be reviewed for possible inclusion under the SEC provision. If no action is required, a FAB staff member is to write a brief memo to the file as noted under paragraph 8b (8).

CHAPTER 15 – ESTABLISHING TOXIC SUBSTANCE EXPOSURE AND CAUSATION

1. Purpose and Scope. This chapter describes the procedures that DEEOIC staff use to make findings regarding toxic substances that a Part E employee encounters during the course of employment at a DOE facility or during qualifying RECA employment. The chapter also provides guidance regarding the establishment of causation.

a. OIS. DEEOIC employees responsible for claim management must image into OIS all documents received or created that relate to a claim. This guidance applies to all of the procedures described throughout this chapter.

b. ECS. ECS is a claim status database used to manage case adjudication activities of the DEEOIC. CEs or FAB staff record the various development actions relating to exposure or causation development into ECS. CEs must pay particular attention to ECS coding requirements regarding cases referred to a specialist. DEEOIC staff is to access ECS user guides and training material available through shared resources.

2. Toxic Substances. The program defines a toxic substance as any material that has the potential to aggravate, contribute to, or cause an illness or death because of its radiological, chemical, or biological nature.

a. A substance is considered a physical material and not a field or a wave. Therefore, DEEOIC does not recognize noise, radio waves, microwaves, infrared light waves, or visible light waves as toxic substances.

b. Radioactive substances are toxic substances for purposes of Part E adjudication.

3. Health Effects. The CE first conducts an examination of the basic claim evidence to confirm the diagnosis of the claimed illness(es); the period of verified, covered DOE contractor or subcontractor employment or qualifying RECA employment; and eligible survivors (if pertinent). The CE then reviews the case to ascertain whether there is evidence to establish that an exposure to a toxic substance has a potential scientific or medical relationship to the diagnosed illness. The DEEOIC accepts health effect data originating from the following sources.

a. SEM – Haz-Map. DEEOIC recognizes those relational connections between particular toxic substances and diagnosed illnesses established by scientific consensus. The DEEOIC generally relies on health effect data as reported by the National Library of Medicine's (NLM) Haz-Map Database via the SEM.

b. Human Epidemiological Data. Epidemiology is the study of how often diseases occur in different groups of people and why. Studies reporting causal connections that have not been recognized by DEEOIC through SEM will be reviewed by the DEEOIC Toxicologist as described later in this chapter.

c. Medical evidence specific to the individual. Individuals can have unique medical responses to different toxic substance exposures. SEM and scientific studies may not show a causal connection, but the claim may still be compensable based on an employee's unique biology and the employee's physician's opinion regarding causation. Medical evidence specific to the individual can also be important regarding claims of aggravation and contribution as SEM and the Toxicologist only provide associations as relating to direct cause (i.e., human epidemiological evidence that a toxic substance is known to cause an illness) and also provides a potential path forward for the claim.

(1) In instances where a physician submits an opinion that a toxic substance exposure was a contributory or aggravating factor in the development of a claimed illness specific to the individual, his or her opinion must be determined to be well rationalized, as that phrase is defined later in this chapter, before the Part E claim can be accepted. In particular, the physician must offer an interpretation of epidemiological or medical health science data that reasonably supports the opinion presented. Moreover, the CE must corroborate the factual presentation of information used in the formulation of the opinion (e.g. medical history, verified periods of covered employment, and toxic substance exposure characterization) with evidence available in the case file or obtained through the application of program resources, such as the SEM or referral to a medical health science expert.

d. Development of a health effect. Once the CE has completed development using available programmatic resources and the CE is unable to establish a potential relationship between the diagnosed condition (i.e., health effect) and occupational exposure, the CE provides the claimant with an opportunity to submit evidence establishing such a connection.

4. Toxicologist Review. A DEEOIC Health Scientist qualified in the principles of epidemiology and toxicology performs analysis of scientific data to assist the CE in the claims process. Generally, the DEEOIC Toxicologist's role is to review published scientific journal articles to determine their applicability in various ways described below, as they may apply to the administration of the DEEOIC. In the review of this material, the DEEOIC Toxicologist provides analysis and opinion on the establishment of health effects due to occupational exposure. The Toxicologist also provides analysis and opinion regarding causative thresholds such as latency, routes of exposure, and permissible/acceptable levels of exposure to toxic substances with known health effects. The Toxicologist will determine if individual claim evidence should be applied broadly as programmatic guidance.

The information in journal articles reviewed by the Toxicologist generally originates from different types of analytical health studies including Cohort, Cross-Sectional, and Case-Control designs. The Toxicologist gives priority to those studies that minimize bias and those that show statistical significance between exposed or unexposed groups and those with or without a disease. The DEEOIC does not recognize epidemiological data derived solely from animal

studies as the results are not usually comparable. However, animal studies may be used to supplement the interpretation of human scientific studies.

a. The CE refers case-specific issues to the DEEOIC Toxicologist when the claimant submits scientific health effect documentation that is not validated by available program resources (e.g., SEM). In these situations, the claimant has to have submitted documentation of a scientific nature that shows a possible relationship between the health effect and exposure to a toxic substance. Assessing whether such studies are appropriate to establish a scientifically established health effect is the responsibility of the DEEOIC Toxicologist.

   (1) The CE also submits to the Toxicologist claimant challenges relating to programmatically decided causation standards. The challenge must be supported by an assessment performed by a credible expert who offers a competing opinion on the appropriateness of any programmatically decided standard and offers scientifically compelling rationale (including reference to pertinent scientific literature or studies) to support his or her position. The claimant may also submit relevant and compelling scientific literature that warrants examination by the Toxicologist. Mere disagreement with agency policy regarding causative standards is not sufficient basis for review by the DEEOIC Toxicologist.

b. A referral is unnecessary when the documentation does not relate to the diagnosed medical condition or occupational exposure. A referral is also unnecessary when the findings are speculative, vague, or originate from sources not readily identified as having scientific merit (e.g., no citations or reference to a credible scientific source).

c. Submission of the referral. If the Supervisor or other office designee grants approval for the referral, the CE prepares a Statement of Accepted Facts (SOAF) , along with a set of questions relating to the issue(s) for determination. A sample SOAF is included as Exhibit 15-1 (This is an example of a generic SOAF which may be utilized for different types of referrals). For a toxicology referral, the CE must include as much factual information on the SOAF that is relevant to assist the toxicologist with his or her review. The CE prepares an e-mail to the designated Program Specialist within the MHSU. The CE includes a copy of each document or reference submitted in support of the claim. The CE images the referral package into OIS.

d. Toxicologist Response. The DEEOIC Toxicologist undertakes an analysis of the referral to decide if it warrants the establishment of a new health effect or a modification to the causative thresholds applied in programmatic guidance. The Toxicologist prepares a formal written response that describes the analysis of the issue and offers a well-rationalized opinion that responds to each question posed by the CE. The Toxicologist supports the outcome with references to supportive scientific literature.

e. Upon receipt of the completed Toxicologist response, the CE images the completed response into OIS. The CE reviews the response and moves forward with the claim based on the outcome. For cases in which the Toxicologist's response does not result in a newly established causal health effect, the CEs must still consider whether the medical evidence of file is sufficient to establish causation by way of aggravation or contribution.

5. Sources of Exposure Data. Once the CE determines the diagnosed condition is *potentially* related to toxic substance exposure, the CE then proceeds with the development to determine the extent of the employee's occupational exposure to the toxin(s). The CE evaluates the different sources of exposure data to determine the toxic substances that the employee most likely encountered. The CE also utilizes the different sources of evidence to clarify the labor category or job title, work locations, type of work performed, the frequency of work activities, and any evidence regarding direct or indirect contact with a specific toxic material. As the CE evaluates the evidence, the CE may utilize the Exposure Worksheet (Exhibit 15-2) as a means of organizing pertinent information. The worksheet is intended as a job aid to assist the CE in gathering, organizing and analyzing all the information needed as part of an exposure assessment. More detailed instructions for completing the worksheet are included in the exhibit with the worksheet.

a. Employment History for Claim (EE-3) is always the starting place for assessing information relating to a claim. The individual completing the form indicates when and where the employee worked, the employer, the identified position title or activity held at that location, and a description of the work duties engaged in for that position title. It also provides the individual the opportunity to describe the working conditions or exposures they believe are related to the claimed condition.

b. Information from the DOE-completed EE-5 contains information regarding the work history for the employee that DOE maintains in its records. Specifically, the EE-5 lists the dates of employment for the specified facility. The EE-5 may also provide the locations of the employment activities if that information is known.

(1) Other Employment evidence. For most DOE subcontractor employment, DOE may not be able to verify employment via the EE-5, but may provide other information such as clearance records, radiological monitoring records or infirmary records.

c. The DAR represents the response to the CE's request for data in possession of the DOE. The DOE supplies the CE with any medical, employment, or exposure data specific to the named employee. 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).

(1) Personnel Records. The DAR response may include personnel records or job descriptions. These records will assist the CE in identifying labor categories, dates of employment in those labor categories, and possible work processes.

(2) DOE site medical records. On-site medical clinics performed a whole host of medical tests to ensure a healthy workforce and provide onsite care. These records can provide information regarding possible exposures and a medical opinion regarding those exposures. They may have information related to buildings in which the employee was working or accidents that may have occurred. For example, information about a back injury may be relevant. While these types of injuries are not related to toxic exposures, the description of what happened, where it happened, and the date it happened may provide additional information useful to adjudication of the claim. The report may provide the type of work the employee performed, where and how it was performed, and when. The CE reviews the records for any information linking the employee to buildings, labor categories, work processes, and correlating dates. The records may also contain information regarding enrollment in protection programs. The type of protection program may provide insight into agents encountered.

(3) Industrial Hygiene records specific to the employee. The DAR response may include industrial hygiene monitoring information. The CE is to review this information and note all toxins identified in the records as being a concern for the employee. If the employee has DOE monitoring records, then those substances for which monitoring records identify exposure are considered verified. This may occur even if the information cannot be validated by other program exposure sources (i.e., the SEM). However, an IH may need to interpret the monitoring records to determine the nature, frequency, and duration of that exposure. Additionally, if the CE is unsure of the meaning of a document in the DAR, the CE may consult with a NO IH.

(4) Radiological & Dose records. While these records are primarily of interest to NIOSH as part of the dose reconstruction process or to the HP, the CE is to evaluate the records to determine if there is any information that links the employee to job processes, buildings, and the correlating dates.

d. The FWP is an ongoing effort to evaluate the effects of occupational exposures (e.g., to beryllium, asbestos, silica) on the health of DOE workers. These records contain employment, medical, and exposure data. If the employee participated in the FWP, the CE is to obtain the FWP records using the procedures outlined in Chapter 11 - Initial Development, Item 12, DOE FWP.

e. The OHQ is an important document because it is used to record information supplied by an employee or a survivor concerning first-hand knowledge of the

employee's occupational exposure to toxic substances. An OHQ serves several functions:

(1) Identifies the labor categories or job titles an employee held during their employment and when these jobs were held at each claimed site.

(2) Gives the claimant an opportunity to identify any Union affiliation which can give context to the tasks performed on site. For example, an employee who was part of the Carpenters' Union would have likely engaged in carpentry duties.

(3) Provides the opportunity to identify any buildings and/or work areas the employee may have worked or been assigned.

(4) Allows the claimant an opportunity to describe the use of any personal protective equipment and how that equipment may have been used. This can indicate the type of work performed and the level of safety involved.

(5) Lists any information regarding chemicals or substances that may have been used or encountered by the employee (when known).

f. Affidavits. Statements from knowledgeable co-workers/supervisors attesting to known toxic substance exposures, job descriptions or labor categories, buildings, and/or timeframes that build upon and are consistent with all the other information in the file are considered when determining an employee's likely exposure.

6. Requesting the DAR. The CE reviews the EPOD to determine if the DOE facility accepts DAR requests through SERT. EPOD and SERT are discussed further in Chapter 13 - Establishing Covered Employment.

a. DAR Form (Exhibit 15-3). The CE completes the top portion of the form with the employee's name (noting any name changes), SSN, the DOE facility and employer's name if a contractor or subcontractor employee. The CE indicates the types of records being requested. The CE may also submit a site-specific exposure question that may assist with the development of the claim.

b. Submission of the DAR through SERT. The CE creates a PDF document that includes the EE-1 or EE-2, EE-3, and the DAR Form. The CE uploads the request into the SERT system and selects the appropriate DOE operations office(s) responsible for gathering the requested documents. The CE images a copy of the SERT request into OIS.

c. Response from DOE. The CE will receive notification via email when DOE has the documents ready for download through SERT. The CE accesses the SERT, selects the applicable documents, downloads the file to his/her computer, and images the response into OIS.

d. Upon receipt of the DAR from DOE. The CE reviews the completed DAR Form and the accompanying documents. The CE confirms all requested documents have been received and any questions about exposure have been adequately answered.

e. No response from DOE or no records found. The CE develops exposure by other means of development if no response or records are found.

7. SEM. The SEM is a relational database containing data on toxic substances known to have been present at DOE facilities and uranium mines, mills, ore-buying stations, and during ore transport covered under RECA. SEM identifies toxic substances that were used at the DOE and RECA sites. SEM additionally associates these toxins to the work processes, labor categories, buildings, and incidents which relate to the toxin in some documented way. SEM also provides information about toxic substances and the scientifically known health effects associated with those toxic substances.

a. SEM Data. SEM data continues to be refined as new, relevant and compelling data becomes available. This data derives from documents originating from the DOE, gathered during worker interviews, or collected from public submission. Since SEM is based on currently available evidence, the CE needs to be aware that other evidence may be obtained through DAR records or other development that may not correlate with the data in SEM. The CE generally weighs the evidence obtained via a DAR as more probative than other sources as it represents more employee-specific data. SEM, on the other hand, is generalized non-specific information that only represents potential exposures. A CE is not to discredit evidence from the DAR or other sources because SEM does not validate an exposure.

b. SEM Data Search Categories. SEM contains several data categories to assist the CE when assessing exposures potentially encountered by an employee. The CE can use multiple filters simultaneously for best results. The following filters are available when searching SEM:

(1) Health Effect. SEM identifies the related toxic substances associated with a selected health effect.

(2) Labor Categories. SEM identifies the toxic substances that are associated with an employee's labor category or an appropriate alias. SEM identifies the processes/activities performed by that labor category and where an employee who occupied this labor category may have been present at the site. SEM also lists any incidents that may have involved with the labor category.

(3) Work Processes. SEM identifies the related toxic substances that are associated with a certain work process. SEM identifies the labor categories that may have performed the work process/activity and where

the process/activity may have been performed. SEM also lists any incidents that may have involved the work process/activity.

(4) Areas/Facilities/Buildings. SEM identifies the toxic substances that may be found in a particular area, facility, or location of a site. SEM identifies the labor categories that may have been involved in the specified location and the site work processes/activities that may have been performed in the specified location. SEM also lists any incidents that may have taken place in the specified location.

8. Using SEM in Exposure Development. The CE can find detailed instructions for SEM functionality in the SEM Website User Reference Guide, which is available to DEEOIC claims staff. The CE is responsible for constructing a proper SEM search to produce a filtered output of the toxins an employee potentially encountered during employment that are related to the diagnosed condition. The CE searches SEM utilizing all the available search capabilities based on all the available information known about an employee's entire work history.

a. SEM considerations. In some circumstances, SEM can produce results that are less probative if the CE does not properly utilize SEM and recognize the system does not always provide all the necessary evidence needed to evaluate a claim. The CE will need to consider the following when utilizing SEM as a development tool when establishing an employee's potential or likely exposures.

(1) Facility, Area or Building-Level searches conducted without additional filters are to be avoided because they produce overly broad results. Use of the SEM building filter in conjunction with other filters, however, is very useful.

(2) SEM only establishes that an employee was potentially exposed to a toxin based on the filtered search criteria used, such as work process and/or labor category. SEM cannot establish that a specific employee was exposed to a specific toxic substance.

(3) Level of Exposure. SEM does not provide the level of exposure an employee encountered to a specific toxic substance.

(4) Use of health effect aliases. SEM provides aliases that may be an appropriate substitute for a listed health effect. Health effects may be identified by several different names, or several diagnosed conditions may be relevant to a particular search. Because there are so many variations or conditions that seem similar, a substitution may not always be appropriate. If the CE has questions regarding the use of an alias, the CE can use the SEM Mailbox for guidance.

(5) Causal links. SEM only provides information regarding conditions that are scientifically known to be caused by toxic exposure. In cases

involving aggravation, contribution, or unique medical characteristics of an employee, SEM may not be as helpful.

b. SEM Mailbox. The SEM Mailbox is a valuable tool for the CE to utilize. If the CE is uncertain about the appropriateness of the use of SEM or has any questions regarding the information in SEM that is unclear or contradicts the evidence in the file, the CE is to seek clarification by submitting a question to the SEM Mailbox through the DOs SEM POC. The SEM team will research the question and post an answer on the SEM website.

(1) The CE may use the SEM Mailbox to obtain information on matters relating to the use of SEM including: information on a labor category that may not be in SEM; determining which labor category is most appropriate for similar labor categories and/or the evidence is not clear which one should be used; obtaining guidance on which labor profile and/or work process to use; addressing questions regarding whether to use the production or construction profiles; requesting guidance when information differs between SEM and employer supplied documents or credible affidavits; and requesting guidance regarding the appropriateness of a diagnosis as a health effect alias.

(2) No PII is to be included in any SEM Mailbox inquiry.

(3) The SEM Mailbox is not used to obtain guidance on matters of policy.

(4) Information or guidance received through the SEM Mailbox that is used to adjudicate a claim is to be appropriately imaged into OIS for reference in the decision. Prior questions and answers should not be applied to current cases with similar fact patterns without first confirming the response applies to the case in question.

c. Construction (all sites). "Construction (all sites)" is a way to identify toxins associated with a trade that is based on knowledge of the construction trades and is not DOE or DOE site-specific. The information obtained during a search of one of the labor categories in "Construction (all sites)" represents the work processes and exposures any employee working in a particular construction trade would experience at any location, even outside the purview of the DOE. The CE should use this search in the following situations.

(1) An employee worked for a subcontractor and worked in a job that is considered a construction trade. The CE can get an idea of the construction trades by reviewing the labor categories listed under "Construction (all sites)." If the employee's labor category is not listed, the CE should search under the alias to see if the labor category is an acceptable alias. If the CE has any question as to which search to perform, site specific or "Construction (all sites)," the CE should seek guidance through the SEM Mailbox as discussed in this section.

d. Construction (prime contractor). If the employee worked for one of the prime contractors of the site in a construction or trades position, the CE utilizes the site-specific search. The site-specific search will include toxins for which documentation demonstrates that worker's additional potential exposures. The site-specific search may also remove exposures if there is documentation that workers at a specific site and/or in a specific trade did not perform a given task at one site or another. For example, different DOE sites had very different policies regarding which labor categories were allowed to perform welding as part of their duties. The site history search category is helpful in determining if an employee worked for one of the prime contractors on site or was a subcontractor at the site. If the employee worked at the site as both a subcontractor and employed by the prime contractor, the CE should combine the exposures from both lists. The toxins appearing on both lists will likely be those to which the employee had more frequent exposure.

e. Filtering Search Results to achieve the best SEM outcome. SEM has several data search categories that a CE utilizes when developing toxic exposure. The function of SEM filtering is to refine an exposure search parameter to achieve the most relevant exposure output data possible. Refined SEM queries will produce more valid and probative outputs compared to broader, expansive search parameters. For example, exposure data produced from a filtered search based on health effect, labor category, and work process is more compelling than a search output based solely on health effect and labor category. SEM filters are also an effective tool for prioritizing exposures and determining the exposures most likely encountered. The more connections made showing a linkage between an employee's actual work and a specific toxin the greater the likelihood that an exposure likely occurred.

(1) The CE conducts an analysis of the exposure based on a breakdown of each position held by an employee working at a covered facility. The primary search filter for most claims starts with an examination of information relating to the site, health effect, and labor category. The 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. If the CE produces a list of toxins that is greater than seven (7) based on the facts surrounding the case, utilizing the necessary filtering functions, and recognizing any limitations of SEM, the CE should consult with the NO IH to identify which toxins on the list of substances were most likely to have been encountered and which would likely have the greatest impact on the claimant's claim, and include as many of those as is necessary.

f. Direct Disease Linked Work Processes (DDLWP). DDLWP's are links based on scientific literature examining certain job processes associated with certain

occupational diseases. The DDLWP's allow the CE to refer cases to a physician without IH review.

(1) The CE searches SEM as discussed above. DDLWP's will be identified in the "Processes/Activities performed by this labor category" and will include red text indicating "this work process has direct disease linkages."

(2) The CE reviews the file for reasonable and compelling evidence that indicates the employee performed one of the tasks in the DDLWP. Not all employees in a labor category would have performed all the work processes associated with that labor category.

(3) If the DDLWP is identified in the facility search and the employee performed the DDLWP, the CE can make a factual finding for exposure. Information about the work process, including the period of time that the employee performed the work process, can serve as the basis to obtain a medical opinion for causation without an IH review. For example, a pipefitter was employed at the Y-12 Plant and is diagnosed with COPD. The evidence confirms the employee engaged in the work process of "arc weld stainless steel" during this employment from 1962 – 1975.

(4) Once the CE determines that one or more DDLWP's are appropriate, the CE images the SEM pages that established the link into OIS. The CE also returns to the main menu in SEM and selects the DDLWP's that resulted from the site-specific or "Construction (all sites)" searches. The CE images these pages to document the underlying toxins and scientific references. From the example above, the pipefitter's underlying toxins due to "arc weld stainless steel" would have been stainless steel, stainless steels-precipitation hardenable, and welding fumes.

(5) The CE utilizes the above information in obtaining an opinion from the treating physician. If the treating physician is not a viable option, the CE prepares a referral to a CMC.

9. Establishing Likely Exposure. The CE must evaluate all of the evidence thoroughly to decide the most likely toxins the employee encountered during employment. The legal standard for exposure is that "it is at least as likely as not that the exposure to such toxic substance was related to employment at a DOE facility." It is not necessary for the CE to prove that an exposure occurred beyond all reasonable doubt. The CE must demonstrate that based on the evidence available it is reasonable to conclude that the exposure occurred and was related to the employment at the DOE (or RECA) facility. The CE considers the following when assigning the probative value to the different forms of evidence.

a. Employer data. Information from DOE or its contractors or subcontractors, especially contemporaneous data relating to the employee's work history, work processes, and exposure data, is to be assigned the strongest weight. Therefore, it is extremely important for the CE to analyze the evidence obtained from the DAR

to identify any relevant records regarding the exposure and diagnosed condition.

b. SEM data. SEM represents DEEOIC-generated exposure data that is of relatively high value in determining potential and likely exposure. However, the outputs generated by SEM are dependent on the accuracy of the data used in searching SEM.

c. Expert testimony or documentation submitted by the claimant from medical or health scientists on matters of occupational exposure. Data from consultants and other specialists hired by a claimant or their designated AR can be a valuable source of information. The CE may utilize claimant-submitted information when it represents a reasonable, well-rationalized position. Claimant- submitted medical or science data that is overly generalized, inconsistent, or devoid of rationalized justification is of reduced probative value. When the CE identifies such a defect, he or she is to allow the claimant an opportunity to rectify the situation.

d. Affidavits completed by co-workers, supervisors or other credible sources. The CE accepts affidavits as being reliable when they are consistent and make sense with the claim as a whole.

e. Claimant-submitted exposure information. Self-reported employment and workplace information can be very helpful in directing development on exposure. The CE is to recognize that the information supplied by a claimant may be a valuable resource for helping shape SEM searches, resolving issues involving work history, and providing information regarding work processes. Statements regarding work processes are considered reliable when sufficient detail or other information is provided that documents the scope and type of work performed.

f. Documenting the exposure assessment and the likely exposures. Upon completion of the exposure assessment and considering the above evidence, the CE finalizes the Exposure Worksheet (Exhibit 15-2), or equivalent, to document the employee's most likely exposures. After the CE notes any exposure presumptions as discussed below, the CE images the completed worksheet(s) or documentation sufficient to support the CEs exposure assessment into OIS.

g. Insufficient Evidence to establish toxic exposure. The CE utilizes available programmatic resources and analyzes all available evidence when completing their exposure assessment. If the CE is unable to establish any likely exposure to a toxic substance that is associated with the diagnosed condition, the CE provides the claimant with an opportunity to submit evidence establishing exposure.

10. Exposure Presumptions. In some cases, certain presumptions may be made as to the nature, frequency, and duration of a specific exposure. Presumptions are based on knowledge and evidence obtained through industrial hygiene, knowledge of labor categories and work processes, and environmental health and safety practices in existence. Therefore, presumptions

are specific to certain labor categories, work processes, and/or timeframes. Since presumptions may be updated based on new or updated scientific evidence, the currently established presumptions are included as part of Exhibit 15-4, "Exposure and Causation Presumptions with Development guidance for Certain Conditions."

a. If an exposure presumption exists, the CE will apply the level of exposure specifically identified in the guidance to the specified toxic substance as long as all criteria have been met. If an exposure presumption exists, the toxic substance does not need to be reviewed by the IH as the level of exposure is assumed. An IH opinion is required if additional probative or substantial evidence is obtained that may suggest a higher level than what is presumed. The IH assesses the level of exposure based on the evidence presented. If the IH provides an opinion establishing a level of exposure above that provided by the guidance, the level of exposures applies to that specific claim.

11. IH Review. IH's are experts in assessing available employment, labor category, work process or other occupational data. The IH utilizes his/her expertise and knowledge in arriving at a well-rationalized, unbiased opinion on the nature, frequency, and duration of an employee's toxic exposure. As such, an IH opinion on exposure holds significant probative value.

a. Functions of the IH in exposure analysis:

(1) The IH's role is to provide expert opinion regarding an employee's exposure as it relates to nature, frequency, and duration based on assessment of the evidence presented.

(2) The IH may also assist the CE in making determinations regarding likely exposure when the evidence is unclear or inconsistent. This may include issues with routes of exposure (e.g., whether a toxic substance would have been encountered through inhalation, skin contact, skin absorption, or ingestion). This may also include issues with claimed exposures where the evidence is insufficient to suggest the possibility or the evidence is not consistent. For example, an IH can confirm whether or not a toxic substance was encountered in a certain labor category or during a certain work process. This can be accomplished by phone, email, or through formal referral if deemed appropriate by the NO IH. The CE then documents both the inquiry and the response in the case file.

(3) The IH may also evaluate and interpret IH monitoring data such as personal or area industrial hygiene monitoring data provided through DAR records or submitted by the claimant.

b. IH referral. When the CE identifies a case that requires an IH assessment of nature, frequency, and duration or other exposure issue that requires a formal IH review, the CE prepares an IH referral package for approval by the Supervisor or other office designee. The IH referral package is to include the following.

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

c. IH referral insufficient. Upon review of the IH referral by the MHSU, if the referral is found deficient and warrants additional review or development, the referral is returned to the CE for additional action.

d. IH assessment and opinion. The IH reviews the issue framed by the CE and determines whether more information from the case file is required to answer the question, or if the entire case file is needed. This is reserved for the most complex cases and is at the discretion of the IH. The IH role is to anticipate, recognize, and evaluate hazardous conditions in occupational environments, and to opine based upon his/her specialized knowledge. The IH strives to answer the question based upon the information outlined by the CE.

During the evaluation of the CE's IH referral, DEEOIC IH (federal or contractor) staff may determine if it is necessary to obtain clarification from a claimant regarding the circumstance of an employee's work that brought the employee into contact with a particular toxic substance. This could include clarifying the employee's specific occupational roles and responsibilities; proximity to work processes or particular materials; frequency of activity occurrence; knowledge of work with particular materials; or clarifying information provided in referral case evidence. Under this circumstance, the IH will email the designated federal IH Team Lead advising of the need for clarifying information and requesting a telephone call with the claimant. Within the email the IH will identify the claim file number, explain the specific information requested and the justification for the request. Upon review, the federal IH Team Lead will then coordinate with the assigned CE to have a telephone call with the claimant and a federal IH staff person to address the request for information. Upon completion of the call, in addition to the usual ECS call summary, the CE will prepare a Memo to File describing the outcome of additional development, including a detailed narrative of any conversation held with the claimant. Once complete, the CE will forward the memo to the requesting IH for consideration in preparation of the IH referral response.

(1) IH Memorandum. The IH renders an expert opinion in the form of a memorandum that addresses the issue as specifically as possible. The IH's reply addresses the specific question(s) posed by the CE in the IH Referral. The IH is to employ his or her subject matter expertise to make reasonable findings regarding exposure based upon the unique features of the case under review. The IH is to consider any information obtained from the claimant in a verbal exchange that occurred because the IH requested clarification.

e. Exposure levels used by the IH. DEEOIC IH staff broadly separate exposures into those which were significant and those which were incidental. Significant exposures are further categorized as low, medium and high. Examples of these categorizations are provided here.

(1) Significant, High. A Pipefitter working in the 1960s would have likely had high level of daily exposures to asbestos.

(2) Significant, Moderate. A Machinist working in the 1970s would have likely had moderate level exposures to mineral oil (perhaps on a daily basis).

(3) Significant, Low. A maintenance worker in the early 1980s may have had occasional (i.e., weekly or perhaps monthly) low level exposures to asbestos (based upon work assignments).

(4) Incidental Exposure. This can also be characterized as exposures occurring "in passing only." Incidental exposure is exposure that is not significant, even at a low level. An example of incidental exposure would be if you went to pump your own gas for 10 minutes. Your exposure to gasoline vapors would be incidental (occurring in passing only) while the gas station attendant working a full 8-hour shift for 40 hours, would have a considerably different profile (significant exposures, low, moderate or high, depending on other factors).

Similarly, if you were a clerk at a DOE facility who had to drop off a work order in an area where vehicle repair work was taking place, you may be incidentally exposed to diesel engine exhaust. However, the full-time workers in that maintenance shop are clearly at risk of being significantly exposed.

f. Upon receipt of the completed IH response, the CE images the response into OIS. The CE reviews the response and moves forward with the claim based on the outcome.

12. Radiation Exposure and NO HP Review. Radiation is a toxic substance under Part E. Dose reconstruction analysis performed by the NIOSH or the expertise of the HP may be necessary in the development of exposure and causation for a Part E claim.

a. Cancerous conditions. The effect of radiation in establishing a diagnosed cancer, as a covered Part E illness, requires the application of the PoC calculation derived from a NIOSH dose reconstruction.

(1) The CE will develop other non-radioactive toxic exposures while waiting for the dose reconstruction. If this development results in a positive outcome, the CE will accept the cancer claim under Part E without waiting for the dose reconstruction.

(2) If the claim does not result in a positive outcome and the dose reconstruction has not been received, the CE completes a memo to file. The memo explains toxic development is complete but a decision cannot be issued until the dose reconstruction has been received so radiation exposure can be considered when issuing the decision. If the case involves multiple claimed conditions, the memo is not completed until all toxic development has been completed for all open conditions. This is important since the memo signifies no other development is required and no affirmative decisions can be issued based on the current evidence. Therefore, this memo is approved by the Supervisor or other office designee to confirm its appropriateness in the claim. The CE images the memo into OIS.

b. Non-cancerous conditions linked to radiation exposure will not undergo the dose reconstruction process by NIOSH, but will need a review by the NO HP if there is a medical or scientifically-based link between the condition and radiation exposure.

(1) Submission of HP referral. If the Supervisor or other office designee grants approval for the referral, the CE prepares a SOAF along with a set of questions relating to the issue(s) for determination. The CE prepares an e-mail to the designated Program Specialist within the MHSU. The CE also includes a copy of any radiation exposure records available. The CE images the referral package into OIS.

(2) HP response. The Program Specialist assigns the question to the HP. The HP prepares a formal written response that describes the review and offers a well-rationalized opinion regarding causation.

(3) Upon receipt of the completed HP response, the CE images the response into OIS. The CE reviews the response and moves forward with the claim based on the outcome.

13. Establishing Causation. Causation is a medical determination that a qualified physician must make regarding whether or not a condition is related to covered employment and exposure to a toxic substance. The standard for establishing causation is "it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the illness." The CE considers the following when reviewing evidence and developing causation.

a. Part B acceptance. Causation under Part E may be established by an acceptance under Part B. Based on this acceptance, exposure and causation are presumed to already exist. However, the claim must also meet the employment and/or survivor-related eligibility requirements when applicable.

b. Physician's opinion. Unless specified in other programmatic guidance, such as the presumptions listed in the appendix of this chapter, DEEOIC requires a

medical opinion on causation from a qualified physician. A claimant may choose to have his or her physician opine on the causal relationship between an exposure to a toxic substance and a diagnosed medical condition. Absent a physician chosen by the claimant to offer an opinion on causation, the CE may utilize the services of a CMC. A causation opinion presented from a qualified physician, including a CMC, must be well rationalized for a CE to accept as the basis for claim adjudication. As is explained in Chapter 16 - Developing and Weighing Medical Evidence a "rationalized" opinion means that the statement of the physician is supported by an explanation of how his or her conclusions are reached, including reference to appropriate medical health science literature. Under Part E, a physician may opine on topics for which DEEOIC has not made a finding of a link between exposure and disease, but in so opining a physician must communicate his or her understanding of the different factors considered that justify a particular opinion regarding causation, including providing a scientific basis upon which to base such an opinion. Specifically, a well-rationalized causation opinion from a qualified physician is one that communicates an accurate understanding of an employee's toxic substance exposure; discusses an employee's medical history and pertinent diagnostic evidence; and applies reasonable medical judgement informed by relevant, creditable medical health science information, as to how the exposure(s) at least as likely as not significantly contributed to, caused or aggravated the employee's claimed condition. Conversely, a physician's opinion that relies on inaccurate factual findings, especially speculative exposures not supported by the evidence, or opinions that are formed independent of any creditable, substantive medical health science data cannot be considered well-rationalized. The mere presentation of a positive causation opinion from a physician, without any well-rationalized justification, or one that is based upon speculative exposures is not sufficient for establishing a compensable Part E claim.

(1) In these situations, the CE is to provide the physician with any employment or scientific evidence that DEEOIC has obtained to establish an accurate factual presentation of exposure; including exposure analysis worksheets, affirmative SEM search outputs, epidemiological data, or IH assessments.

c. Causation presumptions and development for certain conditions. Certain conditions are associated with certain toxic substances. These links may involve certain labor categories, work processes, timeframes, and/or latency periods. Exhibit 15-4 includes both exposure presumptions, as mentioned earlier, and causation presumptions. This Exhibit incorporates prior DEEOIC guidance from the PM, Bulletins and Circulars which have been amalgamated and summarized into Exhibit 15-4. It is anticipated that this exhibit will be updated as new guidance is developed.

(1) Causation Presumptions. A physician's opinion is not necessary for all identified conditions. The CE reviews the evidence of file against the

specific criteria listed for the specified condition. If the case meets each criterion, the CE may accept the claim.

(2) Development for certain conditions. The Exhibit also assists the CE with causation development and guides the CE on possible circumstances that may result in a positive outcome. A physician's opinion may still be necessary. The guidance in the Exhibit does not represent the only scenarios that may exist to accept a claim. The CE may accept a claim that presents with other fact patterns for the conditions and/or exposures listed.

d. Insufficient evidence to support claim. If the CE is unable to establish causation, the CE provides the claimant with an opportunity to submit additional evidence.

e. Survivorship Part E cases. For Part E cases in which the employee is deceased, guidance is provided in Chapter 20 - Establishing Survivorship.

14. Before Issuing RD and FD. Since changes to SEM can happen at any time, a new SEM search is to be conducted before the RD is released to ensure that no substantive changes have occurred. The CE is to image the new search results into OIS to clearly document that a new review took place. The FAB reviewer also completes a new SEM search before issuing the FD and bronzes the results into OIS.

CHAPTER 16 – DEVELOPING AND WEIGHING MEDICAL EVIDENCE

1. Purpose and Scope. Proper development and weighing of medical evidence is essential to the sound adjudication of claims for benefits and to the comprehensive management of EEOICPA claims. This chapter discusses the function of a CE in developing and evaluating medical evidence and weighing conflicting medical opinions.

2. Sources of Medical Evidence. Most medical reports come from one of these sources:

a. Claimant's health care provider, which includes the attending physician, consulting experts, and medical facilities. The CE may consider treatment records from a clinic operated at an employing facility as medical evidence.

b. The DOE Medical Monitoring Programs, administered by certain DOE facilities, maintain medical examination records and exposure data on their employees. For example, the DOE FWP began in 1996 and functions to evaluate the effect of the DOE's past operations on the health of former workers at DOE facilities, and to offer medical screening to former workers.

c. ORISE administers the beryllium screening program by providing beryllium-related testing at locations across the country. ORISE offers extensive testing for CBD and medical monitoring to individuals testing positive for beryllium sensitivity.

d. CMC. Furnishes medical opinions, guidance, and advice based upon review of the case file. Moreover, the physician provides independent and rationalized responses to CE questions regarding various medical issues that may arise during case adjudication, such as causation, impairment, wage-loss, or medical necessity of care.

e. Second Opinion Physicians are physicians contracted by the DEEOIC to provide a narrative report describing the findings from physical examination of a patient and review of diagnostic testing or other medical records.

f. Referee Specialists are physicians of an appropriate specialty, chosen randomly, to examine the employee or a case file and furnish a rationalized medical opinion, to resolve a conflict of medical opinion in a case between the employee's physician and a CMC, Second Opinion Physician, or other medical specialist.

3. Types of Medical Evidence. Medical evidence in EEOICPA cases consists of the following major categories:

a. Treatment records are the most prevalent form of medical evidence. They consist of any record made during the evaluation, diagnosis and treatment of a patient by his or her health care providers. They include:

(1) Attending physician records (e.g., chart notes, reports, etc.) which include records from medical consultants assisting the attending physician.

(2) Records of physicians consulted by the patient for an independent medical opinion.

(3) Evidence of diagnostic testing (e.g., X-ray films, electrocardiogram (EKG) tracing, etc.) and the reports of medical providers interpreting the tests. For the purposes of interpreting tests, medical providers include physicians as defined in Section 30.5(ee) of the regulations.

(4) Treatment records from hospitals, hospices, in-home health or residential health care facilities.

b. Medical evaluations may occur for a variety of reasons other than to further the diagnosis and treatment of the patient. The purpose of the examination distinguishes medical evaluations from treatment records. Medical evaluations include:

(1) Evidence from the DOE's FWP (e.g., former worker screening records, pre-employment physicals, termination physicals, etc.)

(2) Examinations required under state or federal compensation programs [e.g., evaluations for SWC) claims, Social Security disability examination, Veterans' Administration (VA) programs, etc.]

(3) Medical reports or opinions obtained for litigation under state or federal rules of evidence.

(4) Reports produced in response to a DEEOIC referral to a CMC, Second Opinion physician, or Referee Specialist.

d. Other types of evidence include:

(1) Cancer Registry records may be used in some cases to establish a diagnosis of cancer and date of diagnosis.

(2) Death certificates which contain information about the cause of death or date of diagnosis. (See Section 7 of this chapter for additional information regarding death certificates.)

(3) Secondary evidence relied upon by a physician in forming an opinion. For example, a doctor may rely upon the information provided by a medical specialist in determining the cause of an illness.

(4) Affidavits containing facts based on the knowledge of the affiant regarding the date of diagnosis.

4. Contents of a Medical Report. The value of findings and conclusions contained in medical records varies.

a. Treatment Records.

(1) A doctor's report of examination usually contains a description of subjective complaints, objective findings, assessment, and a plan for follow up or treatment. The Subjective, Objective, Assessment and Plan format is often shown in the medical records by the letters S, O, A and P. Even where the "SOAP" abbreviation is not used, the records tend to follow this pattern.

(a) The subjective section records information obtained from the patient. It generally contains information about why he or she is seeking treatment, complaints, medical history and current treatment. A subjective section might state, for example, "Patient comes in today to have us look at a lump on his neck that has gotten larger over the last month."

(b) The objective section records the physician's findings based on his or her observation, examination and testing. An objective section might state, for example, "The patient's breathing is labored and his X-ray shows a spot on his left lung." The three general classes of objective findings are:

(i) Laboratory findings such as complete blood count (CBC), tissue biopsy, bone marrow smear or biopsy, BeLPT, etc.

(ii) Diagnostic procedures such as X-rays, ultrasound, computerized axial tomography (CAT) scans, magnetic resonance imaging (MRI), electromyelogram (EMG) and similar techniques of visualizing or recording physiological conditions. Some objective tests are subject to greater interpretation by the physician.

(iii) Physical findings that are noted by the physician's visual inspection, palpation and manipulation of the body. They include description of demeanor, readings of temperature or pulse, description of respiration, observation of affect, etc.

(c) The assessment section contains the physician's opinions, suspicions and diagnoses. In most cases, the value of a medical report is determined by the quality and detail of the narrative describing the physician's assessment. The scope of the assessment will vary with the type of medical condition and its complexity.

The assessment section may contain statements such as, "The pathology report was reviewed and showed the presence of small cell carcinoma of the lung." or "Based on the patient's rest tremor, balance problems and rigidity of muscles, he has Parkinson's disease."

(d) The plan section describes the treatment plan and prognosis. The physician may, for example, prescribe medication, refer the patient to a specialist, or suggest additional testing.

(2) Reports of tests and procedures should contain the employee's name, date of the test, the objective data obtained, and the signature of the person responsible for conducting the test or procedure. Where appropriate, reports should include a physician's interpretation of laboratory tests or diagnostic procedures.

Tests for which interpretation is necessary include, but are not limited to, pathology reports, BeLPT, X-rays, MRI, CAT scans, Pulmonary Function Tests (PFT), Minnesota Multiphasic Personality Inventories (MMPIs), and the Beck Depression Inventory. In cases where the physician offers insufficient interpretation of medical evidence, the CE must seek clarification either from the source of the report, or a CMC referral, as appropriate. The CE is not to interpret test results, as that is a medical judgment to be made by a medical professional.

(3) Hospital, hospice and clinic records will contain the same type of physicians' records and diagnostic testing as outlined above. Also, the CE should review the admission summary, surgery reports, nursing notes, the discharge summary, autopsy reports, etc.

b. Medical Evaluations. Generally, medical evaluation reports contain the following types of information:

(1) An explanation as to why the physician is conducting an examination of the patient. The report may state, for example, "Mr. Smith is referred by the DOL for an independent medical evaluation regarding his claim for asbestosis."

(2) A description of the information the physician has reviewed and relied upon in reaching his or her conclusions. This often includes a discussion of the course of treatment, which describes past treatment undergone by the patient, and the physician's recommendation for present and future care. References to studies and other medical or scientific data that supports the analysis may also be included.

(3) A description of any examination and tests performed during the evaluation.

(4) The opinion(s) of the evaluating physician with an explanation of the rationale supporting his or her conclusion.

c. DEEOIC Referrals. The CMC, Second Opinion physician, or Referee Specialist reports should contain the same general information as any other medical assessment. In addition, the report should contain a well-reasoned response to questions presented by the CE, including a summary of the evidence and medical references used.

5. Developing Medical Evidence. Although it is ultimately the responsibility of the claimant to submit medical evidence in support of his or her claim, the CE is to assist the claimant in collecting evidence necessary to establish a compensable medical illness. This includes communicating with the claimant to explain deficiencies in case evidence, requesting supportive documentation, and allowing reasonable time for the claimant to provide a response. The CE also assists by taking affirmative action to obtain medical evidence through communications with treating physicians and/or other medical providers. Assistance can also be achieved with the use of Program resources to obtain clarifying medical evidence including the use of a CMC, Second Opinion physician, or Referee Specialist. The development of medical evidence is performed in various aspects of case adjudication: to establish diagnosis, to establish causation, to determine a percentage of impairment in impairment claims, to establish a causal relationship between a covered illness and wage-loss, and to resolve inconsistencies and conflicts in medical opinions.

a. Physicians and chiropractors. Medical evidence must be from a physician. The definition of a physician includes surgeons, podiatrists, dentists, clinical psychologists, psychiatrists, occupational medicine practitioners, optometrists, and osteopathic practitioners within the scope of their practice as defined by state law. Chiropractors may only be considered physicians in EEOICPA cases for treatment of manual manipulation of the spine to correct a subluxation that is demonstrated to exist by X-ray (usually relevant only in consequential injuries.) However, chiropractic care may be authorized as treatment for an accepted condition. Any such treatment must be prescribed by the authorized treating physician, and the physician must provide rationale as to how the treatment in question relates to the covered condition.

(1) Establishment of a diagnosis requires that a physician interpret available clinical and diagnostic evidence to identify a disease or disorder. Alternatively, signs and symptoms are abnormalities that a physician may use to form a judgment of medical diagnosis. A claimed illness filed by a claimant that medical evidence establishes as a finding, sign or symptom is not necessarily a diagnosed condition. In those instances where unclear evidence exists whether the CE should categorize the claimed condition as a medical diagnosis or not, the CE is to seek clarification from the claimant's physician or a CMC.

b. Deficient Evidence. During adjudication of a claim, there are many topics that require evaluation of medical evidence including: medical diagnosis,

interpretation of diagnostic evidence, causal relationship between illness and occupational toxic substance exposure, permanent partial impairment, effect of illness on historical wages, and medical necessity of care or other service needs. In each of these matters, legal, regulatory, or procedural guidance exists through on-line Programmatic resources (Bulletins, Circulars, EEOICPA Regulations, etc.) to instruct the CE on evaluating the sufficiency of evidence submitted in support of a claim. The CE is to adhere to these guidelines and to direct development in a manner that will best overcome evidence omissions or deficiencies.

c. Telephone Requests. In many situations, a minor deficiency in medical evidence can be easily overcome with a telephone call to the physician's office to request specific documents. If, however, a phone call does not produce an immediate result (i.e., a fax of the required documentation) the CE should send a written request. If the physician's office indicates that the medical evidence will be mailed, the CE will follow-up with written correspondence memorializing the telephone call and noting the specific documents that are being requested.

(1) The CE must document the call in ECS.

(2) Statements made by the physician over the telephone do not constitute valid medical evidence.

d. Written Requests. The CE may decide that the best method of collecting the evidence is to submit a written inquiry directly to the physician (with a copy to the claimant). However, the CE has the authority to submit written requests for information to any possible source that may reasonably be able to provide a substantive response to a need for medical documentation. A written request for information is to communicate the identified defect, in a clear and concise fashion, and the various options available for presenting information or documentation that will best overcome the defect.

(1) If records are requested from a treating physician or other sources, the Form EE-1/EE-2 submitted by the claimant serves as a medical release to obtain the requested medical information.

(2) If a reply is not received within 30 days or the response does not resolve the deficiency, the CE considers other options for obtaining the required medical evidence (e.g., a CMC referral, cancer registry or death certificate). Reasonable time extensions may be granted by the CE. It may be helpful to initiate telephone contact with the recipient to gauge the likelihood for response, or to respond to questions or other concerns.

e. Unavailable Medical Records. If the CE obtains information that pertinent medical records have been destroyed or are otherwise unavailable, the CE should attempt to obtain from the physician written confirmation which contains the following information:

(1) An affirmation that the physician treated the employee for the claimed condition(s).

(2) A statement that the requested medical records are no longer available.

(3) A discussion that includes the diagnosis and date of diagnosis.

(4) The physician's signature and the date signed.

6. Weighing Medical Evidence. When the CE receives medical evidence from more than one source, he or she must evaluate the relative value, or merit, of each piece of medical evidence. This is particularly important in cases where there is a conflict between the medical evidence received from a CMC and a treating physician. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken. The CE should also understand how to assign weight to the medical evidence received.

a. How to Evaluate Evidence. In evaluating the merits of medical reports, the CE evaluates the probative value of the report and assigns greater value to:

(1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the opinion on an accurate factual basis, has weight over a physician conducting a file review. For example, a physician who opines that his patient's lung cancer is related to exposure to diesel engine exhaust has less probative value if the opinion demonstrates no knowledge of the frequency or levels of exposure to diesel engine exhaust.

(2) An opinion based on a definitive test(s) and includes the physician's findings. Some medical conditions can be established by objective testing. A positive pathology report from a physician is sufficient evidence of the diagnosis of cancer. However, a physician's opinion that a patient has cancer is of little probative value if the pathology report shows no malignancy. A physician's report of a positive BeLPT or lung lavage cells showing abnormal findings is sufficient evidence of the diagnosis of beryllium sensitivity.

It is important for the CE to undertake appropriate steps to work with a treating physician in the collection of evidence, before referring the case to a CMC.

(3) A well-rationalized opinion over one that is unsupported by affirmative evidence. The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached, including appropriate citations or studies. An opinion that is

well-rationalized provides a convincing argument for a stated conclusion that is supported by the physician's reasonably justified analysis of relevant evidence. For example, an opinion which is supported by the interpretation of diagnostic evidence and relevant medical or scientific literature is well-rationalized. Conversely, an opinion which states a conclusion without explaining the interpretation of evidence and reasoning that led to the conclusion is not well-rationalized.

(4) The opinion of an expert over the opinion of a general practitioner or an expert in an unrelated field. For example, if a general practitioner has a patient with rest tremors, balance problems, and muscle rigidity, a diagnosis of alcohol abuse with dehydration may seem reasonable. However, if a conflicting report is received from a Board-Certified neurologist diagnosing Parkinson's disease based on the same symptoms, it would carry greater weight because a neurologist is an expert on neurological disorders. This is particularly true for an illness like Parkinson's disease that cannot be confirmed by an objective laboratory test. Conclusive statements of an expert without any underlying justification, other than affirmation of the physician's expertise, are not to be viewed as carrying significant probative value.

(5) An unequivocal opinion over one that is vague or speculative. A physician offering a clear, unequivocal opinion on a medical matter is to be viewed as more probative compared to an opinion that waivers or hesitates in its presentation or, contains vague and speculative language. An opinion which contains verbiage such as "possibly could have" or "may have been" or provides a guess or estimation indicates speculation on the part of the physician.

7. Using Death Certificate to Establish Diagnosis. Prior to considering the use of a death certificate to establish a diagnosis, the following actions must be undertaken:

a. Claimant Advised. The CE must advise the claimant, in writing, of the medical evidence necessary to establish a diagnosis and grant him or her the opportunity to submit available medical records (See Chapter 11.6, Advising the Claimant of Deficient Evidence). The letter sent to the claimant is to include a statement describing the need to obtain medical evidence of a diagnosed condition. Medical evidence with the potential to identify a diagnosed illness include any hospital admission/discharge reports or reports describing an illness; inconclusive diagnostic testing results, or other medical records alluding to the existence of a potential illness. The function of this development is to ensure that the CE receives all available medical records for consideration.

b. Diagnosis listed on death certificate. Once development is completed and it is unlikely any other affirmative medical evidence is available for review, a CE may use a death certificate acknowledged by a physician or recognized by a state medical authority to establish a diagnosed illness.

Nothing in this section should be interpreted as limiting the use of a death certificate for other purposes, such as evidence of the cause of death under Part E.

8. Using Affidavits to Establish Date of Diagnosis. While an affidavit cannot be used to establish a medical diagnosis, it can be used to establish a date of diagnosis after the CE has made a reasonable effort to establish the date of diagnosis from the medical records. CE actions should include the following:

a. Advice to Claimant. The claimant must be advised, in writing, that medical evidence (i.e., pathology report, autopsy report, physician's reports) should be submitted to establish a date of diagnosis.

b. Additional Medical Development. If the claimant and the CE cannot obtain medical evidence to establish the date of diagnosis, the CE must notify the claimant of the need to submit copies of affidavits from those in a position to know the former worker's condition during the illness. For example, a home health nurse or relative who provided care to the employee may provide an affidavit.

c. Death Certificate. If reliable affidavits are not received, then the CE may use the date of diagnosis (if shown) or date of death from the death certificate. The CE should not guess at a diagnosis date based on a death certificate's "approximate interval between onset and death" as the date of onset is not necessarily the date of diagnosis.

d. Medical Review. If an affidavit reveals evidence of a medical condition, but no physician's diagnosis is contained in the file, the case may be forwarded to a CMC for review and confirmation of a diagnosis.

9. Reviews by a CMC. DEEOIC uses the services of a contractor to coordinate referrals of cases to qualified medical specialists. A CMC is a contracted physician who conducts a review of case records to render opinions on medical questions. Medical opinions from a CMC are essential to the resolution of claims due to ambiguous causation, lack of medical evidence, unique exposures or other medical questions. The function of a CMC is to provide clarity to claims situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. The function of a CMC is not to validate probative input by the claimant's chosen treating physician. The description of appropriate reasons for CMC referral includes the following:

a. Diagnosis. Clarification and confirmation of diagnosis.

b. Causation. Assessment of exposure and medical documentation for the purpose of rendering an opinion on causation.

c. Impairment. Percentage of permanent impairment to the whole person as a result of an accepted illness or illnesses.

d. Onset Date. Onset and period of illness relating to reported wage-loss.

e. Consequential Injuries. Determination of consequential illness/injury due to accepted illness or treatment of that illness.

f. Treatment. Medical necessity of medical care, DME or home/auto modification.

g. Clarification. Interpretation of medical reports, test results or other medical evidence.

h. Conflict. Resolve conflict of medical opinions.

10. Deciding on Need for a CMC Referral. The decision to refer a case to a CMC for review is at the discretion of the assigned CE. An obvious defect in case evidence must exist, including the absence of affirmative medical evidence or other diagnostic evidence, for which a medical opinion is necessary. A CMC referral may also be necessary for review of impairment or wage-loss issues. The CE should not view a medical referral as an automatic requirement for each claim, but an option available in situations where no other reasonable option exists to obtain a resolution to an outstanding medical question.

a. Review Not Necessary. The following are examples of when a CMC referral may not be necessary:

(1) The CE determines that other action, such as requesting additional records from the claimant or treating physician, may be more appropriate. In most cases, the CE does not need to refer a claim to a CMC when a treating physician has provided a substantive, well-rationalized opinion in response to a claim question. Moreover, the CE should view the existence of a treating physician as the primary source of medical evidence before consideration of a CMC referral. Accordingly, the CE should typically give the treating physician the first opportunity to review medical evidence from the file, such as a SOAF and other documents, for the purpose of responding to claim questions. If the treating physician does not provide substantive responses to claim questions, the CE may consider the claim in posture for a CMC review.

(2) The claim evidence renders a CMC opinion unnecessary, such as instances where a presumption of causation exists, or the circumstances of case development does not necessitate a medical opinion, such as when there is no evidence of exposure to a toxic substance or no plausible scientific association between a toxin and a diagnosed illness.

b. Appropriateness of Review. The following are some examples of when a CMC referral may be required:

(1) The CE is unable to conclude whether pre-1993 medical evidence is sufficient to diagnose CBD.

(2) Medical tests are submitted which do not provide clear diagnosis or interpretation (e.g., a BeLPT that does not clearly state that the test is positive or negative).

(3) It is unclear whether a medical condition, unlisted on a death certificate, was a significant factor in causing, contributing to or aggravating an employee's death. For example, an employee dies of a heart condition, but the covered condition is asbestosis.

(4) It is unclear whether the confirmed exposure to a toxic substance is linked to the illness claimed by the employee.

(5) A treating physician has offered a speculative, or vague opinion, or one that is not substantiated by reasonable medical rationale, and the CE has undertaken reasonable steps identifying the defects to the physician, but he or she has not responded or responded unsatisfactorily.

11. Referral to CMC. It is ultimately the responsibility of the jurisdictional DO to ensure that all the necessary components of a CMC referral are prepared accurately, the content of the referral is appropriate and specific to the issue under determination, and sufficient factual documentation is prepared to allow the CMC a clear understanding of the medical question(s) to be addressed. When guidance requires that email communication be prepared, a copy of the email is scanned/bronzed into the case file in OIS.

Interactions between DEEOIC staff and the CMC contractor occur through a secure internet portal, referred to as the Client Portal. All DEEOIC staff are to reference the "Client Portal User Guide" for additional information about using the Client Portal and referring cases to CMCs. Coordination of information between DEEOIC staff and the CMC contractor, including transmission of referral packages, is the responsibility of designated staff (i.e., CA). The CE, however, initiates the CMC referral process.

a. Preparation of referral email. The CE sends an email to the Medical Scheduler indicating that a CMC review is required, and requesting referral to the CMC contractor. The body of the email should contain:

(1) Claimant name.

(2) Claim number.

(3) Type of review requested.

(4) Medical Specialty requested. The "Client Portal User Guide" contains a list of medical specialty types available for claims review. It is crucial that the CE selects the most appropriate preferred medical specialty to perform the review. The CE considers the following in determining the preferred medical specialty.

(a) Causation questions are best handled by occupational medicine specialists. Occupational medicine specialists can also evaluate the diagnosis and treatment of occupational lung conditions; such as asbestosis, silicosis, CBD, pneumoconiosis, and COPD.

(b) Diagnosis or treatment questions are best handled by medical specialists for the condition or procedure under evaluation. Selecting generalist/internal medicine/family practice is appropriate if the condition involves a medical specialty not listed in the"Client Portal User Guide."

(c) Impairment questions are best performed by specialists with experience in treating the particular organ system affected by the accepted work-related illness.

b. Scanning. The CE creates an electronic image of the following items as a single PDF file, and attaches the file to the referral email. A copy of the completed SOAF is to be scanned/bronzed to the case file in OIS.

(1) A SOAF is a narrative summary of the factual framework of the case record. The SOAF logically conveys factual findings that have been decided by the CE upon examination of the case record, or application of Programmatic resources, such as the SEM. The CE makes factual findings derived from a reasonable interpretation of evidence contained in the case record, and not from undocumented sources.
Factual findings presented in the SOAF are to be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. The CE is to avoid using legal terms and Program jargon. Moreover, the CE must ensure that factual findings are presented in a logical order, and grouped chronologically within subject-specific sections relating to medical, employment, exposure, etc. The SOAF is to include the following information:

(a) Identifying demographics, including the employee's name, case file number and relevant personal information (e.g., employee's date of birth, date of employee's death, etc.).

(b) Description of any accepted conditions or other diagnosed medical conditions. Medical information in the case file that is not relevant to the referral need not be reiterated in the SOAF.

(c) Detailed description of the employee's employment history. This includes information about where the employee worked, dates of employment, and his or her job title and duties, if relevant to the referral. The CE will review Form EE-3 to assess the employee's claimed employment; however, in preparing the SOAF, the CE should only include employment that has been verified by the

DEEOIC and determined to be covered employment (See Chapter 13 - Establishing Covered Employment).

The CE refers to the OHQ for more detailed descriptions of work processes and must be diligent to identify all relevant employment data that has been determined to be factually established from the case evidence. This is particularly true in referral situations involving causation, as there is a need to clearly understand job descriptions, duties performed, working conditions, etc.

(d) For causation determinations, identification of the occupational toxic substance exposures encountered by the employee. The CE makes findings of toxic substance exposure based on a careful analysis of case evidence, and reference to Program resources such as researching the SEM, or seeking guidance from the IH or TOX when appropriate (See Chapter 15 - Establishing Toxic Substance Exposure and Causation). Toxic substance exposures, reasonably established by available evidence, and shown to have a potential health effect to the diagnosed condition, are listed in the SOAF. When possible, the CE is also to provide relevant information on the nature, extent and duration of such exposures.

Quantification might include levels of exposure, concentrations of asbestos fibers in the air, levels of noxious substances, the (approximate) number of times exposed, etc. The CE is to avoid the use of terms such as light, heavy, undue, severe, and abnormal because they are subject to great differences of interpretation. In certain situations, where the CE must provide an explanation as to how certain exposure findings are achieved, he or she is to document such analysis in the case file with a memorandum to the file.

(e) The CE should include a brief history of the significant events that have transpired in the case (i.e., date of filing of Part B and/or Part E, date submitted to the NIOSH for dose reconstruction, date of denial/acceptance, etc.) if determined to be relevant to the referral.

(2) List of Questions for the CMC to address. (See Exhibit 16-1 for example). The questions put to the CMC must relate to a particular informational need that a physician is to address. The questions to a CMC should clearly communicate the information required. To this end, the questions should be straightforward and objectively stated. Avoid questions that are overly broad, or contain numerous subcomponents. In addition, questions that are leading or biased to a particular outcome are not appropriate. The CE is to limit the questions to the CMC to the relevant information necessary to address the particular claim for which a decision is required.

A copy of the list of questions is to be scanned/bronzed to the case file in OIS.

(a) For referrals under Part B, questions should be specific to a statutory requirement for any of the compensable occupational illnesses. Questions must be specific to a medical determination, rather than an adjudicatory standard.

For example, in a pre-1993 CBD claim, a specific medical question is, "Does any X-ray show characteristic abnormalities consistent with CBD?" rather than, "Do the medical records support an acceptance of CBD under our Program requirements?"

(b) For referrals under Part E, questions should identify the standard of proof required. For example, the CE asks, "Is it at least as likely as not that asbestos was a significant factor in causing, contributing to or aggravating the employee's diagnosed illness?"

In some instances, there may be two unrelated conditions that the CE determines require a review by two separate specialists. The CE will need to prepare one SOAF and specify the two specialists required for review. The CE will prepare separate questions for each specialist to address.

(3) Medical Records relevant to the issues for which the CMC is to render an opinion are to be imaged into a PDF formatted to the file and attached to the CMC referral email. For cases where an impairment rating is being sought, the CE may image the most pertinent or recent (two or three years old) medical records. For Second Opinion, Referee Specialist examination, or other case reviews, comprehensive medical records may need to be imaged. In some instances, the CE or designated staff person may need to divide the electronic images into several files to allow for electronic submission. The designated staff person should label each file clearly to allow for chronological or other categorical identification.

12. Role of CA in CMC Referrals. Each DD designates a CA who processes and tracks CMC referrals. The CA is also responsible for coordinating communication between DO staff and the CMC contractor. When guidance requires that email communication be prepared, a copy of the email is to be scanned/bronzed into the case file. Upon receipt of a CMC referral submission from a CE, the CA is to take the following actions:

a. Review of Referral. Conducts a thorough review of the referral package to ensure all required documentation is present, questions to the CMC are clear, and imaged records are legible. The SOAF should also be inspected to ensure that relevant factual findings have been reached that will allow for a comprehensive and reliable CMC analysis. Upon inspection, any referral package that is deemed to be incomplete or defective is returned to the CE for corrective action. The CA is

to return the referral package to the originating CE with a memo describing the problem to be addressed before a referral can be initiated.

b. Submission of Referral. Once the CA has determined that a referral is complete and ready for submission to the CMC contractor, he or she is to log onto the CMC contractor's internet portal, and follow the steps in the "Client Portal User Guide" for creating a claimant referral. Using the referral tab on the Client Portal, the CA inputs the claimant's information as needed, and uploads all relevant electronic documents to complete the transaction.

c. Confirmation. Upon receipt of submission confirmation from the CMC contractor, the CA is to notify the originating CE via email that the referral is complete.

d. Processing for Payment. When the FO receives confirmation from the CE that the report is complete and accurate (see Section 13 of this chapter), the FO compares the referral sheet to the billing information submitted by the contractor to validate that the charged amount corresponds to the service request. The FO must ensure that the billing information identified within the OWCP's Workers' Compensation Medical Bill Processing (WCMBP) system corresponds appropriately to what the CE requested be performed by the contractor. The FO must be aware of the following when reviewing billing for CMC reports completed through the contractor process:

(1) For cases with multiple questions regarding the same or related conditions requiring the services of one specialist (e.g., occupational medicine) one billable charge is permitted.

(2) For cases with one or more unrelated conditions, requiring the services of a single specialist (e.g., pulmonary or occupational medicine) one billable charge is permitted.

(3) For cases with unrelated conditions requiring the services of multiple specialists (e.g., oncology, pulmonary, dermatology) separate charges are appropriate for each referral to a different specialist.

e. If the billing information captured within WCMBP is correct, the FO processes the invoice for approval. The FO then forwards the approved invoice for review by COR or designated COR via WCMBP.

f. If a problem with the billing is identified, the FO communicates the issue with the contractor and copies the COR or designated COR via e-mail.

g. Problems with Reports. The CA notifies the COR of any problems dealing with the CMC contractor.

13. Post Referral to CMC. Upon submission of a referral to the CMC contractor, the contractor will then assign a particular CMC to respond. The CMC selection is the function of the CMC contractor, and DEEOIC has no input in the selection of the physician chosen to review the case, other than the preferred specialty of the physician. Once assigned, the CMC is to assess all submitted documentation, and prepare a comprehensive and responsive medical narrative to the questions posed by the referring CE. The CMC then submits his or her report back to the contractor. The contractor then undertakes a quality control review to ensure that the report is complete, rationalized, and fully responsive to the questions posed by the CE. Upon clearance for release, the CMC contractor will then post the completed report and invoice electronically to the WCMBP.

To access the CMC report, the FO logs into WCMBP at https://owcpmed.dol.gov to access the pending invoice. WCMBP will identify imaged correspondence submitted with the invoice, including the CMC report, via hyperlink. The FO may also opt to obtain a copy of the CMC report via the Correspondence Retrieval Page within WCMBP.

a. Completed Reports. Once the medical report is downloaded, the CE reviews it for accuracy and completeness. The review should include the CMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the CMC's rationale showing how his or her opinion is supported by the evidence in the file.

(1) If the medical report is accurate, appropriate, and complete, the CE sends approval to the FO, via email, to authorize payment of the medical bill no later than the next business day. The CE indicates in the text of the email that the review completed by the CMC is acceptable. The email is scanned/bronzed to the case file in OIS.

(2) If the medical report is incomplete or incorrect, or not properly responsive to the questions posed, the CE notifies the FO, via email, of the issues with the medical report. The email is scanned/bronzed to the case file in OIS. The CE will request clarification to address any inadequacies within the original CMC report. A copy of the clarification request should be scanned/bronzed to the case file in OIS. The CMC shall provide the additional report within 14 days of receipt of the request without additional charge. To ensure prompt payment of all physician referral bills, (i.e., CMC, Second Opinion, Referee Specialist bills), the CA will initiate proper coding of the Authorize Payment for Medical Review screen within ECS.

b. Request for Report. If the claimant requests a copy of the CMC's report, the CE provides a copy of the report with a cover letter, which includes the following disclaimer paragraph:

Attached is a copy of the medical report that you requested. Please be advised that {Enter the CMC's name} is a medical consultant for the Department of Labor. The

Department of Labor will make the final decision in this claim. Please do not contact {Enter the CMC's name} regarding this report. If you have additional evidence to submit in support of your claim or if you have any questions or concerns regarding this report, please contact me at {Enter the DO's toll-free number}.

Staff may redact the CMC's personal address, personal telephone number, and personal email address, but must give the CMC's business telephone number, business address, and business email information.

A copy of the CMC's IH/TOX report will be sent with all RDs denying a claim based on causation.

c. Contract Compliance. Upon the identification of any systematic deficiencies or other problematic situations involving the CMC referral process, immediate action is to be taken to advise the DD or a designee and the NO COR. This would include situations involving consistently poor or low quality CMC reports, timeliness problems, or unresponsiveness to questions.

14. Second Opinion Examinations. A Second Opinion examination is a type of medical referral arranged by the DEEOIC that requires the employee to undergo a physical examination. The results of that examination, along with the physician's review of pertinent medical documentation, facilitate the production of a narrative medical report describing the physician's independent medical opinion in response to questions raised by the assigned CE.

To schedule Second Opinion examinations, the DEEOIC utilizes the CMC contractor with access to a database of physicians capable of performing in-person physical examinations by geographical location. Much like the CMC referral process, the decision to initiate a Second Opinion examination and the appropriate specialist falls to the CE assigned to the claim, but selection of the physician is the sole responsibility of the scheduling contractor.

a. Role of the CE. The CE is responsible for deciding when a Second Opinion examination is necessary in lieu of obtaining information from other sources, such as inquiry to a treating physician or CMC referral. A Second Opinion examination should be reserved for situations for which an actual physical examination of the patient will assist with the resolution of an outstanding claim, such as those involving issues of medical necessity or in situations where claimants have difficulty obtaining information necessary for completion of an impairment rating.

b. Referral for Second Opinion Examination. As discussed in Section 11 of this chapter, interactions between the DEEOIC staff, the CMC, and physicians selected for Second Opinion examinations occur through the Client Portal. The CA or designated staff is responsible for the coordination of information between DEEOIC staff and the contractor, including transmission of referral packages. The CE initiates the process for obtaining a Second Opinion examination and

ensures all necessary referral and medical documentation is sent to the CA or designated staff.

Arranging for a Second Opinion examination follows the same basic referral steps listed as when making a CMC referral.

(1) Preparation of referral email. The CE sends an email to the CA indicating that a Second Opinion examination is needed, and requesting referral to the CMC contractor. The body of the email should contain:

(a) Claimant name.

(b) Claim number.

(c) Second Opinion review request.

(d) Medical Specialty requested. Refer to Section 11.a(4) of this chapter for further discussion of medical specialty.

(e) Previous physicians involved in the case.

(f) SOAF

(g) List of Questions for the Second Opinion physician to address. (Exhibit 16-2)

(h) Medical Records.

(i) Cover Letter to the claimant. (Exhibit 16-3)

A copy of the referral email is scanned/bronzed to the case file in OIS.

(2) Role of the CA. The CA follows the steps listed in Sections 11 and 12 of this chapter to transmit the Second Opinion examination request to the CMC contractor and perform follow-up actions. As is the case with the CMC referral process, the identification of any systematic deficiencies or other problematic situations involving the Second Opinion examination referral process should be brought to the attention of the CMC contractor.

Once the contractor has selected a physician to perform the Second Opinion examination, the contractor will notify the claimant, in writing, of the specialist's name, address and telephone number, and date and time of the appointment. The contractor will also send the claimant a copy of the cover letter (See Exhibit 16-3 for example). The contractor will follow-up with the claimant to ensure that the claimant attended the appointment.

In the event the claimant requests to reschedule the Second Opinion examination, the CE will determine whether the appointment should be changed, as outlined in Section 16 of this chapter. If the claimant does not attend the Second Opinion examination, the CE may suspend action on any open claims and administratively close the case until such time as the employee agrees to and attends the examination as outlined in Section 16.

15. Referee Specialist Examinations. A conflict of medical opinion can arise between a physician selected by a claimant, and that of a CMC or Second Opinion physician. In most instances, the CE's careful weighing of the medical evidence should permit the resolution of the conflict. However, where the weight of medical evidence is equal between the opinion of the treating doctor and that of the CMC or Second Opinion physician, a Referee Specialist opinion is necessary. The CE obtains a Referee Specialist opinion by requesting a third, impartial physician review the competing opinions presented. The assigned physician then evaluates both sides of the competing argument, and makes the deciding conclusion.

a. Value of Referee's Opinion. The probative value of a Referee's opinion, if sufficiently rationalized and derived from careful examination of evidence from the competing physicians, is granted special weight. This means that once the Referee has fully considered the argument presented by both sides engaged in a conflict in medical opinion, and reached a rationalized conclusion regarding the matter, the CE is to consider the opinion of the Referee as the conclusive answer to the issue to be resolved.

b. File review or physical examination. A Referee Specialist examination will consist of either a review of the case record or an actual physical examination of the employee. If a conflict exists between the medical opinion of the employee's treating physician and the medical opinion of a CMC, a Referee referral file review is needed. However, if a conflict exists between the medical opinion of employee's treating physician and the medical opinion of the Second Opinion physician, a Referee referral physical examination should be scheduled.

c. Assignment of the Referee. The CE will utilize the same basic referral process for referral to a Referee examiner as is used for a Second Opinion, except for some notable differences.

(1) In the referring email to the CA, the CE is to denote the type of review as a Referee Specialist examination. A copy of the email is to be scanned/bronzed to the case file in OIS.

(2) The CE's questions to the Referee Specialist are to be sufficiently detailed and narrow to resolve the conflict of medical evidence. The questions should not introduce new or unique topics for the physician to address. The purpose of the Referee Specialist examination is limited to that which is necessary to resolve an existing conflict of medical opinion.

16. Failure to Undergo Second Opinion or Referee Specialist Examination. The employee assigned to undergo either a Second Opinion or Referee Specialist examination is obligated to attend the examination. Moreover, the CE is responsible for evaluating any request to change the date or time of an appointment to determine if sufficient reasons exist to allow for such a change. The employee and/or claimant will not be authorized to change a scheduled Second Opinion or Referee Specialist examination without providing a substantive and documented cause. The determination of whether an appointment should be changed is at the discretion of the CE who is responsible for initiating the referral. Generally, appointment changes should only be permitted in emergency situations, or when the employee has given a sufficiently convincing rationale for a need to change the appointment. Appointment changes that are necessary merely for the general convenience of the employee are usually not permitted. Once authorization for an appointment change is granted, the CE, through the CA, must notify the designated contractor.

Once a Second Opinion or Referee Specialist examination has been scheduled, it is expected that the employee attend. Failure to attend a scheduled examination may result in suspension of action on any open claims and administrative closure until such time as the employee agrees to and attends the necessary examination.

a. Follow-up Action. If the employee was examined, the CE should expect a report within 21 days. This guideline also applies if a case is referred for a file review.

b. Failure to Appear. If the physician's office reports that the employee did not appear for his or her scheduled appointment, the employee and any representative should be contacted by a documented phone call or in writing to request an explanation. If a reasonable explanation is provided, the CE re-schedules the examination, through the CMC Contractor.

   If the employee does not respond to the CE's request for an explanation or if an explanation is provided and the CE determines good cause is not established, or if the employee fails to appear for the re-scheduled examination without good cause, the CE issues a letter advising the employee and representative that the issue to be resolved (i.e., adjudication of a consequential injury, request for surgery, medical supply, etc.) cannot be further adjudicated until the medical examination is completed.

   The CE suspends any further action to adjudicate the outstanding issue and administratively closes the claim. Development may resume if the employee agrees to undergo a medical examination and undergoes it.

c. Disruptions at the Medical Examination. If a medical examination cannot be completed due to disruptions caused by someone accompanying the employee, the medical examination must be rescheduled with a different qualified physician. The employee will not be entitled to have anyone else present at this subsequent examination unless the CE determines that exceptional circumstances exist, for example, if a hearing impaired employee requires a sign language interpreter.

CHAPTER 17 – DEVELOPMENT OF RADIOGENIC CANCER CLAIMS

1. Purpose and Scope. This chapter includes a narrative discussion of the procedures for determining whether an employee has been diagnosed with a cancer and the procedures for establishing causation as a result of exposure to occupational radiation.

2. Identifying a Claim for Cancer. The CE must first identify whether the claim is being made for cancer. If Form EE-1 or Form EE-2 is marked for a cancer, then a cancer claim is established. The claimant is asked to identify the specific type of diagnosed cancer on the claim form.

3. Medical Evidence of Cancer. EEOICPA regulations state that to establish a diagnosis of cancer, a claimant must submit medical evidence that sets forth the diagnosis and the date of the diagnosis. The CE verifies that sufficient medical evidence is in the case file that substantiates a diagnosis of cancer.

a. Diagnosis of Cancer. The case record must include a medical report from a qualified physician that lists a cancer diagnosis. The CE can make referrals to a CMC to assist in interpreting medical evidence as establishing a diagnosis of cancer. Whether the evidence originates from a claimant's physician or a CMC, a diagnosis generally derives from the following evidence:

(1) Tissue examination is the most conclusive method for making a cancer diagnosis, as it provides the physician with the vital information listed below regarding the tumor or lesion. A testing facility reports the outcome of human tissue analysis in a pathology report. The pathology report follows from a biopsy undertaken by a physician during routine screening or post mortem (autopsy). The pathology report identifies particular data that are critical for making a cancer diagnosis.

(a) The tissue of origin (where the tumor or lesion originated); and

(b) The status of the tested cellular tissue as benign, uncertain, or malignant. This chapter of the PM only addresses processing malignant (cancerous) tumors/lesions.

(2) A diagnosis can sometimes be made using one or more of the following methods, which are listed in order of preference. If the CE is unable to identify an affirmative diagnosis based on the medical evidence submitted, the case may be referred to a CMC.

(a) Cytology report describing cells obtained by scraping (e.g., from bone marrow), or by washing (e.g., fluid from lungs). An examination conducted by one of these cytology methods is generally less conclusive than tissue examination because the organization and extent of the tumor may not be as apparent. A positive cytology report would be a basis for further tests.

(b) Imaging (e.g., X-ray, CAT Scan, MRI) are the least specific type of tests in the diagnosis of cancer. Generally, X-rays are used as a basis for further tests. Radiology tests are extremely beneficial in determining the spread of cancer and/or determining the effects of cancer treatments.

(3) If the employee is deceased or if a living employee is unable to undergo additional diagnostic testing for medical reasons, clinical evidence is needed which shows that a qualified physician has evaluated available medical evidence and has provided a well-rationalized opinion that interprets such evidence as establishing a diagnosis of cancer. Documentation that a physician can use for such a purpose includes hospital admission/discharge reports or reports describing a tumor or possible malignancy; inconclusive diagnostic testing results, or other medical records alluding to the existence of a potential cancer.

(a) In the absence of other affirmative medical evidence collected during development, a CE may use a death certificate acknowledged by a physician or recognized by a state medical authority to establish a cancer diagnosis.

b. Diagnosis of Multiple Primary Cancers.

(1) If a CE identifies more than one primary cancer in the medical evidence in the same organ with the same diagnosis date and a physician has classified each as the same type of cancer, the CE considers all as one primary cancer.

For example, a surgeon performs two biopsies of the left breast on the same date. Several days afterwards, a pathologist interprets the samples as showing infiltrating ductal carcinomas. In this case, the CE considers the results as diagnosing one primary cancer of the left breast.

Alternatively, if the pathologist interpreted the same biopsies as documenting a lobular carcinoma and an infiltrating ductal carcinoma, the CE considers these cancers as two primary cancers, since the cancer types are different.

The CE can only resolve issues relating to the number of primary cancers diagnosed from pathology or clinical evidence by obtaining the opinion of a qualified physician. In the absence of a well-rationalized opinion from a claimant's treating physician, a CE refers such matters to a CMC for review.

(2) The above guidance applies only to multiple primary cancers of the same type in an organ. Situations involving bilateral organs are more

complicated. Bilateral organs include the lungs, breasts, kidneys, adrenals, ovaries, and testes.

Biopsies taken from the left and right lungs might indicate the same type of cancer, e.g., non-small cell adenocarcinoma, in the right and left lungs. While one cancer may actually be metastatic from the other lung, without any indication in the pathology report or other medical evidence, it would be difficult to determine whether these two adenocarcinomas are two primary cancers or just one cancer. In these situations, the CE requests clarification from either the treating physician or a CMC.

c. Date of Diagnosis. The date of initial diagnosis is required in any claim for cancer. The date of diagnosis is also a critical element used in the IREP for calculating the PoC. The employee's occupational exposure to radiation must be before the initial date of diagnosis for it to be compensable under Part B. While a claimant may list the date of diagnosis on Form EE-1 or Form EE-2, the CE reviews all of the medical evidence submitted in a claim package to determine the earliest date of cancer diagnosis.

(1) When using a pathology report to determine the date of diagnosis, the date that a physician biopsied the tissue is used as the date of diagnosis.

(2) In certain claim situations, the CE will have to use reasonable discretion to decide the date of diagnosis. For example, if the employee is deceased, and the only documentation available to support the diagnosis of cancer is the employee's death certificate signed by a physician, the CE may accept an affidavit from a survivor(s) and/or other individuals to establish that the employee's diagnosis date is subsequent to the employee's initial exposure to occupational radiation.

For example, a home health nurse might indicate in an affidavit his or her knowledge that on a specified date, a physician made a diagnosis of the employee's condition, as well as the circumstances under which he or she acquired such knowledge.

d. Deficiency in Medical Evidence. The CE advises the claimant of any deficiency in medical evidence and allows the claimant a period of up to 60 days to submit additional medical evidence. All development communication from the CE must be clear and include understandable guidance of what evidence is required to support the claim.

4. Pre-Cancerous and Non-Malignant Conditions. If the medical evidence provided by the claimant establishes a diagnosis of a condition in a pre-cancerous stage or is non-malignant, the CE cannot accept the condition as a cancer. However, the CE proceeds with development of the condition for coverage under Part E. The receipt of a qualified physician's opinion can only resolve the interpretation of whether a condition is a diagnosed cancer or not. If the CE cannot

obtain clarification of such issues from the claimant's chosen physician, he or she can refer the medical evidence to a CMC.

5. Specified Cancers. Members of the SEC who are diagnosed with any of the 22 specified cancers are eligible for benefits without the need for a dose reconstruction. Eligible members of a SEC class have a presumption that the diagnosed specified cancer was caused by radiation exposure during their eligible SEC employment.

6. Non-SEC Cancers and Dose Reconstruction. Any primary cancer that is not a specified cancer is a non-SEC cancer. Once the CE has determined that the employee has a diagnosed non-SEC cancer and covered employment, he or she prepares the claim for referral to the NIOSH for a dose reconstruction. The CE is to report a secondary cancer only when the development of the claim has not resulted in the identification of the primary cancer.

a. Claimant Not SEC Member. When the employee is not a SEC member (i.e., the employment was outside the designated SEC period or the employee did not work the necessary workdays at an SEC site), the CE forwards the claim to NIOSH for dose reconstruction, once a cancer diagnosis and covered employment are confirmed.

b. SEC Case with Award. For any SEC cases where an award has been made for a specified cancer, any non-SEC cancers for the case must be forwarded to NIOSH for dose reconstruction to determine eligibility for medical benefits for the non-SEC primary cancers. In these SEC cases, all cancers are listed on the NIOSH NRSD, including the specified cancer(s).

(1) An exception to this rule includes those SEC claims where a primary cancer, which is not a specified cancer, metastasizes to a secondary cancer site that a CE has decided is a specified cancer. For instance, prostate cancer (non-specified cancer) metastasizes to secondary bone cancer (specified cancer). If the bone cancer is accepted as a specified cancer under the SEC provision, the claimant can receive medical benefits for both primary and secondary cancers (prostate and bone cancer). However, according to EEOICPA regulations, payment for medical treatment of the underlying primary cancer…does not constitute a determination by OWCP that the primary cancer is a covered illness. As such, it will be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E for prostate cancer. In this situation, since the bone cancer is a secondary cancer with known primary site (prostate), it is not included on the NIOSH NRSD.

c. Multiple Skin Cancers. When a claimant provides evidence that the covered employee has a large number of skin cancers, the CE will proceed as follows:

(1) The CE considers each malignant skin neoplasm (e.g., basal or squamous cell cancer) as a separate primary cancer, unless the medical records state that the neoplasm is a metastatic lesion.

(2) For NIOSH dose calculations, the date of diagnosis and the location (e.g., arm, neck, back) of the skin cancer are important. The CE must include this information in the medical section of the NRSD.

d. Multiple Primary Cancers for Other Organs/Locations. If a CE identifies more than one primary cancer location for an organ in the medical records (e.g., multiple sites of primary cancer in the lung), the CE notes this information in the medical section of the NRSD, including the cancer locations within the organ and the diagnosis date. NIOSH will perform dose calculations for each primary cancer site in a specific organ. When NIOSH reports the dose reconstruction results, the CE calculates the PoC values for each of the primary cancers in that organ.

7. Preparing Non-SEC Cancer Claim Files for Referral to NIOSH. The NRSD (Exhibit 17-1) is a tabular form containing the medical and employment information accepted by the CE as factual. This form provides NIOSH with the necessary information to proceed with the dose reconstruction process.

a. Instructions. Step-by-step instructions for completing the NRSD are included in Exhibit 17-2.

b. Smoking History. The employee's smoking history is required for cases that include primary lung cancer (including primary trachea, bronchus, and lung) or for secondary cancer with an unknown primary cancer that includes lung cancer as a possible primary cancer.

(1) The method used to gather smoking history is Form EE/EN-8.

(2) Upon receipt of the information from the claimant, indicate the smoking level (at the time of cancer diagnosis) using the designations shown in the NRSD. If the case evidence contradicts information obtained on the questionnaire, the CE must clarify the discrepancy with the claimant prior to referral to NIOSH.

(3) If the claimant does not return the initial smoking questionnaire within 30 days, the CE sends a follow-up letter advising the claimant that they are to return the questionnaire within the next 30 days or their case will be closed administratively. After a total of 60 days has elapsed, the CE administratively closes the claim and informs the claimant by letter that the claim is closed and no further action will be taken relating to the claimed illness(es) under Part B. The CE proceeds with any necessary development relating to a Part E claim.

(a) If the CE can obtain the relevant information from the employee's medical or DAR records, the CE uses that information to complete the NRSD. The CE includes a memo to file explaining the source of the information.

c. Ethnicity. Employee's ethnicity is required for skin cancer cases.

(1) The method used to gather this information is Form EE/EN-9.

(2) Upon receipt of the information from the claimant, indicate the ethnicity using the designations shown in the NRSD.

(3) If the claimant does not return the initial ethnicity questionnaire within 30 days, the CE follows the same steps required for collecting information relating to the employee's smoking history (i.e., second request, administrative closure and notice). Like the guidance for obtaining an employee's smoking history, if the CE can obtain the relevant ethnicity information from the employee's medical or DAR records, the CE uses that information to complete the NRSD. The CE includes a memo to file explaining the source of the information.

d. Case Referred to NIOSH.

(1) All findings made by the CE must be supported by the evidence in file and documented in the NRSD. The CE forwards a copy of the entire case file with the NRSD to NIOSH.

(2) The CE advises the claimant in writing that he or she has sent the case to NIOSH for dose reconstruction (Exhibit 17-3).

8. Preparing Amendments to the NRSD for Non-SEC Cancer Claims. Sometimes CEs obtain additional information on a case after they refer it to NIOSH but before the completion of the dose reconstruction. This includes new information related to the employee's employment, new medical condition(s), new AR, or other survivor-related information. The CE is to bronze into OIS all documentation created or received for a case file.

When new information becomes available, the CE forwards this information to NIOSH so it is available for dose reconstruction. The CE identifies the portion of the NRSD that has changed based on new evidence reviewed by the DO. He or she also marks "Amendment" on the top of the NRSD and lists the employee's name, DOL case ID number, NIOSH tracking number, and DOL Information. The CE describes clearly and separates any "Amendment" NRSDs from NRSDs submitted with the DO's weekly package to NIOSH. A CE or other designated staff person ensures that any supplemental packages are separated from regular NRSDs for clear identification by NIOSH.

a. NIOSH Reports. NIOSH provides weekly reports to the DOs listing the cases for which the NIOSH contractor started performing dose calculations in the past

week. For any revisions to information contained in the original NRSD, the CE is to forward to NIOSH an amended NRSD clearly identifying the revised information. This will allow NIOSH to use the most accurate information in its dose reconstruction.

b. "Supplement" NRSD. If the CE needs to submit additional evidence to NIOSH, such as additional medical information for the same reported cancer, the CE submits a NRSD marked "Supplement." The CE lists on the referral the DOL Case ID number, NIOSH tracking number, and employee's name. A CE uses a supplemental NRSD only for a submission that does not change the original information in the NRSD.

9. Cases Pulled While at NIOSH. During the dose reconstruction process, it may be necessary for NIOSH to contact the CE to resolve a discrepancy, or request clarification. Normally, this contact is via e-mail or telephone. The CE handles all contacts from NIOSH as quickly as possible. If the CE cannot provide an answer to a question without further development, the CE advises NIOSH of the steps being taken to resolve the matter and an approximate period for completion.

In cases where further development is needed as determined by NIOSH or DOL, NIOSH pulls the case from the dose reconstruction process and advises the CE by e-mail. NIOSH may also pull a case to allow DOL to determine if a case can be accepted under a SEC class. Since a pulled case stops the dose reconstruction process, the CE must proactively develop the case so the dose reconstruction process can proceed or a decision can be rendered on a SEC case.

a. Cases Pulled by DOL. When DOL determines that further development is needed before a dose reconstruction can proceed, the supervisor, SrCE (or journey level CE), or DO NIOSH liaison sends an e-mail (with copies to the other two DO staff) to the NIOSH Public Health Advisor (PHA) with a request that NIOSH pull the case while DOL develops the case for additional information. The CE must advise the claimant in writing when a case is pulled by DOL from the dose reconstruction process.

(1) The e-mail briefly explains the specific information the DO is attempting to clarify or obtain, e.g., employment, medical, smoking or race/ethnicity questionnaire, etc.

(2) On receipt of the development information, the designated DOL staff person notifies the NIOSH PHA (with copies to the other two DO staff) by e-mail of the resolution of the issue and requests that the case be removed from pulled status. The DO also prepares and forwards, as necessary, an amended NRSD containing the new information. The CE advises the claimant in writing that their case has been removed from pulled status and that the dose reconstruction is proceeding.

b. Cases Pulled Due to SEC. NIOSH may identify cases submitted for dose reconstruction that are potentially eligible for inclusion in a SEC class. This may

typically occur when a new SEC class is designated. NIOSH pulls these cases from the dose reconstruction process and returns these cases with the dose reconstruction records to the appropriate DO for further development. The CE handling the case ensures that any record received from NIOSH as part of the dose reconstruction process is bronzed into OIS or maintained by the DO as a permanent record of the case file. NIOSH will send the claimant a letter advising the claimant that it is returning the claim to DOL for adjudication.

If DOL identifies a case that qualifies under the SEC provision but NIOSH did not pull it from the dose reconstruction process, the CE, through the SrCE or journey level CE, notifies the appropriate NIOSH PHA via e-mail to return the dose reconstruction records for further development. In these cases, the CE sends a letter to the claimant advising that his or her case is pulled from the dose reconstruction process for evaluation under the SEC provision.

If it is determined that the case does not qualify for the SEC class, the CE, through the SrCE or journey level CE, notifies the appropriate NIOSH PHA via e-mail to proceed with the dose reconstruction. The CE prints a copy of the "sent" e-mail and bronzes it into OIS. The e-mail includes a brief statement explaining why the case should proceed with dose reconstruction, e.g., non-specified cancer, insufficient latency period or does not meet the 250 workday requirement. In addition, the CE notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE also sends a copy of this letter to NIOSH.

10. NIOSH Actions. Upon receipt of a claims package from DOL, NIOSH takes several actions to determine the employee's radiation dose. NIOSH will request DOE records and interview the claimant(s) to identify any additional relevant information on employment history and develop detailed information on work tasks and radiological exposures. NIOSH will also apply dose reconstruction methods to estimate radiation doses for workers seeking compensation for cancer who were not monitored or inadequately monitored, or whose records are missing or incomplete for exposure to radiation at a DOE or AWE facility. NIOSH will then conduct a closing interview with the claimant(s) to review the dose reconstruction results and the basis upon which the results were calculated.

a. Obtain Signature on Form OCAS-1. Subject to any additional information provided by the claimant, the claimant is required to sign and return Form OCAS-1 to NIOSH within 60 days, certifying that he or she has no additional information and that the record for dose reconstruction should be closed.

Upon receipt of the signed Form OCAS-1 and completion of any changes in the dose reconstruction resulting from new information provided, NIOSH forwards a final dose reconstruction report, "NIOSH Report of Dose Reconstruction under EEOICPA", to DOL and to the claimant.

(1) NIOSH does not forward the dose reconstruction report to DOL for adjudication without receipt of Form OCAS-1 signed by the claimant or an AR of the claimant.

(a) If the claimant or the AR does not sign and return Form OCAS-1 within 60 days, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimant or the AR.

(b) Upon receiving this notification by NIOSH, the CE records in ECS the administrative closure of the affected Part B claim based on the lack of a signed Form OCAS-1.

(c) If the employee meets the Part E employment requirements (contractor or subcontractor), prior to administrative closure, the CE determines if a causal link exists between the claimed illness and exposure to toxic substances (other than radiation) at a DOE facility or certain RECA facility. When a causal link is determined, the CE is able to accept the cancer under Part E. If no non-radiogenic toxic substance causal link is established, the CE administratively closes the case in ECS under Part E.

(d) The CE advises the claimant by letter that the case is closed. If the claimant later decides to sign the Form OCAS-1, he or she needs to notify DOL, after which the CE returns the case to NIOSH for processing.

(e) If additional information is submitted, NIOSH will review the evidence, prepare a new dose reconstruction report, and send a new Form OCAS-1 to the claimant and allow for an additional 60-day comment period.

(2) If the case has multiple claimants, NIOSH will wait 60 days for receipt of all signed Forms OCAS-1. If, after 60 days, NIOSH does not receive Form OCAS-1 from any of the claimants, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimants or the AR. The CE also administratively closes the corresponding DEEOIC claim(s) in accordance with paragraph 10a(1). If, after 60 days, NIOSH receives only one signed Form OCAS-1, NIOSH will forward the dose reconstruction package to DOL.

(a) One signed Form OCAS-1 is sufficient to proceed with issuing a decision for all filing claimants.

11. Receipt of Dose Reconstruction Results from NIOSH.

a. Content of NIOSH Report. The "NIOSH Report of Dose Reconstruction under EEOICPA" provides the information that the CE needs to perform a PoC calculation, which is necessary to render a decision on the claim. The NIOSH report includes the following information:

(1) Annual dose estimates related to covered employment for each year from the date of initial radiation exposure at a covered facility to the date of cancer diagnosis;

(2) Separate dose estimates for acute and chronic exposures, different types of ionizing radiation, and internal and external doses, providing dose information for the organ or tissue relevant to the primary cancer site(s) established in the claim;

(3) Uncertainty distributions associated with each dose estimated, as necessary;

(4) Explanation of each type of dose estimate included in terms of its relevance for estimating PoC;

(5) Identification of any information provided by the claimant relevant to dose estimation that NIOSH decided to omit from the basis for dose reconstruction, justification for the decision, and if possible, a quantitative estimate of the effect of the omission on the dose reconstruction results; and,

(6) A summary and explanation of information and methods applied to produce the dose reconstruction estimates, including any factual findings and the evidence upon which those findings are based.

b. NIOSH CD or Electronic Record. When NIOSH returns a dose reconstruction to DEEOIC, NIOSH will forward all case file documents via CD or as an electronic record, since NIOSH optically scans all documents referred to it for use in performing the dose reconstruction. The CD or electronic record will include the dose reconstruction input file (Excel spreadsheet) used for calculating the IREP PoC. The CE bronzes into OIS or includes as a permanent record of the case file any record received from NIOSH as part of the dose reconstruction process.

(1) Information contained on the NIOSH CD or electronic record will include:

(a) Dose reconstruction files; Computer Assisted Telephone Interview (CATI); dosimetry data; the NIOSH Report of Dose Reconstruction under EEOICPA; NIOSH's PoC calculation; Form OCAS-1; the NIOSH-IREP input file; and pertinent AEC/DOE reports, journal articles or other documents.

(b) Correspondence, including NIOSH letters to claimants, phone conversation notes, and e-mails.

(c) DOE files (data files listed in order of importance on the CD), including DOE dose and work history information and other DOE documents that NIOSH requested, such as incident reports and special studies.

(d) DOL files, including a copy of the case file optically imaged by NIOSH and the OCAS tracking sheets (signatures and dates).

(2) NIOSH will incorporate information from the above sources into the dose reconstruction report. Publicly available documents will be referenced by citation. NIOSH will add documents not publicly available in the record and, as noted above, will be included on the CD or as part of the electronic record transferred to DEEOIC.

(3) The CE need not review all of the documents on the CD or electronic record. Those documents that normally will not require review include the DOE documents, the claimant interview, and the NIOSH-conducted closing interview. The CE must always run the IREP separately.

c. NIOSH Unable to Perform Dose Reconstruction. In some cases, it may not be possible for NIOSH to complete a dose reconstruction because of insufficient information to reasonably estimate the occupational radiation dose received by the employee. In these situations, NIOSH notifies any claimant for whom it cannot complete a dose reconstruction and it describes the basis for this finding. NIOSH forwards its determination to DOL and the CE issues a RD to deny the claim based on NIOSH's inability to complete the dose reconstruction.

12. Review of Claim for Rework of Dose Reconstruction. The CE is responsible for comparing the dose reconstruction report to the evidence in the case file. If there are any significant discrepancies or changes between the information in the case file and the dose reconstruction report, including erroneous or incomplete information, or for which DEEOIC has received new information, the CE determines if rework may be necessary.

Significant discrepancies or changes would include, for example, additional cancer identified or changed cancer site, changed employment facilities or dates, different diagnosis code, or change in date of cancer diagnosis.

a. Cancer Change Rework.

(1) If additional cancer(s) is identified after the dose reconstruction is performed and:

(a) PoC is less than 50%, the CE submits a rework request to NIOSH.

(b) PoC is 50% or greater, a rework is not required. All additional primary cancers would be eligible for medical benefits under Part B and Part E. The CE documents the newly identified cancer(s) in the case file.

(2) If two or more primary cancers are addressed in the dose reconstruction, and it is later determined that one or more of the cancers should not have been included in the dose reconstruction (e.g., the cancer was found to be a recurrent cancer or an erroneously reported cancer) and:

(a) PoC is less than 50%, a rework is not required. The PoC for the remaining cancers will still be below 50%. The CE must use the PoC as calculated as the PoC of record; document the discrepancy between the cancer(s) identified in the dose reconstruction and those determined by DOL to be cancers in the case file and in the RD; and notify the NIOSH PHA of the change to the cancer(s) status so that NIOSH can update its records.

If PoC is 50% or greater, submit a rework request to NIOSH. Also, if a primary cancer addressed in the dose reconstruction is found subsequently to be a secondary cancer with an unknown primary, submit a rework request to NIOSH.

DOs cannot substitute newly identified cancers or additional cancers not used in the dose reconstruction, or their diagnosis dates, for incorrectly reported cancers found in the dose reconstruction.

b. Smoking and Race/Ethnicity Changes Rework. If information related to race/ethnicity or smoking history changes after the dose reconstruction is performed, the CE re-runs IREP using the revised information. A rework is not required except for the following:

(1) If the PoC is initially below 45% and then increases above 50% or greater after re-running IREP using the revised information, the CE submits a rework request to the DEEOIC HP.

(2) If the PoC was above 50% and the change reduces the PoC below that threshold, the CE submits a rework request to the DEEOIC HP.

c. Diagnosis Code Changes Rework. Changes can affect the internal and/or external dose models used in the dose reconstruction and/or the IREP model. Accordingly, the CE submits a rework request for changes in diagnosis codes to the DEEOIC HP. If the diagnosis code changes for the following condition, no rework is required:

(1) For carcinoma in situ skin, if the type of cancer is specified by DOL (Malignant melanoma or Non-melanoma skin-Squamous cell), NIOSH will use only the specified IREP model. If the cancer is not specified, NIOSH will run both IREP models and the model which results in the highest PoC will be used.

d. NIOSH-IREP Changes Rework. If the diagnosis code changes, submit a rework request to the DEEOIC HP.

e. Diagnosis Date Changes Rework. The net effect of a change in the diagnosis date depends mostly on the type of cancer, the worker's age at the time of diagnosis, and whether or not the year of diagnosis falls within the latency period for development of the cancer (which, in turn, varies by IREP cancer model). Depending on the factors listed above, it is possible for an earlier diagnosis date to result in an increase in the PoC. For changes to the diagnosis date:

(1) When the PoC is less than 40% and,

(a) The diagnosis date is in the same calendar year, a rework is not required.

(b) If the diagnosis date is found to be outside the calendar year (either earlier or later), the CE submits a rework request to NIOSH.

(2) When the PoC is between 40% and 49.99%, and there is any change to the diagnosis date, the CE submits a rework request to the DEEOIC HP.

(3) When the PoC is 50% or greater,

(a) If the diagnosis date is found to be later, a rework is not required.

(b) If the diagnosis date is found to be earlier, the CE submits a rework request to NIOSH.

(c) The CE documents the difference in the diagnosis date in the case file and ensures that the difference in the diagnosis date used in the dose reconstruction is noted in the RD.

(d) The CE notifies the NIOSH PHA of the change in the diagnosis date so that NIOSH can update its records.

f. Employment Changes Rework.

(1) If the PoC is 50% or greater and the CE identifies additional DOL-verified employment, a rework is not required.

(2) If the PoC is 50% or greater and the DOL-verified employment is found to be less than that used in the dose reconstruction, the CE submits a request for rework to the DEEOIC HP for review, and includes an electronic copy of the dose reconstruction report.

(3) If the PoC is between 40% and 49.99%, and the CE identifies additional DOL-verified employment, the CE submits a request for rework to the DEEOIC HP for review, and includes an electronic copy of the dose reconstruction report.

(4) If the PoC is less than 40%, and additional DOL-verified employment is identified:

(a) If all the additional employment falls within the same calendar year and the year is addressed in the dose reconstruction, a rework is not required.

(b) If the additional employment extends into, or is wholly within another calendar year not addressed in the dose reconstruction, the CE submits a rework request to the NIOSH.

(5) Some dose reconstructions contain more employment than originally verified by DOL in the NRSD. NIOSH may have DOE dosimetry or employment records for periods not identified by DOL, or the dose reconstruction may use a continuous period rather than considering numerous breaks in employment.

(a) If the case is likely non-compensable, NIOSH may add the additional time period to the DOL-verified employment for the purpose of completing a dose reconstruction (unless it is military, navy nuclear, or non-DOE federal service) in a timely manner.

(b) If the PoC is less than 50% and the dose reconstruction contains employment added by NIOSH, a rework is not required. However, the CE must write a memo to file that DOL did not verify part of the employment period assumed by NIOSH, but that the employment period was assumed correct for completing the dose reconstruction in a timely manner.

Should new information arise to warrant performing the dose reconstruction again (e.g., additional cancer diagnosis, additional employment at another site), only employment verified by DOL will be used, which may be more restrictive than that allowed in the current dose reconstruction. The CE ensures that he or she includes an explanation of this as part of the narrative analysis included in any forthcoming RD.

If NIOSH has added employment to a claim that is likely compensable, NIOSH contacts the CE with the additional employment information for DOL review and verification. After verification, the CE submits an amended NRSD listing all accepted employment to NIOSH.

(c) If the PoC is 50% or greater and the dose reconstruction contains employment added by NIOSH but not approved by the DO, the CE submits a rework request to the DEEOIC HP.

(6) If a CE identifies military, navy nuclear, or non-DOE federal service employment referenced in the dose reconstruction, the CE submits a rework request to the DEEOIC HP because this may mean that covered employment is not established.

(7) For any PoC, if the CE identifies changes to the employment site(s), the CE submits a rework request to the DEEOIC HP because this may alter the applicable site profile used in assessing occupational radiation exposure.

(8) When a rework is not required, the CE documents the changes to the employment in a memo to file and ensures that the difference(s) between the employment used in the dose reconstruction compared to the DOL-verified employment is noted in the RD. Finally, the CE notifies the NIOSH PHA of the change(s) in employment so NIOSH can update its records.

g. Additional Survivors (Claimants) Identified Rework.

(1) If the PoC is 50% or greater, NIOSH does not need to interview any newly identified claimants. A rework is not required.

(2) If the PoC is less than 50%, a rework request is sent to NIOSH to interview the new claimant(s), at the claimant(s)' request, to determine if there is some information that could significantly affect the dose reconstruction.

13. Procedures for Requesting Rework. For cases in which the CE determines that a rework is necessary, the CE e-mails his or her assigned SCE, SrCE or journey level CE with the amended NRSD attached, noting the issues with the dose reconstruction.

a. The CE's e-mail includes the following:

(1) Use an e-mail subject that is specific to the individual rework request. For example: DOL Case ID, NIOSH ID Number, DO, and "Rework", i.e., 1234-NIOSH ID #123456-Denver-Rework.

(2) The CE briefly summarizes how he or she used the current dose reconstruction. Include the employment history used by NIOSH in the dose reconstruction; the cancer(s), diagnosis code(s) and diagnosis date(s) used in the dose reconstruction, and the PoC resulting from this information used in the dose reconstruction.

(3) Describe the reason(s) for the rework request. For example, an additional cancer has been verified, the wrong cancer was reported in the NRSD, the primary cancer was determined for a secondary cancer reported as an "unknown primary," more or less employment was determined, or the diagnosis date for one of the cancers in the dose reconstruction was found to be incorrect.

(4) Determine whether the employment history and cancer information listed on the Dose Reconstruction Coversheet is the exact information used by NIOSH in the dose reconstruction. If the information reported in the NRSD does not match the information stated on the Dose Reconstruction Coversheet, review the dose reconstruction report, particularly in the sections "Dose Reconstruction Overview," and "Information Used", where NIOSH describes in more detail the information used to complete the dose reconstruction. This text may resolve an apparent discrepancy.

(5) Refer to Exhibit 17-4 for examples of rework requests and types of information needed.

b. The CE prepares an amended NRSD as necessary.

c. To track the action, the CE records the rework request in ECS.

d. The DEEOIC HP serves as the central liaison between NIOSH and DOL on all issues related to dose reconstruction. If the SCE, SrCE, or journey level CE agrees with the CE's findings regarding rework, he or she forwards the CE's e-mail along with the amended NRSD to the DO NIOSH liaison. In turn, the DO NIOSH liaison sends the request along with the amended NRSD to the DEEOIC HP and copies the CE, SCE, SrCE or journey level CE, and DD. For instances where the CE determines that a rework request does not need to be forwarded to the DEEOIC HP (e.g., non-compensable claim with an accepted cancer not included in the dose reconstruction), the CE is to forward the rework request directly to NIOSH.

(1) The DEEOIC HP reviews the request for rework and determines whether a rework is required.

(2) If the DEEOIC HP needs additional information to make a determination, which may include requesting the case file, he or she contacts the CE.

e. Rework Not Needed. If the DEEOIC HP determines that the submitted information does not change the outcome of the dose reconstruction, he or she sends an e-mail to the DO NIOSH liaison, with a copy to the CE, or SCE, and DD, explaining the rationale for not continuing the review of the dose reconstruction. When the CE receives this response, he or she ensures the response is entered into ECS and proceeds with the IREP calculation.

(1) Updating Records. The CE is responsible for documenting any change to the case records in OIS. This is true regardless of whether the CE submits the case for a rework review by the DEEOIC HP. The CE is to always document, with memos to file, any analysis that applies to assessing the sufficiency of a dose reconstruction, along with the guidelines used to make that determination.

When the DO makes changes to information used in the NIOSH dose reconstruction, and no rework is required, the DO NIOSH liaison or other designated person sends an e-mail to the appropriate NIOSH PHA. This e-mail indicates what information changed, such as the diagnosis code, cancer name, employment dates, etc.

This allows NIOSH to update its records for the case, which is most critical with respect to changes involving diagnosis codes and PoC values different from those initially generated by the dose reconstruction. Forwarding these changes also allows NIOSH to compile accurate statistics on the types of cancers addressed in EEOICPA decisions that required a NIOSH dose reconstruction.

If a CE performs a new PoC calculation using new information without the need for rework, the DO NIOSH liaison must advise the NIOSH PHA via e-mail and attach the new IREP summary file. For example, in a case with an initial PoC less than 45%, the DEEOIC HP determined that a change in the diagnosis code did not require a rework of the dose reconstruction, but just a different NIOSH-IREP model run. If the new IREP run resulted in a PoC less than 45%, the CE uses the new IREP run and PoC as the value for the dose reconstruction but must advise NIOSH as noted above.

(2) Any future dose reconstruction rework based on additional verified cancer(s) or employment is performed by NIOSH using only DOL-verified information, which may be more restrictive than information used in the previous dose reconstruction (i.e., in some likely non-compensable cases, NIOSH may assume a continuous employment period rather than considering numerous breaks in employment for the purpose of completing a dose reconstruction in a timely manner). Therefore, it is possible in some cases for the subsequent PoC to remain the same, increase only slightly, or even decrease to some degree if the dose reconstruction is reworked in the future.

f. Rework Needed. If the DEEOIC HP determines that a rework is necessary, he or she e-mails the CE, SrCE or journey level CE, SCE, DD and the DO NIOSH liaison. In certain non-standard rework requests, the DEEOIC HP also copies the designated NIOSH Division of Compensation Analysis and Support (DCAS) contact person(s) on the e-mail.

(1) The CE takes the following actions:

(a) Forward the amended NRSD as an electronic attachment via e-mail to the NIOSH PHA assigned to the DO.

(b) Send a letter to the claimant (Exhibit 17-5) explaining that the case has been returned to NIOSH for a review of the dose reconstruction.

(c) Send a copy of this letter to the appropriate NIOSH PHA along with the weekly DO submissions to NIOSH.

g. After a revised dose reconstruction report is completed, NIOSH sends it to the claimant along with another Form OCAS-1. The claimant has 60 days to sign and return the form.

14. Comments to Dose Reconstruction Submitted to FAB. A claimant may choose to present comments regarding the findings reported in the NIOSH dose reconstruction. Claimant comments may be submitted for consideration as part of the following circumstances: a request for a review of the written record, oral hearing, or reconsideration; testimony or presentation of exhibits for an oral hearing; or a request for reopening or other post-adjudication action. In these situations, the DEEOIC HP serves as the initial point of contact for addressing claimant-related comments to a NIOSH dose reconstruction. The CE or assigned DEEOIC FAB staff person takes the following steps to track dose reconstruction comments submitted for DEEOIC HP review:

a. Prepares a memo to the DEEOIC HP that identifies all comments related to the NIOSH dose reconstruction.

b. E-mails an electronic version of the memo to the DEEOIC HP. Attached to the e-mail is a copy of the claimant's comments/letter of objection, hearing transcript and applicable exhibits, if available. Copies of this e-mail are sent to the supervisor of the assigned CE or DEEOIC FAB staff member and the Policy Branch Program Specialist. The e-mail message should contain the following information in the subject line: the assigned DEEOIC staff member's FAB or DO location; "Tech Obj"; the DOL Case ID#; and the name of the covered facility, e.g., (FAB NO) Tech Obj-4112(Hanford).

c. Bronzes a copy of the memo with associated documents attached into OIS to document the referral and the person completing the action documents ECS Notes, verifying that the aforementioned actions have been completed.

d. Upon receipt of the comments related to the dose reconstruction, the DEEOIC HP determines whether the issues raised require further review by NIOSH. As part of this review, he or she will review applicable documents from OIS including: the NIOSH dose reconstruction report, an IREP summary for each cancer, and CATI summary for each claimant from the NIOSH dose reconstruction documentation. If the DEEOIC HP determines that the issues raised are appropriate for NIOSH review, he or she compiles a package consisting of a copy of the memo from the assigned DEEOIC staff member, a summary of the concerns raised regarding the NIOSH dose reconstruction process or copy of pertinent transcript data from the oral hearing, including exhibits (if applicable), the comments/objection letter from the claimant, and any additional documentation (e.g., exposure data). The DEEOIC HP submits this package to NIOSH for review and written response. The DEEOIC HP can consult with NIOSH to clarify whether an issue is appropriate for NIOSH review.

e. Upon receipt of NIOSH's response, the DEEOIC HP reviews the response to confirm that it addresses the claimant's concerns. He or she will add any additional comments, noting that the comments are from DEEOIC, and forward this information to the assigned DEEOIC staff member and his or her respective supervisor via e-mail. Upon receipt of the review of NIOSH's response, the assigned DEEOIC staff member bronzes the responses into OIS. The assigned DEEOIC staff member incorporates the NIOSH findings into a FD/Remand or other post-adjudicatory decision (e.g., reconsideration, reopening, etc.). The FD/Remand or other post-adjudicatory decision must clearly summarize the claimant's concerns regarding the dose reconstruction and include a detailed summary of NIOSH's responses or, when appropriate to provide clarity, a verbatim recitation of NIOSH's comment response.

If the DEEOIC HP determines that the concerns do not warrant further review by NIOSH, the DEEOIC HP prepares an e-mail to the assigned DEEOIC staff member and his/her supervisor addressing the issues raised by the claimant regarding NIOSH dose reconstruction. In such instances, the assigned DEEOIC staff member incorporates the findings of the DEEOIC HP into either a FD/Remand or other post-adjudicatory decision. The FD/Remand or other post-adjudicatory decision must summarize clearly the claimant's concerns regarding the dose reconstruction and include the DEEOIC HP's comments to such concerns.

15. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. Under Part B, a covered employee seeking compensation for cancer, other than as a member of the SEC seeking compensation for a specified cancer, is eligible for compensation if DOL determines that the cancer was "at least as likely as not" (that is, a 50% or greater probability) caused by radiation doses incurred in the performance of duty while working at a DOE facility and/or an AWE facility. DEEOIC uses an algorithmic calculation provided by NIOSH to determine the PoC.

a. Cancers for Which the Primary Site is Unknown. Some claims involve cancers identified by their secondary sites (sites to which a malignant cancer has spread), where the primary site is unknown.

(1) This situation most commonly arises when death certificate information is the primary source of a cancer diagnosis. It is accepted that cancer-causing agents, such as ionizing radiation, produce primary cancers. In a case in which the primary site of cancer is unknown, this means that the primary site must be established by inference to estimate the PoC.

(2) For background purposes, Exhibit 17-6, which is produced from Table 1 in 42 C.F.R. Part 81, indicates, for each secondary cancer, the set of primary cancers producing approximately 75% of that secondary cancer among the U.S. population (males and females were considered separately). NIOSH performs the dose reconstruction for the cancer site that yields the highest PoC.

If the PoC yields a result greater than 50%, all of the secondary cancers are covered for medical benefits even if no dose reconstruction was performed for that secondary cancer.

b. Cancers of the Lymph Node. The CE considers all secondary and unspecified cancers of the lymph node as secondary cancers (those resulting from metastasis of cancer from a primary site). For claims identifying cancers of the lymph node, Exhibit 17-6 provides guidance for assigning a primary site and calculating the PoC using NIOSH-IREP.

c. Claims with Two or More Primary Cancers. For these claims, DOL uses NIOSH-IREP to calculate the estimated PoC for each cancer individually. The CE then performs an additional statistical procedure following the use of NIOSH-IREP to determine the probability that at least one of the cancers was caused by radiation (discussed further in the NIOSH-IREP procedures). This approach is important to the claimant because it determines a higher PoC than is determined for either cancer individually.

For cases involving multiple primary cancers where the PoC is greater than 50%, all of the primary cancers will be covered for medical benefits.

d. Claims for Certain Cancers. Sometimes NIOSH guidance requires that a CE run two or three NIOSH-IREP models for a particular cancer. This most often occurs with different types of leukemia. NIOSH only includes the NIOSH-IREP input and associated summary sheet providing the highest PoC in the "Dose Reconstruction Files" in the data sent to the DO.

16. Calculation of PoC Using NIOSH-IREP Computer Program. DOL calculates the PoC for all cancers using NIOSH-IREP. The risk models developed by the NCI and the Center for Disease Control for NIOSH-IREP provide the primary basis for developing guidelines for

estimating PoC under EEOICPA. They directly address 33 cancers and most types of radiation exposure relevant to claimants covered by EEOICPA. A glossary of cancer descriptions is provided in 42 C.F.R. Part 81 and is produced as Exhibit 17-7.

a. NIOSH-IREP Operating Guide. The CE uses procedures specified in the NIOSH–IREP Operating Guide to calculate PoC estimates under EEOICPA. The guide provides step-by-step instructions for the operation of NIOSH–IREP. There are two user guides, one for cases with a PoC less than 45% or greater than 52%; and another, termed the Enterprise Edition, for cases with PoCs of 45% to 52%. Enterprise Edition cases can be identified by looking at the Excel input file name which would include the notation "EE."

(1) For cases with a PoC less than 45% or greater than 52%, the CE accesses NIOSH-IREP on the NIOSH website to perform the PoC calculation. The CE uses data from the CD or electronic record for the NIOSH-provided input file for each cancer.

When two or more cancers are present, the CE uses the multiple primary cancer equation to calculate the total PoC.

(2) For cases with POCs between 45% and 52%, another software program, called the NIOSH-IREP Enterprise Edition (NIOSH-IREP-EE), is used to perform the PoC calculation. The Enterprise Edition is used for this PoC range to achieve better statistical precision and further reduces the chance of denying a claim because of sampling error.

(3) For multiple primary cancers (or secondary cancers with no known primary), the CE performs the NIOSH-IREP-EE calculation for each cancer.

17. Establishing Causation for Cancer Under Part E. EEOICPA presumes medical conditions approved under Part B are caused by exposure to a toxic substance under Part E, so long as there is covered contractor employment and in the case of deceased employees, which a survivor is found eligible.

CHAPTER 18 – ELIGIBILITY CRITERIA FOR NON-CANCEROUS CONDITIONS

1. Purpose and Scope. This chapter describes the criteria necessary to establish eligibility for non-cancerous conditions covered under Part B and/or Part E of the EEOICPA. The chapter provides a discussion of the steps the CE undertakes in the development of the causal relationship between toxic substance exposure at a covered facility and diagnosed non-cancerous conditions.

2. Approved Part B Illnesses. The EEOICPA provides that a CE may presume an occupational illness approved under Part B relates to a toxic substance exposure under Part E, as long as the employee is a DOE contractor or subcontractor working at a covered DOE or RECA Section 5 facility under Part E. In all instances when issuing a Part E RD based on a Part B acceptance, the CE applies the factual findings of the original Part B FD. This includes the establishment of verified covered employment, diagnosed medical condition(s), and survivor (if applicable) relationship to the deceased employee. Survivors approved under Part B need to establish the distinct survivorship criteria under Part E and provide evidence that it is "at least as likely as not" that the employee's exposure to a toxic substance was a significant factor that aggravated, contributed to, or caused his or her death.

3. Identifying Claimed Condition as Part B, Part E, or Both. The CE first determines whether the type of claim filed is for employee benefits (i.e., Form EE-1) or for survivor benefits (i.e., Form EE-2). Then the CE reviews the condition(s) claimed, either marked or written on the form, and determines whether the claimed condition is potentially covered under Part B, Part E, or both.

Those conditions covered under Part B are beryllium sensitivity, CBD, chronic silicosis, and cancer. Under Part E, consideration extends to any illness claimed as related to an occupational toxic substance exposure, including those covered under Part B. This includes, but is not limited to, diagnosed cancers, respiratory illnesses, cardiac illnesses, and also mental illnesses that originate from a physical condition, such as a neurological condition. An illness or injury that arises because of an accepted Part B or Part E condition is compensable as a consequential condition.

To identify accurately a claimed condition as covered under Part B, Part E, or both, the CE has to evaluate initially the claimed employment, because that is indicative of the type of coverage that extends to the employee. Some types of qualifying employment under Part B do not qualify for coverage under Part E. For example, Part B coverage extends to AWEs, beryllium vendor employees, and DOE contractor/subcontractors and federal employees. Alternatively, Part E coverage extends to DOE subcontractor/contractor employees working at DOE facilities. Part E does not cover employees of AWE, beryllium vendors, or federal agencies, except if the employee worked at an AWE facility or with a beryllium vendor designated as a DOE facility for remediation and the employee worked for the remediation contractor. The CE has to assess properly each claimed medical condition, along with the type of employment claimed, to associate it to the respective Part B or E component.

4. Proof of Covered Employment for Beryllium Illness. For beryllium claims, exposure to beryllium is necessary. The DEEOIC recognizes that the potential for beryllium exposure existed at all beryllium vendor and DOE facilities.

a. Under Part B. To satisfy the employment requirement, the evidence needs to establish either (1) that the employee had at least one day of verified employment at a DOE facility or (2) that the employee was present for at least one day at a DOE facility, or a facility owned and operated by a beryllium vendor.

b. Under Part E. To satisfy the employment requirement under Part E, the employee must have at least one day of verified employment as a DOE contractor or subcontractor at a DOE facility.

5. Beryllium Sensitivity. Beryllium sensitivity is an allergic reaction of the immune system to the presence of beryllium in the body because of contact with beryllium dust particles or fumes. The evidence required to establish beryllium sensitivity is described under 42 U.S.C. §7384l(8)(A) and the CE develops the beryllium claim accordingly, verifying whether or not the medical evidence submitted by the claimant is sufficient.

a. Testing. A claimant establishes beryllium sensitivity under Part B and/or Part E by submitting the results of either one BeLPT or one BeLTT, performed on blood or lung lavage cells, which shows abnormal or positive findings. A claimant can also establish beryllium sensitivity by submitting the results of one beryllium patch test, which shows a positive reaction. The DEEOIC requirement to accept beryllium sensitivity is one abnormal test.

b. Evaluation. A physician is required to validate the results of an abnormal BeLPT/BeLTT or beryllium patch test with his or her findings specifically outlined (e.g., abnormal response to beryllium). A BeLPT/BeLTT or beryllium patch test exhibiting a "borderline" result is not sufficient to establish beryllium sensitivity.

The CE does not attempt to interpret the findings of the BeLPT/BeLTT or the beryllium patch test. If the test is not accompanied by a physician's interpretation, the CE obtains the interpretation from the physician who performed the test. If the testing physician is not available, the CE obtains an evaluation from another qualified physician (e.g., a CMC).

c. False Negative Results. If a claimant has a history of steroid use, a false negative result on a BeLPT/BeLTT or the beryllium patch test can occur. DEEOIC will accept that a false negative test qualifies as an abnormal BeLPT/BeLTT only when a physician provides a well-rationalized opinion supporting the contention that a normal BeLPT/BeLTT represents a false-negative result. The opinion of the physician must align with the objective medical evidence of record including that the patient used steroid medication at the time of BeLPT/BeLTT testing.

d. Definitions. A BeLPT/BeLTT is a laboratory test that measures how a type of disease-fighting blood cell, called a lymphocyte, reacts to beryllium. The blood cells' reaction to beryllium determines whether the test results are normal or abnormal. If the cells do not react sufficiently to beryllium, the test result is normal; if the cells react very strongly to beryllium, the test result is abnormal. The Bronchoalveolar Lavage LPT is a laboratory test performed on lung tissue that is washed from the lungs. The lung wash contains lung tissue obtained via an intranasal insertion of a bronchoscope into the lung. When the bronchoscope is lowered into the lower lung, a saline solution is washed into the airways and retrieved (lung washing). The retrieved solution is cultured in the presence of beryllium salts. A reaction or response to the beryllium salts represents a lymphocytic process and is sufficient to establish beryllium sensitivity.

e. Benefits Under Part B. Once the medical, employment, and causation criteria are satisfied for a beryllium sensitivity claim under Part B, the employee receives medical monitoring (which includes all tests for CBD), treatment, and therapy for the condition effective on the date of filing. Unlike for CBD, the Act provides for no lump-sum compensation for beryllium sensitivity under Part B.

f. Benefits Under Part E. Once the medical, employment, and causation criteria are satisfied for a beryllium sensitivity claim under Part E, the employee receives medical monitoring, treatment, and therapy for the condition effective on the date of filing. In addition, the employee is eligible for lump-sum compensation for impairment and/or wage-loss if the CE finds that the criteria for those benefits are satisfied.

6. Established CBD Before 1993, Part B. The evidence required to establish a claim for established CBD under Part B of the Act is described under 42 U.S.C. §7384l(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested positive for, diagnosed with, and/or treated for a chronic respiratory disorder.

If the earliest dated document showing that the employee was tested positive for, treated for, or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria should be used. Evidence of a chronic respiratory disorder includes records communicating existence of a long term, prolonged pulmonary disease process. References to acute pulmonary conditions, such as short-term pulmonary distress associated with temporary viral or bacterial infection do not qualify as a chronic respiratory disorder. Pulmonary testing performed in occupational or medical settings, which identify abnormalities, are not appropriate to document a chronic respiratory disorder, unless interpreted as such by a physician. In situations where it is critical that the question of whether historical documentation communicates the existence of a chronic respiratory disorder, the CE is to undertake development to allow for a physician chosen by the claimant to provide clarification, or when the claimant is unable to provide such evidence, seek the input of a CMC.

If the earliest dated document showing a chronic respiratory disorder lists a date after January 1, 1993, the post-1993 CBD criteria should be used. If the employee sought treatment before 1993,

but the medical documentation relating to the treating document is dated on or after January 1, 1993, the pre-1993 CBD criteria should be used. In this situation, the medical evidence is to clearly communicate the fact that treatment occurred prior to 1993.

To establish pre-1993 CBD, the medical documentation is to include at least three of the following: characteristic chest radiographic [or computed tomography (CT)] abnormalities; restrictive or obstructive lung physiology testing or diffusing lung capacity defect; lung pathology consistent with CBD (including the results of an abnormal mediastinal lymph node biopsy); a clinical course consistent with a chronic respiratory disorder, or immunologic tests showing beryllium sensitivity (e.g., skin patch test or beryllium blood test preferred). Once it is established that the employee had a chronic respiratory disorder prior to 1993, the CE is not limited to the use of medical reports dated prior to 1993 to meet three of the five criteria.

a. Characteristic Chest Radiograph (X-ray). In a chest X-ray, rays are emitted through the chest and the image is projected onto film, creating a picture of the image. Chest X-ray findings that a physician may commonly communicate as characteristic of CBD include:

(1) Small round areas of opacity distributed throughout all of the lung fields. Mixtures of round and irregular areas of opacity are also often seen.

(2) Other characteristic X-ray findings include interstitial lung fibrosis, interstitial or pleural fibrosis (i.e., pleural fibrosis alone is not sufficient, as there have to be other findings present), and granulomas (i.e., non-calcified and non-caseating).

(a) Caseating granulomas are sometimes considered characteristic; however, the treating physician or a CMC needs to review these findings for a determination. The term “caseating” identifies necrosis (i.e., decay) in the center of a granuloma. This term was originally applied to a granuloma associated with tuberculosis or a fungal infection. A non-caseating granuloma is one without necrosis and is characteristic of CBD.

(b) Calcification in a granuloma is usually associated with the healing of the granuloma. A calcified granuloma is not characteristic of CBD.

(3) Coarse linear fibrosis is sometimes found with advanced CBD which results in progressive loss of lung volume.

b. CT Scan. A CT scan uses X-rays to produce detailed pictures of structures inside the body. Each X-ray pulse lasts only a fraction of a second and represents a “slice” of the organ or area being studied. A CT scan is sometimes referred to as a CAT (computed axial tomography) scan. CT scan abnormalities a physician may reference as indicative of CBD include the following:

(1) Consolidation, ground glass, septal thickening, diffuse nodules (different distributions), interstitial fibrosis, bronchiectasis, and honeycombing.

(2) Other CT scan findings include parenchymal nodules, septal lines, patches of ground-glass attenuation, bronchial wall thickening, and thickening of the interlobular septa. Nodules are often seen clustered together around the bronchi or in the subpleural region. Subpleural clusters of nodules sometimes form pseudo plaques. In advanced CBD, large subpleural cysts are sometimes found.

c. Radiographic Patterns. The following list represents radiographic (X-ray/CT) patterns that a physician may reference as characteristic of CBD:

Chest X-ray	CT/*HRCT
Alveolar Patterns	Alveolar Patterns
- Consolidation	- Consolidation
- Ground glass	- Ground glass
Interstitial Patterns	Interstitial Patterns
- Reticular (irregular lines)	- Septal thickening
- Diffuse Nodules	- Diffuse Nodules (different distributions)
- Reticulonodular	- Ground glass
Interstitial Fibrosis	Interstitial Fibrosis
- Honeycombing	- Traction Bronchiectasis
- Upper lobe retraction	- Honeycombing
*HRCT = high-resolution computed tomography	

d. Restrictive or Obstructive Lung Physiology Testing or Diffusing Lung Capacity Defect. Obstruction, either severe or mild, is the most common abnormality found by spirometry. Severe obstruction prevents complete exhalation (i.e., air trapping). A definitive diagnosis of restriction (e.g., reduced lung volumes) through spirometry is not made without lung volumes. Generally, the pulmonary function studies include the physician's interpretation of whether there is restriction or obstruction.

e. Arterial Blood Gas (ABG). An ABG test is not used in lieu of a PFT. There are many factors involved in interpreting an ABG test. If the CE is unable to obtain a PFT and the ABG test is the only test available, the treating physician or a CMC needs to review the ABG test results along with the medical evidence of record to determine whether it is indicative of a restrictive or an obstructive lung physiology. An ABG test result generally does not show a diffusing lung capacity defect.

f. Pathology Report. A physician may reference the existence of lung pathology consistent with CBD in a pathology report. The opinion of the physician will

generally result in his or her examination of specific diagnostic test results or other results from examination. If a pathology report does not include a physician's interpretation, or if the CE is unsure whether the findings are consistent with CBD, the CE obtains clarification from the treating physician or a CMC.

g. Clinical course consistent with chronic respiratory disorder may include the following disorders and methods of treatment that a physician finds relevant in his or her assessment relating to CBD:

(1) Hypoxemia requires supplemental oxygen and supplies.

(2) Air flow obstruction (e.g., COPD, emphysema) and asthma/wheezing-like symptoms require inhalers (e.g., Flovent, Advair, Serevent, Albuterol, etc.), corticosteroid drugs, bronchodilators, and oxygen therapy.

(3) Right heart failure, Cor pulmonale: Cardiology consult and subsequent management, diuretics (e.g., Lasix, HCTZ, Spironolactone, etc.), supplemental oxygen.

(4) Pulmonary Hypertension: Cardiology consult and subsequent management, supplemental oxygen.

(5) Respiratory infections (pneumonia, acute bronchitis): Antibiotics, sputum cultures, blood cultures, sometimes bronchoscopy.

(6) Sarcoidosis: corticosteroid drugs, such as Prednisone.

h. Immunologic Tests. Examples of immunologic tests that establish beryllium sensitivity include skin patch tests and beryllium blood tests which involve the interaction of antigens with antibodies.

7. Established CBD On/After January 1, 1993, Part B. The medical documentation needs to include an abnormal BeLPT/BeLTT performed on either blood or lung lavage cells or a positive beryllium patch test, in addition to evidence of lung pathology consistent with CBD. Proof of lung pathology consistent with CBD includes, but is not limited to: a lung biopsy showing granulomas or a lymphocytic process consistent with CBD; a CAT scan showing changes consistent with CBD; or a pulmonary function or exercise test showing pulmonary deficits consistent with CBD.

In addition to the three criteria listed, a mediastinal lymph node biopsy interpreted by a physician as evidence of "lung pathology consistent with CBD" may be used to establish CBD. A mediastinal lymph node biopsy is not the equivalent of a "lung biopsy" and, as such, does not substitute for such in the assessment of a post-1993 CBD claim. The evidence has to be interpreted as "lung pathology." A mediastinal lymph node is not dispositive proof of CBD in the same way as a lung biopsy.

a. Lung Biopsy.

(1) The term "lung biopsy" is any sampling of lung tissue to assess the possibility of disease. Lung tissue samples include any one of the following:

(a) Lung tissue obtained from whole lung specimens at the time of an autopsy;

(b) Lung tissue obtained by open or video-assisted thoracotomy;

(c) Lung tissue obtained by bronchoscopic transbronchial biopsy; or

(d) Lung tissue obtained by bronchoalveolar lavage, which includes alveolar and bronchial epithelial cells, macrophages, lymphocytes, neutrophils, eosinophils, and other lung cells.

Tissue samples obtained by any one of these methods are used to document the presence of a lymphocytic process consistent with CBD.

(2) In claims where a normal or borderline BeLPT/BeLTT has been interpreted by a physician as false-negative result due to steroid use, and a lung tissue biopsy has been performed, the CE is to obtain a medical opinion from the employee's physician explaining whether the biopsy results is interpreted as "consistent with CBD." The physician must provide his or her opinion that explains what aspects of the biopsy objectively support that the results reasonably represent a disease process consistent with CBD. In the absence of a rationalized opinion from the employee's physician, the CE is to refer the medical evidence to a CMC for analysis and opinion. Once a normal BeLPT/BeLTT has been interpreted by a physician as false-negative result and a rationalized opinion from a qualified physician establishing that the results of a lung biopsy is consistent with CBD has been received, the CE may accept the claim**.**

b. Lymphocytic Process. A lymphocytic process consistent with CBD is measured in the lung by any one of the following methods:

(1) Biopsies showing lymphocytes (i.e., part of the population of so-called mononuclear cells) in bronchial or interstitial (alveolar) lung tissue;

(2) Biopsies showing non-caseating granuloma;

(3) Bronchoalveolar lavage showing an increase in the percentage of lymphocytes in the differential cell count (i.e., typically >15%

lymphocytes is considered a BAL lymphocytosis, but physician interpretation is paramount); or

(4) Bronchoalveolar lavage beryllium LPT showing that the lymphocytes washed from the lungs react/respond to beryllium salts. This includes an abnormal BeLPT/BeLTT, performed on either blood or lung lavage cells, or a positive beryllium patch test.

c. CAT Scan. A CAT scan uses X-rays and computers to produce an image of a cross-section of the body. For post-1993 CBD claims, a physician evaluates the results of the CAT scan for a determination on whether the findings are consistent with CBD.

d. Pulmonary Function or Exercise Testing. For this criterion, the treating physician or a CMC evaluates the results of the pulmonary function study or exercise tests for a determination on whether or not the deficits are consistent with CBD.

8. Established CBD Decisions, Part B. The pre-1993 CBD criteria are recognized as generalized because before 1993, it was difficult to confirm beryllium sensitization. As such, the respiratory problems potentially related to beryllium were often misdiagnosed and thought to be related to other causal factors. After 1993, diagnostic measures reliably identified a patient's sensitivity to beryllium and linked it to the potential onset of CBD. As such, the post-1993 CBD criteria are significantly more accurate for confirming or negating the existence of beryllium sensitization and CBD.

a. Conflicting Medical Evidence. During the adjudication process, there are instances when the CE encounters claims containing conflicts between the pre-1993 and post-1993 standard. This will most commonly occur where the pre-1993 criteria apply, but post-1993 evidence exists suggestive that an employee does not have CBD. For example, a claim contains a post-1993 BeLPT with normal results and medical evidence meeting the pre-1993 CBD criteria (i.e., evidence of chronic respiratory disorder prior to 1993 and three of the five diagnostic criteria). In these situations, the CE proceeds with acceptance, if the necessary criteria for a pre-1993 or post-1993 CBD claim are met.

b. Referral to a CMC. CEs should refer claims to a CMC for a medical review after all means of obtaining the evidence from the treating physician is exhausted. The CE may also refer cases to a CMC when the medical reports and/or tests do not include a clear interpretation and/or if there is a specific question(s) about the medical evidence. When the CE makes a referral to a CMC, he or she is to send relevant medical records in the case file to the CMC for review. Examples of situations when a referral is needed include:

(1) Assessment of pre-1993 medical evidence to determine if the claimant suffered from a chronic respiratory disorder;

(2) Medical test results that do not provide a clear interpretation (e.g., pathology report, BeLPT, X-ray, CT scan); and

(3) Pre-1993 and/or post-1993 CBD tests (e.g., chest X-ray, diffusion lung capacity defect, lung biopsy showing granulomas, lymphocytic process, or pulmonary function study) that do not denote abnormalities or defects, contain the finding "consistent with CBD", or are inconclusive.

The opinion of the CMC, when properly supported by medical rationale, carries significant probative value. However, the CE has to assess carefully the weight of medical evidence whenever there is a conflict between two physicians. The CE is to communicate clearly his or her assessment of the weight of medical evidence in any RD to clearly explain the reasons why one physician's opinion takes precedence over another.

c. Beryllium Sensitivity Decision When CBD Is Claimed. When CBD is claimed on Form EE-1 for a living employee, but evidence supports the existence of beryllium sensitivity only, the CE issues a RD to accept for beryllium sensitivity and deny the claim for CBD. If at a later date, the DO receives evidence that the employee's beryllium sensitivity has progressed to CBD, it can initiate a reopening to resume development of the existing CBD claim. The claimant may also file a reopening request to resume development of his or her CBD claim, if new medical evidence supports the claim.

9. Beryllium Sensitivity and CBD, Part E. A BeLPT or BeLTT are definitive tests for confirming beryllium sensitivity. As such, a positive BeLPT or BeLTT is required for any Part E claim for CBD that cannot be processed based on a positive determination under Part B. For additional discussion regarding the requirements for establishing beryllium sensitivity, refer to Section 5 (Beryllium Sensitivity) of this chapter.

a. Beryllium Sensitivity. As under Part B, beryllium sensitivity is established by submitting the results of one beryllium patch test, one abnormal beryllium LPT or LTT result indicating that an employee's blood shows an abnormal proliferative response to beryllium sulfate.

b. Physician Narrative. A Part B FD under the EEOICPA approving beryllium sensitivity or CBD is sufficient to establish the diagnosis and causation under Part E. However, if there is no Part B decision, in addition to a positive BeLPT or BeLTT, the claimant is to submit a rationalized medical report including a diagnosis of CBD from a qualified physician to establish CBD under Part E. The rationalized report should contain an evaluation of the employee's medical condition and the physician's opinion whether it is "at least as likely as not" that exposure to beryllium at a DOE covered facility was a significant factor in aggravating, contributing to, or causing the CBD.

c. Referral to CMC. If the CE determines that the totality of the evidence is inconclusive in establishing the diagnosis or causation for the claimed condition,

he or she is to refer the matter to a CMC for review. This is especially true if the treating physician is unavailable or unable to provide the necessary information.

d. Causal Relationship, Survivor Development. When a survivor claim for CBD is accepted under Part B and an "Other Chronic Pulmonary Disease" is listed on the death certificate as contributing to or causing the employee's death, the CE concludes that it is "at least as likely as not" that the presence of CBD, or the chronic respiratory disorder consistent with CBD, aggravated or contributed to the "Other Chronic Pulmonary Disease," and therefore to the employee's death. The accepted "Other Chronic Pulmonary Diseases" are:

(1) Asbestosis;

(2) Silicosis;

(3) COPD;

(4) Emphysema; and

(5) Pulmonary Fibrosis

Once the CE has collected the medical, employment, and causation evidence necessary for a beryllium sensitivity or CBD claim under Part E, the employee receives medical monitoring, treatment, and therapy for the condition(s) effective to the date of filing. In addition, the employee is eligible for lump-sum compensation for impairment and/or wage-loss. In the case of a deceased employee, if the evidence supports that he or she had work-related CBD that contributed to death, the employee's qualified survivors are eligible for lump-sum compensation.

10. Presumption of CBD, Diagnosis of Sarcoidosis, and History of Beryllium Exposure. Sarcoidosis is a disease that represents as inflammation of cells that form into nodules or granulomas. Sarcoidosis can occur in different organ systems. Under Part B, the DEEOIC recognizes that a diagnosis of pulmonary sarcoidosis, especially in cases with pre-1993 diagnosis dates, could represent a misdiagnosis for CBD. As such, a diagnosis of pulmonary sarcoidosis is not medically appropriate under Part B if there is a documented history of beryllium exposure. In those situations, a diagnosis of sarcoidosis is evaluated as a claim for beryllium sensitivity and/or CBD. Under Part E, if there is a diagnosis of pulmonary sarcoidosis, but no affirmative evidence in the form of a positive BeLPT or BeLTT exists, the CE adjudicates the condition as sarcoidosis, not CBD.

Part B of the EEOICPA specifies diagnostic criteria necessary to qualify for compensation. As such, in the case of a diagnosed pulmonary sarcoidosis being treated as beryllium sensitivity or CBD, it is necessary for the CE to obtain the evidence satisfying pre-1993 or post-1993 CBD criteria enumerated under the Act.

For a Part E claim, the CE can evaluate a pulmonary sarcoidosis claim as CBD; however, a positive BeLPT or BeLTT is necessary to accept a diagnosis of beryllium sensitivity/CBD under

Part E. Without affirmative evidence in the form of a positive beryllium BeLPT or BeLTT, the CE is to proceed with the adjudication of the claim as one for a diagnosis of sarcoidosis.

In cases where there is medical evidence that establishes a diagnosis of pulmonary sarcoidosis and a positive BeLPT or BeLTT, the CE is to obtain a physician's opinion regarding whether it is "at least as likely as not" that exposure was a significant factor in aggravating, contributing to, or causing CBD.

11. Consequential Illnesses from CBD or its Treatment. For information about consequential illnesses from CBD, see Chapter 23, Consequential Conditions.

12. Silicosis. Chronic silicosis is a non-malignant disease of the lung caused by prolonged exposure to silica dust. Under Part B, if all covered employment and exposure criteria are met, only chronic silicosis is covered. However under Part E, if all covered employment and exposure criteria are met, chronic silicosis, acute silicosis, accelerated silicosis, and complicated silicosis are covered.

If chronic silicosis, acute silicosis, accelerated silicosis, or complicated silicosis is claimed on the Form EE-1 or EE-2, then the CE develops for that specific silicosis under the appropriate Part(s) of the Act.

a. Silicosis Employment and Exposure Criteria, Part B. 42 U.S.C. §7384r(c) and (d) describe the employment requirements for an employee diagnosed with chronic silicosis. The CE reviews the evidence to ensure that the employee was:

(1) A DOE employee or a DOE contractor employee; and

(2) Present for an aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon (Part B claims only). This tunnel work occurred through October 1992, at which time the unilateral moratorium on nuclear weapons testing went into effect.

b. Medical Evidence. 42 U.S.C. §7384r(e) describes the medical evidence needed to establish a diagnosis of chronic silicosis. The CE verifies that all the necessary medical evidence is present in accordance with the requirements listed in the statute, as follows:

(1) The initial occupational exposure to silica dust preceded the onset of chronic silicosis by at least 10 years; and

(2) A written medical narrative from a qualified physician that includes a diagnosis of chronic silicosis and the date of initial onset. In addition, one of the following is required:

(a) A chest radiograph, interpreted by a physician certified by the NIOSH as a B-reader (physician's signature not required),

classifying the existence of pneumoconiosis of category 1/0 or higher;

(b) Results from a computer assisted tomograph or other imaging technique that are consistent with chronic silicosis; or

(c) Lung biopsy findings consistent with chronic silicosis.

Upon review of the evidence submitted, the CE verifies the presence of the necessary medical and diagnostic evidence to support a diagnosis of chronic silicosis. If deficiencies are noted, the CE requests evidence from the claimant and/or the treating physician.

c. Silicosis Employment and Exposure Criteria, Part E. Silica exposure in the performance of duty is assumed if the employee was present at a DOE or RECA Section 5 facility where silica is known to have been present. There are no required number of days of employment under Part E. The initial occupational exposure to silica dust needs to precede the onset of silicosis by at least 10 years. However, there are instances where an employee's initial occupational exposure to silica dust can be great enough to result in the onset of silicosis prior to 10 years. Therefore, the CE reviews the employment evidence and weighs the exposure evidence, accordingly, when making causation determinations.

The provisions regarding separate treatment for chronic silicosis set forth in §7384r of the Act for Part B do not apply to Part E. Therefore, for purposes of evaluating the employee's Part E claim for silicosis, the element of causation is not presumed unless it was determined that the employee was entitled to compensation under Part B for silicosis (see §7385s-4(a)) or the Secretary of Energy has made a positive determination of causation (see §7385s-4(b)). In all other cases of claimed silicosis under Part E, the employment and exposure criteria applicable to all other claimed illnesses under Part E shall also apply to silicosis claims; that is, the employee must have been a DOE contractor employee and it must be "at least as likely as not" that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to, or causing the employee's silicosis and it must be "at least as likely as not" that the exposure to such toxic substance was related to employment at a DOE facility.

Silicosis is a nonmalignant respiratory disease covered under RECA Section 5. Therefore, for purposes of evaluating the Part E silicosis claim of a uranium employee covered under Section 5 of RECA, the DOJ verifies covered employment and the CE makes the causation determination under §7385s-4(c) as to whether the employee contracted silicosis through exposure to a toxic substance at a Section 5 mine or mill.

(1) Exceptions – Acute, Accelerated, and Complicated Silicosis. The extreme nature, function, or duration of exposure can trigger various forms of silicosis. The CE determines whether or not the employee's occupation

entailed such exposure that the disease manifested into an acute, accelerated, or complicated form due to such exposure. These forms of silicosis are not covered under Part B, but are covered under Part E based upon the CE's review of the totality of the evidence.

(2) Employment and Exposure Evidence. The CE obtains evidence of employment and exposure from various sources. The DOJ verifies employment for RECA Section 5 claimants. The CE obtains other evidence from DAR records, DOE FWP records, SEM, employment records, OHQ findings, affidavits, and from the claimant.

d. Medical Evidence, Part E. A physician's written diagnosis and date of initial onset is required to establish silicosis.

When there is insufficient evidence of exposure, diagnostic testing, and/or diagnosis, the CE requests additional information from the claimant and affords the claimant sufficient time to respond.

Where no diagnosis exists, but the required employment element is met and evidence of a lung disease is presented, the CE requests additional medical evidence to establish the diagnosis of silicosis from either the claimant and/or the treating physician, or makes a referral to a CMC if the requested evidence is not submitted. The CE evaluates the CMC opinion and the evidence of file to make a factual determination as to the diagnosis and/or causation.

13. Pneumoconiosis, Part E. Pneumoconiosis is caused by the deposition of particulate matter, such as coal dust, asbestos, and silica in the lungs. Pneumoconiosis is oftentimes a broad categorization physicians use for various subtypes of pulmonary disease. For example, asbestosis is a type of pneumoconiosis, as is silicosis. The CE 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." It is not appropriate for a CE to make assumptions beyond these that a diagnosis of pneumoconiosis is equivalent to any number of its subtypes without seeking clarification from a physician. Pneumoconiosis is a Part E covered illness only. A physician's diagnosis of pneumoconiosis can be supported by clinical evidence from the physician, along with other affirmative diagnostic evidence including:

a. A written diagnosis of pneumoconiosis made by a physician;

b. Results from a breathing test (e.g., a PFT or spirometry) showing a restrictive lung pattern of an FVC less than 80% predicted;

c. A chest radiograph, interpreted by a NIOSH certified B reader classifying the existence of pneumoconiosis of category 1/0 or higher;

d. Results from a chest X-ray, CT or other imaging technique that are consistent with asbestosis and/or findings of pleural plaques or rounded atelectasis; or

e. Lung biopsy findings consistent with pneumoconiosis.

14. Asbestosis, Part E. Asbestosis or asbestos-related lung disease is a chronic, progressive pulmonary disease caused by the inhalation and accumulation of asbestos particles or fibers in the lungs. Asbestosis is a Part E covered illness only.

Asbestosis is characterized by extensive pulmonary interstitial fibrosis (e.g., scarring) and pleural thickening. Progressive thickening and scar formation of the lung tissues occur along with associated loss of respiratory function. These developments are noticeable in the lower part of the lungs because this area of the lungs receives a greater part of the inhaled load of particulate matter. In assessing claims for an employee with a diagnosis of asbestosis, the CE is to consider several factors when adjudicating the claim:

a. Employment/Exposure Requirements. The CE verifies that the employee was a covered DOE contractor employee at a covered DOE or RECA Section 5 facility, during a covered time period, and in the course of employment was exposed to asbestos while at the DOE or RECA Section 5 facility.

b. Medical Evidence. Various types of medical evidence can support a physician's asbestosis diagnosis. Not all types of medical evidence need to be present, and the CE weighs the evidence as a whole to make a determination. A diagnosis of asbestosis is established with the presentation of medical evidence that identifies the employee as having developed the condition, along with a date of diagnosis. Sources of evidence include:

(1) The opinion of a qualified physician that available medical and diagnostic evidence is sufficiently probative to document a diagnosis of asbestosis. In instances where the evidence is suggestive of an asbestos-related lung disease and further development with the claimant or treating physician has been unsuccessful, the CE is to refer the matter to a CMC for review. Diagnostic evidence that is indicative of asbestosis or asbestos-related lung disease includes:

(a) Chest X-ray reports that show pulmonary interstitial fibrosis and cardiac enlargement are regarded as characteristic of asbestosis. The CE takes into account such findings as possibly indicative of asbestosis, based upon the totality of the evidence. However, cardiac enlargement is not always seen with asbestosis. Therefore, if cardiac enlargement is not noted in the chest X-ray report, the CE still considers the possibility of asbestosis, based upon the totality of the evidence.

(b) CAT and MRI that show characteristic lung scarring, pleural thickening, and cardiac enlargement are also possible indications of asbestosis.

(c) A PFT reveals pulmonary function and capacity. Asbestosis typically restricts pulmonary function; therefore, total lung capacity, vital capacity, compliance measurements, and pulmonary diffusing capacity are reduced if asbestosis is present. It is necessary that the CE obtains a physician evaluation of the PFT results.

(d) A lung biopsy is a sampling of lung tissue. Cytological examination of the sputum or bronchial lavage often shows the presence of asbestos bodies. This test is not considered as definitive for the diagnosis of asbestosis because it is commonly positive in cases of asbestos exposure alone and is seen in other populations such as hematite (i.e., iron ore) miners.

(2) DOE FWP results which document assessment with abnormal diagnostic findings and physician assessment resulting in a positive finding of asbestosis or asbestos-related lung disease.

(3) Asbestosis identified on the death certificate, signed by a physician, as a cause of or contributing factor to death establishes a diagnosis. If the death certificate shows any respiratory illness other than asbestosis, the CE needs to obtain a well-rationalized conclusion from a physician that asbestosis contributed to the death based on the totality of the medical evidence contained in the file. If the evidence supports a diagnosis of asbestosis and the death certificate lists the cause of death as pneumoconiosis, the CE is to presume that causation to death is established.

c. Assessing asbestosis claims. DEEOIC accepts that asbestos was a common toxic substance that existed throughout all DOE facilities. While asbestos did exist at DOE facilities, the nature of an employee's exposure would have varied based on different factors such as the period that the employee worked, the type of work performed, and the location of employment.

15. Idiopathic Disease Diagnosis. "Idiopathic" means that the causative agent is unknown. However, in the case of pulmonary fibrosis, peripheral neuropathy/polyneuropathy, and interstitial pneumonitis, DEEOIC maintains health effect data for these commonly referenced idiopathic conditions that could allow a physician to render an opinion on the potential work-relatedness of the underlying medical condition.

In claims that present with medical evidence characterizing one of the above medical conditions as idiopathic, the CE is to treat those illnesses as potentially work-related and he or she is to evaluate the condition without consideration given to the idiopathic designation. With the identification of any potential exposures associated with the employee's work at a covered site, an Industrial Hygienist's referral, followed by a review of the claim by the claimant's treating physician or a Contract Medical Consultant, as appropriate, must occur.

Regardless of whether or not DEEOIC maintains health effect data on a medical condition labeled as idiopathic, CEs may not presume that the condition is unrelated to toxic substance exposure and deny it without development. For a medical condition labeled as idiopathic, with no available health effect data relating to the underlying condition, the CE is to undertake development as outlined in Chapter 15 - Establishing Toxic Substance Exposure and Causation, including asking the claimant to submit any medical or health effect information that could associate the claimed medical condition to the employee's exposure to a toxic substance.

16. Medical Conditions Associated with Asbestos Exposures.

a. Mesothelioma. Mesothelioma is a rare cancer of the pleura that is caused almost exclusively by asbestos exposure. Because of this relationship to asbestos, any Part E claims involving a confirmed diagnosis of mesothelioma are accepted, given the requirements for asbestos exposure at a covered facility (e.g., medical and diagnostic requirements, employment/exposure requirements) have been met.

b. Pleural Plaques and Pleural Effusions. Pleural plaques and pleural effusions are considered conditions caused by asbestos, but do not constitute an asbestosis diagnosis or finding. If a claim is made for asbestosis but only pleural plaques or pleural effusions can be accepted, the CE issues a RD to deny the claim for asbestosis and accept for pleural plaques or pleural effusions.
If at a later date, the DO receives evidence that the employee's pleural plaques or pleural effusions has progressed to asbestosis, it can initiate a reopening to resume development of the existing asbestosis claim. The claimant may also file a reopening request to resume development of his or her asbestosis claim, if new medical evidence supports the claim. In addition, it is possible for pleural plaques or pleural effusions to result in an impairment rating and/or wage- loss.

(1) Medical evidence supporting a claim for pleural plaques and pleural effusions includes the following:

(a) A diagnosis of pleural plaques or pleural effusions made by a physician;

(b) Medical evidence as established by the results from a chest X-ray, CT scan, or other imaging technique that are consistent with pleural plaques or pleural effusions, as evidenced by any of the following findings:

(i) Pleural plaques;

(ii) Pleural thickening, not associated with an area of prior surgery or trauma;

(iii) Rounded atelectasis; or

(iv) Bilateral pleural effusions, also known as benign asbestos-related pleural effusion.

(2) When development is to occur with the claimant's physician or CMC:

(a) If the totality of the medical evidence is inconclusive or insufficient to establish a diagnosis of pleural plaques or pleural effusions.

(b) If the results from a chest X-ray, CT, or other imaging technique are consistent with any of the following findings:

(i) Pleural thickening in an area of prior surgery or trauma; or

(ii) Pleural effusions, only if the record does not indicate that there is another disease process that would otherwise account for the effusion, such as congestive heart failure (CHF), cancer, or other lung disease;

c. Lung Fibrosis (Pulmonary Fibrosis). Lung fibrosis is commonly referred to as scarring of the lung. With lung fibrosis, normal lung tissue is replaced by the accumulation of connective fibrosis tissue.

(1) Medical Evidence of lung fibrosis. A diagnosis of lung fibrosis is made by a physician and is generally supported by diagnostic evidence including:

(a) Results from a chest X-ray, CT scan, or other imaging technique that are consistent with fibrosis such as small lung fields or volumes, minimal ground glass opacities, and/or bibasilar reticular abnormalities;

(b) Results of breathing tests (e.g., PFTs or spirometry) showing a restrictive or mixed pattern, such as FVC less than 80% predicted; or,

(c) Lung biopsy findings consistent with fibrosis; and,

(d) The medical evidence does not contain any indication that the lung fibrosis is present due to another disease process.

(2) Synonymous fibrotic lung conditions. DEEOIC has determined that respiratory illnesses such as restrictive/interstitial lung disease, pulmonary fibrosis and/or pneumoconiosis generally refer to the same disease process. These illnesses include a process by which normal lung tissue is replaced by fibrotic (scar) tissue that interferes with normal lung functioning. This process results in the irreversible loss of oxygen

diffusion, which is the capacity of the lung to transfer carbon dioxide in the bloodstream. As such, the DEEOIC made a programmatic determination to treat these terms/claimed conditions, for purposes of developing Part E cases under EEOICPA, synonymously.
DEEOIC guidelines on fibrotic lung diagnoses provide that for synonymous and interchangeable diagnoses in terms of development and adjudication, the CE has been directed not to develop for each of these fibrotic lung conditions as a separate claim as they are essentially the same diagnosis to the same organ. The guidelines also note that if it is determined that "it is at least as likely as not that exposure to a toxic substance at a DOE facility was a significant factor in aggravating, contributing to or causing" the pneumoconiosis, pulmonary fibrosis, or interstitial lung disease of the employee, then accept all of the conditions, provided there is a valid medical diagnosis in the case file.

17. COPD. COPD is a disease that causes airflow blockage and breathing-related problems.

a. Evaluating Medical Evidence. Any one of the following tests below can provide an indication of COPD, but a diagnosis is not based solely on one of the following criteria. The CE weighs all the medical evidence before making a finding.
All test results are to be accompanied by a physician's interpretation in order to have probative value. If a physician's interpretation is not available, the CE seeks such interpretation from either the treating physician or a CMC.

(1) ABG Test. Abnormal results from the blood gas components include such findings as the body is not getting enough oxygen, is not getting rid of enough carbon dioxide, or that there is a problem with kidney function.

(2) Consistent Chest X-rays/CAT scans. Chest X-ray results vary and show interstitial patterns, scarring, and other abnormalities.

(3) Abnormal Spirometry. The Spirometer measures air flow and air volume. An abnormal reading includes an indication of COPD or some other lung condition.

(4) Bronchoscopy. A bronchoscopy is used by physicians to examine the major air passages of the lungs. A finding of an obstruction in the air passages includes an indication of COPD or some other lung condition.

18. Parkinsonism. Parkinsonism is a neurological disorder or syndrome that can arise from a number or sources, including toxic exposure, drugs, and Parkinson's disease (PD). There is no clinical test or method for distinguishing Parkinsonism from PD and the two terms are often used interchangeably since the symptoms are the same. For the purpose of claim adjudication under Part E, the CE is to consider the medical conditions of PD, Parkinsonism, or any other reasonable alias as synonymous.

19. Other Conditions. With the wide variety of conditions claimed under Part E, this chapter cannot address all common diagnostic or clinical characteristics for every particular diagnosis. Ultimately, the CE uses his or her best judgment in weighing the probative value of available medical evidence to ascertain a diagnosis. The establishment of a diagnosis requires that a qualified physician apply sound medical reasoning to interpret available clinical or diagnostic evidence to identify a disease or disorder. In those instances where the CE cannot establish that the weight of medical evidence supports a diagnosis, the CE is to seek clarification from the claimant's treating physician. If the CE is unable to obtain clarification from the treating physician or in instances where the claimant is not currently under the care of a physician, the CE may seek clarification of a medical diagnosis from a CMC.

CHAPTER 19 – ELIGIBILITY REQUIREMENTS FOR CERTAIN URANIUM WORKERS

1. Purpose and Scope. This chapter describes the policy and procedures the DEEOIC follows for processing claims involving uranium miners, millers, and ore transporters who worked at facilities covered by Section 5 of the RECA and, where applicable, the survivors of such employees. This chapter also describes the policy and procedures for processing claims involving claimants who applied for an award under Section 4 of the RECA.

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

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

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

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

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

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

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

b. Section 4 of RECA covers the following individuals for compensation coverage:

(1) Downwinders. DOJ will make a payment of $50,000 to eligible individuals. Criteria for downwinder coverage include the following:

(a) Individuals who were physically present in one of the affected areas downwind of the Nevada Test Site during a period of atmospheric nuclear testing, and who later developed a covered illness.

(b) Covered illnesses are Leukemia (other than CLL), multiple myeloma, lymphomas (other than Hodgkin's disease), and primary cancer of the thyroid, male or female breast, esophagus, stomach, pharynx, small intestine, pancreas, bile ducts, gall bladder, salivary gland, urinary bladder, brain, colon, ovary, liver (except if cirrhosis or hepatitis B is indicated), or lung.

(2) Onsite Participants. DOJ will make a payment of $75,000 to eligible individuals. Criteria for onsite participant coverage include the following:

(a) Individuals who participated onsite in a test involving the atmospheric detonation of a nuclear device, and who later developed a covered illness.

(b) Covered illnesses for onsite participants are the same as for downwinders.

c. Individuals who receive compensation under RECA Section 4 are not eligible for benefits under Part B of the Act.

3. How DEEOIC Identifies a RECA Section 5 Uranium Worker Claim. DEEOIC can identify a claim submitted by a RECA Section 5 uranium worker, or an eligible surviving beneficiary of such uranium worker, by reviewing the information provided on the EE-1 or EE-2. If the claimant marks on the EE-1 or EE-2 that he or she applied for or received an award under Section 5 of RECA, the assigned CE develops the claim in accordance with the guidance set out under this chapter. In cases where the EE-1 or EE-2 does not specify that the employee has applied for or received a RECA Section 5 determination from DOJ, but there is some indication (such as employment history) that the claimant may be eligible under Section 5 of the RECA, the CE must review other evidence contained in the file to confirm or rule out potential RECA eligibility. When appropriate, the CE must contact the claimant, or DOJ, to seek information on the status, or potential eligibility, of any RECA claim.

4. Obtaining Information From DOJ Regarding RECA Claim Status. In all cases where a claimant files for EEOICPA benefits based on the filing, or indication of filing, for RECA benefits, the CE must seek information from DOJ about the status of the RECA claim. When requesting information, the CE is to forward to DOJ a copy of the EE-1 or EE-2 signed by the claimant, because it serves as a Privacy Act waiver allowing DOJ to release information to DEEOIC. This chapter contains additional guidance (in Section 10) for handling a RECA Section 4 claim.

a. Once the CE receives a claim form or other evidence from the claimant documenting that he or she has filed a Section 5 RECA claim, the CE prepares a

letter to DOJ with a copy of the relevant EE-1 or EE-2 attached. The letter includes a request for information concerning whether the claimant received an award or filed a claim under Section 5 of the RECA. This letter provides DOJ with options for response depending on the status of the RECA claim.

b. In the circumstance where a claimant submits a Form EE-1 or EE-2 with an indication of a RECA filing, but the claimed medical condition is not one of the covered conditions listed under RECA Section 5, the CE prepares a letter to DOJ with a copy of the DEEOIC claim form attached. The letter includes a request that DOJ send all employment, medical, and survivorship evidence available, to DEEOIC, as well as a statement from DOJ verifying employment, regardless of the status of the RECA Section 5 claim.

c. When a claimant files for a medical condition not covered under the RECA, in conjunction with a claim for covered RECA conditions, the CE prepares a request for information to DOJ. The CE requests that the DOJ provide any information on the status of the RECA claim, including any determination regarding coverage, along with a request that DOJ send all employment, medical and survivorship evidence in its possession to DEEOIC.

5. Assessing RECA Status Information From DOJ. DOJ will provide different responses to a DEEOIC information request, depending on the status of the RECA claim.

a. When the DOJ determines that the employee, or a qualified survivor, is entitled to an award of $100,000 under Section 5 of the RECA, it issues a decision to the claimant. Subsequently, when the claimant files for compensation under EEOICPA, as a covered uranium employee, DEEOIC will request that DOJ confirm the status of the Section 5 RECA award.

b. If a claimant files a Section 5 RECA claim, but the claim is pending DOJ adjudication, DOJ will provide DEEOIC with a status letter. DOJ will also provide DEEOIC with a factual statement of employment as requested, along with a copy of all employment, medical and survivorship evidence in its possession. In these situations, the CE defers action on the Part B claim pending the outcome of the Section 5 RECA claim; however, the CE proceeds to develop for benefits under Part E. Any factual statement provided by the DOJ, verifying the uranium worker's specific dates and places of employment covered under Section 5 of the RECA, is sufficient to confirm employment for purposes of developing a Part E claim.

c. A DOJ Section 5 claim denial requires DEEOIC to deny a claim for the same condition(s) under Part B; however, the denial by DOJ has no effect on Part E adjudication. As such, even with a DOJ denial of Section 5 RECA benefits, the CE proceeds to develop the Part E claim.

d. When the DOJ responds indicating the claimant has not filed for an award under Section 5 of the RECA, the CE must contact the claimant in writing (Exhibit 19-

1.) The CE advises the claimant that DEEOIC can only award benefits under Part B of the EEOICPA if the covered employee (or survivor) received a DOJ award under Section 5 of the RECA. The letter further informs the claimant that their Part E claim is not dependent on a RECA Section 5 award and that the CE is undertaking development. In such cases, the CE requests employment verification from DOJ and the letter should ask DOJ to confirm the accuracy of the claimed employment. The CE completes development of the Part E claim and issues a RD as soon as a determination of compensability can be reached.

(1) In those instances where DOJ initially denies a claimant's RECA Section 5 award, but later approves the claim, there is no need for the claimant to request a reopening of the DEEOIC claim. Reopening of such cases should proceed automatically according to established procedures, based upon the submission of new evidence. Whether the claimant initiates a reopening request with new evidence, or the DO receives notice of an acceptance and award by the DOJ, the DO reopens the case and proceeds with a new RD.

6. Processing a Uranium Employee Part B Claim. Under Part B of the EEOICPA, a covered uranium employee means an individual who DOJ determined is entitled to an award under Section 5 of RECA, either as an employee, or as a qualifying survivor.

a. Once the CE receives confirmation of the RECA Section 5 award, the Part B claim is in posture for acceptance. DEEOIC acceptance of a uranium employee claim under Part B results in a supplemental lump sum payment of $50,000 to the covered uranium employee (or survivor) and an award of medical benefits, under the EEOICPA, for the same condition(s) accepted by DOJ. Any applicable Part E claim requires concurrent review by the CE. Guidance relating to RECA and Part E case adjudication occurs later in this chapter.

(1) If DOJ awarded benefits to a deceased employee's survivor(s), DEEOIC will award the additional lump sum payment of $50,000, under the EEOICPA, to the same recipient(s).

b. If a covered uranium employee (employee or the deceased employee's survivor) received a RECA Section 5 award but dies before receiving his or her DEEOIC Part B supplemental lump-sum compensation, certain survivors of the employee may file to receive the compensation. The following is the order of precedence for survivors seeking payment under this circumstance:

(1) If the covered employee is survived by a spouse who is living at the time of payment, such payment shall be made to such surviving spouse.

(a) A "spouse" of an individual is a wife or husband of that individual who was married to that individual for at least one year immediately before the death of that individual.

(b) If there is a surviving spouse and at least one child of the covered employee who is living and a minor at the time of payment and who is not a recognized natural child or adopted child of such surviving spouse, then half of such payment shall be made to such surviving spouse, and the other half of such payment shall be made in equal shares to each child of the covered employee who is living and a minor at the time of payment.

(c) A "child" of an individual under both Parts B and E of the EEOICPA can only be a biological child, a stepchild, or an adopted child of that individual. A person who is or was a dependent of the employee but does not fit within the definition of a qualifying "child" is not an eligible survivor. In the vast majority of situations, a birth certificate showing the employee as the parent of a child is sufficient to establish survivorship. (Refer to Chapter 20 - Establishing Survivorship, for additional guidance regarding definitions and development pertaining to surviving children.)

(2) If there is no surviving spouse described in paragraph (1), such payment shall be made in equal shares to all children of the covered employee who are living at the time of payment.

(3) If there is no surviving spouse described in paragraph (1) and if there are no children described in paragraph (2), such payment shall be made in equal shares to the parents of the covered employee who are living at the time of payment.

(a) A "parent" includes fathers and mothers through adoption.

(3) If there is no surviving spouse described in paragraph (1), and if there are no children described in paragraph (2) or parents described in paragraph (3), such payment shall be made in equal shares to all grandchildren of the covered employee who are living at the time of payment.

(a) A "grandchild" of an individual is a child of a child of that individual.

(4) If there is no surviving spouse described in paragraph (1), and if there are no children described in paragraph (2), parents described in paragraph (3), or grandchildren described in paragraph (4), then such payment shall be made in equal shares to the grandparents of the covered employee who are living at the time of payment.

(a) A "grandparent" of an individual is a parent of a parent of that individual.

7. Part E Eligibility for Covered RECA Uranium Employees. Under Part E of the EEOICPA, the definition of a covered employee extends to RECA Section 5 workers, who DEEOIC determines to have contracted a "covered illness" through exposure at a DOE facility or a RECA Section 5 facility. A covered illness under Part E means an illness or death relating to exposures at a DOE facility, or a RECA Section 5 facility, resulting from exposure to a toxic substance. For approved claims under Part E, the EEOICPA grants the employee medical benefits for care of the accepted condition (s) in addition to lump-sum compensation arising from his or her impairment and/or wage-loss from the covered condition(s). Survivors are entitled to a basic survivor benefit, with potential for an additional amount, if the employee sustained applicable wage-loss prior to his or her normal retirement age.

a. Once DEEOIC accepts an employee's Part B claim, based on a DOJ award of RECA Section 5 benefits, the CE can presumptively conclude that the same RECA illness(es) relates to occupational exposure to a toxic substance, as required under Part E, and accept the claim. This applies solely to a living employee's claim presented under Part E.

(1) Survivors filing for Part E benefits must present evidence that they meet the necessary criteria as an eligible Part E survivor, before the CE undertakes an examination of the case for causation. The CE is to reference Chapter 20 - Establishing Survivorship for information related to Part E survivor requirements. Once a survivor has presented evidence that he or she satisfies the survivorship eligibility requirement under Part E, the CE proceeds with the analysis of the claim to determine if the evidence is sufficient to establish that the employee's death resulted from exposure to a toxic substance.

(a) For a survivor's claim, a DEEOIC Part B finding of compensability, based on DOJ's acceptance of a RECA Section 5 claim, allows the CE to presume that the accepted condition(s) relates to a toxic substance exposure for the purpose of adjudicating a Part E claim; however, the CE must further obtain medical evidence that the condition contributed to the death of the employee before accepting the claim under Part E.

b. A DOJ denial of a RECA Section 5 claim does not preclude a claimant's eligibility under Part E. In situations where DOJ issued a claim denial or acknowledges having no information regarding the employee, the CE is to undertake development to determine if the evidence establishes that there is Part E covered employment, including contacting relevant employment verification points of contact (i.e. DOE) and that the employee's illness or death resulted from exposure to a toxic substance.

8. Developing a Part E Claim. In situations where there is an indication of uranium mining, milling, or ore transporter employment, but where DOJ has not accepted a RECA Section 5 award, it is necessary for the CE to pursue development under Part E with intention of obtaining evidence of a "covered illness" (illness or death resulting from exposure to a toxic substance).

The CE must reference Chapter 15 - Establishing Toxic Substance Exposure and Causation because it describes the general procedures for developing exposure and causation under Part E. When developing a Part E claim involving uranium worker employment, there are several unique factors a CE must consider as he or she assesses the claim:

a. Covered employment under Part E extends to RECA Section 5 workers as delineated in 2.b(1)-(3) of this chapter. When assessing a claim involving RECA Section 5 coverage, the CE applies the following to his or her analysis of the evidence:

(1) The CE may accept as covered employment under Part E, a DOJ finding of employment at a RECA Section 5 covered mill or mine.

(2) In the absence of any finding from DOJ with regard to covered RECA Section 5 employment, the CE must undertake his or her own assessment of all relevant evidence to make a finding as to whether the employee has covered Part E employment. As is the case in any Part E claim, the CE must carefully evaluate all evidence submitted in support of covered employment. Moreover, the CE may use SEM as a research tool. SEM contains a list of uranium mines and mills and the period each was in operation. SEM also identifies ore transporters covered under RECA 5. Additionally, the SEM "Site History" section, for each facility, lists all prime operating entities and respective operating dates. By comparing the different mine and mill information maintained in SEM to data collected during claim development, the CE can make correlations that can assist with determinations needed to reasonably establish covered employment.

(3) A CE must also be mindful of circumstances where the employee has RECA Section 4 coverage as a downwinder or an onsite participant, in addition to a distinct period of separate employment as a DOE contractor, subcontractor, or RECA 5 employee. In these situations, the CE must process the Part E employee claim based solely on the DOE contractor, subcontractor, or RECA 5 employment. Additional information regarding the handling of RECA Section 4 claims under the EEOICPA occurs in Section 10 of this chapter.

b. Verifying Part E Exposure. Once the CE has established that the employee has a diagnosed medical condition and has verified employment, the CE must evaluate the evidence to determine the nature, extent and duration of occupational exposure to a toxic substance. Chapter 15 - Establishing Toxic Substance Exposure and Causation provides guidance for the CE to follow in assessing exposure for a Part E claim. For ascertaining exposure findings for claims involving Section 5 RECA workers, the CE must evaluate all relevant information present in the case to make findings of potential exposure including: employment records; information supplied by the claimant in an OHQ; and, any documentation supplied by DOJ relating to a RECA claim. The CE may also avail themselves of other DEEOIC development resources in assessing exposure

including referrals to an IH.

(1) SEM provides exposure data on all known covered RECA Section 5 uranium mines and mills. Much as the CE uses SEM to correlate mills and mines to a worker for the purpose of employment verification, he or she is to use similar methodology to link employment at a particular mine or mill to potential exposure to a toxic substance(s).

c. Causation for Part E Claims. Once the CE has established covered employment, and makes a finding on the nature, extent or duration of relevant toxic substance exposures associated to the employee (with the input of an IH, as appropriate), he or she follows the guidance in Chapter 15 - Establishing Toxic Substance Exposure and Causation for obtaining a medical opinion on whether exposure to a toxic substance is "at least as likely as not" a significant factor in causing, aggravating, or contributing to the diagnosed condition.

(1) Establishing Causation for Diagnosed Cancers. As a toxic substance means any material that has the potential to cause illness or death because of its radioactive, chemical or biological nature, the CE must obtain an occupational radiation dose reconstruction for any claim where the CE is unable to make a favorable determination based upon non-radiological Part E toxins. In these situations, the CE prepares a referral to NIOSH seeking a dose reconstruction for a period of covered employment established in the case. The CE can find further instructions for making a NIOSH referral in Chapter 17 - Development of Radiogenic Cancer Claims. Once NIOSH provides the data from its dose reconstruction, the CE must use the information to calculate the PoC that he or she can apply to making a causation determination for the Part E cancer.

9. Issuing a Part B or E Decision Involving a RECA Uranium Worker. Upon completion of any necessary development and assessment of the case evidence for compensability under Part B or Part E of the EEOICPA, the CE issues a recommendation to either accept or deny the claim. As criteria for adjudicating claims involving RECA have unique development and adjudication features, it is important that the CE writes the decision, being mindful to communicate the decision process and the information considered, in a clear and understandable manner. It is particularly important to distinguish the distinct and different requirements when considering the application of a RECA Section 5 determination by DOJ, to a Part B claim versus a Part E claim. Should the CE identify discrepancies in the factual findings used in claim adjudication between DEEOIC and DOJ, the CE must take action to address that discrepancy to ensure uniform and consistent interagency decisional outcomes.

10. RECA Section 4 Claims. Some EEOICPA claimants may have filed a claim and received an award from DOJ, under Section 4 of the RECA, as downwinders and/or on-site participants who have developed certain types of cancer. Recipients of a RECA Section 4 award are not eligible to receive a supplemental payment of compensation under Part B of EEOICPA. Moreover, the statutory language in 42 U.S.C. § 7385j bars receipt of compensation for cancer, under the EEOICPA, if a claimant has received an award under Section 4 of RECA. This bar

exists regardless of whether the claimant filed for the same or different cancers under EEOICPA. If a claimant has filed for, but not received a Section 4 RECA award and is eligible for an EEOICPA award, the claimant must choose between the Section 4 RECA award and the EEOICPA award. A RECA Section 4 award has no effect on non-cancerous conditions claimed under EEOICPA. Under RECA, an individual cannot receive an award under both Section 4 and Section 5.

a. Identifying a RECA Section 4 Claimant. The CE can identify a claim submitted by a Section 4 RECA claimant by reviewing the information provided on the EE-1 or EE-2. If the claimant checked the box indicating he or she applied for an award under Section 4 of RECA, or there is other information indicating a RECA Section 4 filing, the claim is to be developed in accordance with the guidance set out in this section.

b. Letter to DOJ – Section 4 RECA. Once a Section 4 RECA claim is identified, the CE prepares a letter to DOJ (Exhibit 19-2) requesting information concerning whether the claimant either received an award or filed a claim under Section 4 of the RECA. The CE attaches a copy of the EE-1 or EE-2 to the letter in all instances.

c. DOJ Approves the Section 4 Award. If cancer is the only claimed illness under the EEOICPA and DOJ confirms its acceptance of, and award for, the claimant's RECA Section 4 claim, the CE may proceed with a recommended denial of compensation under Part E. The denial of compensation will specifically reference the exclusion of benefits for cancer under both EEOICPA and RECA contained in 42 U.S.C. § 7385j.

d. DOJ Claim Pending Adjudication. If the response from DOJ indicates that a RECA Section 4 decision is pending, the CE takes the following actions depending on the claimed conditions:

(1) Cancer. The CE must prepare a letter to the claimant(s), explaining that an EEOICPA and a RECA Section 4 cancer claim cannot be adjudicated concurrently. The CE must ask the claimant(s) to select which program they wish to pursue benefits under, for the claimed cancer(s). The claimant(s) must be notified that if they accept the RECA Section 4 award, they cannot receive an award under the EEOICPA for a cancer claim. The claimant(s) should be notified that if they either do not respond within 30 days, or if they elect to pursue their cancer claim under RECA, their EEOICPA cancer claim will be denied. The claimant(s) should also be advised that if they wish to pursue their cancer claim under EEOICPA, they must formally withdraw their RECA claim from DOJ, and confirmation of such withdrawal must be obtained from DOJ. The letter should further state that if the claimant pursues their RECA claim and the DEEOIC denies their EEOICPA claim, should they later receive a DOJ denial of the Section 4 claim, they will need to request a reopening of their denied EEOICPA claim.

Depending upon the response from the claimant(s), the CE will either proceed with the adjudication of the claimed cancer (upon confirmation of RECA Section 4 withdrawal) or will proceed with development of the case for non-cancerous conditions, and will issue a RD that includes a denial for the claimed cancer. Any RD that includes a denial of a claimed cancer, on the grounds that compensation cannot be awarded under both RECA Section 4 and EEOICPA, must reference 42 U.S.C. § 7385j.

(2) Clams for Non-Cancer Conditions and Section 4 of RECA. As Section 4 of RECA only covers cancer claims, the CE proceeds with normal adjudication of a claim, filed under Part E of the EEOICPA, for a non-cancerous condition. CE development under this circumstance would include contacting relevant employment verification points of contact; assessing toxic substance exposure and collecting medical evidence about whether a toxic substance resulted in a Part E covered illness.

e. Rejection of Section 4 RECA Award. If DOJ reports that a RECA Section 4 award has been granted, but the claimant has elected to reject the settlement, and if a copy of the Acceptance of Payment (AOP) form confirms this, the CE can proceed with the adjudication of the cancer claim under the EEOICPA.

f. Survivors of Section 4 RECA recipients. The statutory language under 42 U.S.C. § 7385j is not applicable to survivors of Section 4 RECA benefit recipients. The bar from receiving EEOICPA cancer benefits due to the approval of a RECA Section 4 claim only applies to the same individual who received the decision. The CE must undertake normal development in any situation where the survivor filing for EEOICPA benefits is different from the person who received the RECA Section 4 award. 42 U.S.C. § 7385j does not operate to bar that claim under Part B or E; however, the claimant must satisfy the normal requirements for a compensable claim under the EEOICPA.

CHAPTER 20 – ESTABLISHING SURVIVORSHIP

1. Purpose and Scope. This chapter contains procedures for the development and review of survivor claims under the EEOICPA. It also describes the process followed when a non-covered spouse or child opts for the alternative to filing a Part E claim.

2. Policy. The CE is responsible for processing survivor claims and ensuring that benefits are properly paid to eligible survivors under the provisions of 42 U.S.C. 7384s(e) and 7384u(e) for Part B and 42 U.S.C. 7385s-1(2), and 7385s-3 for Part E.

3. Eligible Survivors. If an employee eligible for EEOICPA benefits is deceased, one or more of the employee's survivors may file a claim for compensation under the EEOICPA. The claimant documents his or her relationship to the covered employee. If he or she does not present evidence to establish survivorship, the CE writes to the claimant requesting the necessary evidence. When developing a survivorship claim, the CE sends letters to all survivors claiming benefits, requesting medical and employment evidence sufficient to establish eligibility of the deceased employee. However, a request for documentation necessary to support the eligibility of a specific claimant is sent to that claimant.

When a survivor files a claim, the CE is responsible for adjudicating the claim(s) and for processing any compensation which may be payable in the order of eligibility outlined below.

a. Part B. Compensation may be payable to eligible survivors in the following order: spouse, children, parents, grandchildren, and grandparents of the deceased covered Part B employee.

b. Part E. Compensation may be payable to eligible survivors in the following order: spouse; then children who were under the age of 18 years at the time of the employee's death, or under the age of 23 years and continuously enrolled as a full-time student since attaining the age of 18 years at the time of the employee's death, or were any age and incapable of self-support at the time of the employee's death.

   Unlike Part B, the following claimants are not eligible for survivor benefits under Part E: adult children (with the exception of those meeting the requirements of incapable of self-support at the time of the covered employee's death), parents, grandchildren, and grandparents of the deceased covered Part E employee.

c. Conviction of Fraud. A person convicted of fraud in the application for or receipt of benefits under the EEOICPA or any other federal or SWC law forfeits any entitlement to the EEOICPA benefits for any occupational illness or covered illness due to an exposure on or before the date of the conviction.

4. Filing a Claim for Survivor Benefits. A claim for survivor benefits must be in writing. The DEEOIC considers any written communication that requests survivor benefits under the EEOICPA as a claim for purposes of case creation and claim development. However, a claimant must submit a completed and signed Form EE-2 for DEEOIC to fully adjudicate the claim and issue a RD and FD.

a. Acting on Survivor's Behalf. A person acting with legal authority on behalf of a survivor may file a claim under the EEOICPA for that survivor including individuals serving as POA or Conservators. In the case of a minor child, it is preferable that a parent or legal guardian complete the form on the child's behalf. A legal guardian is a person with the responsibility for providing care and management of a child and his or her affairs.

b. No New Claim Needed for Part E. In some instances, a claimant may file for a Part B claim without knowledge that consideration exists for Part E benefits. In these situations, there is no need for a survivor to file a new claim for benefits under Part E when there is an existing, accepted Part B claim for that survivor, or when the survivor filed a Part D claim (Form 350.2) with the DOE. In these instances, the CE is to consider each survivor a claimant under both Part B and E. In any scenario where it is not clear as to the intent of a survivor to seek benefits under Part B or E, the CE must seek clarification from the survivor and, if necessary, obtain submission of a signed EE-2 claim form.

c. Excluding Claims Due to Tort or SWC Benefit. A survivor may choose to exclude from his or her claim any condition caused by an exposure for which there has been a settlement from a tort action or, under Part E, any condition leading to receipt of a payment under a SWC program. This may preclude any need to reduce payable benefits. (Refer to Chapter 30 - Tort Action and Election of Remedies and Chapter 31 - Coordinating State Workers' Compensation Benefits.)

5. Establishing Employee's Death. The first step a CE should take in a survivor claim is to obtain the necessary evidence to establish the death of an employee.

a. Death Certificate. The document used to verify the death of an employee is a death certificate, typically issued by an official state or local governing agency. For the most part, a death certificate lists the name of the decedent, date of death, his or her marital status at time of death, usual occupation, and cause of death certified by a physician or some other official. In cases where a death certificate has not included all of the causes of death, the CE must conduct additional development (i.e., requesting medical records from the last 12 months of the employee's life, referral to a CMC, etc.) to verify the additional causes of death. A death certificate is required to be submitted to confirm the death of an employee in a survivor claim filed under Parts B and E.

(1) An official copy (stamped) of an employee's death certificate is not required. A copy can be accepted.

(2) Some states have implemented the use of electronic death certificates, which may be used to establish the death of the employee. To be acceptable, a printed copy of the electronic record must be obtained that identifies the certifying official. If a physician is the certifying official, his or her license number must also be included.

6. Linking Employee's Death to an Occupational or Covered Illness. For a compensable claim under Part B, it must be shown that the employee was diagnosed with an occupational illness including: cancer, CBD or chronic silicosis. The evidence does not need to show that any one of these conditions was linked to the employee's death, merely that one or more was diagnosed. This also applies to an occupational illness that develops over the course of the employee's life and resolves by way of medical treatment.

However, for a compensable claim under Part E, the evidence must establish that an occupational exposure to a toxic substance was "at least as likely as not" a significant factor in causing, contributing to, or aggravating the death of the employee. For this determination, the CE may reference factual or medical evidence to assist in reaching a decision, including a death certificate or medical records proximate to the date of the employee's death. The CE must also be ready to evaluate the effect that an accepted consequential illness had on the death of an employee.

7. Surviving Spouse. For either a Part B or Part E claim for spousal survivorship, the necessary documentation to establish a viable claim usually consists of a copy of the marriage certificate issued or recognized by a State Authority or an Indian Tribe Authority. A "Certificate of Blessing of Marriage" from a church is not considered the equivalent of a marriage certificate. A marriage license is also unacceptable. To be an eligible surviving spouse, the spouse must have been married to the employee for one year immediately prior to the death of the employee. This prior year includes the date of marriage, through the day prior to the date of death. For example, if an employee married on September 4, 2004 and died on September 3, 2005, the CE does not include September 3, 2005 when calculating the required 365-day term. The CE counts each calendar day from September 4, 2004 up through and including September 2, 2005.

a. In cases where evidence shows that the employee was previously married, it is not necessary to obtain proof of divorce. However, in the event that the evidence in a case raises concern as to the legitimacy of the marriage for which survivorship is being established, the CE must develop further and obtain a copy of the divorce decree (or death certificate if marriage ended due to death of spouse) validating that the marriage was dissolved.

b. In some instances, a common-law marriage may exist between the employee and the surviving partner. When the evidence does not sufficiently establish that the claimant had a licensed/certified marriage with the employee for the 365 days immediately prior to the employee's death – or where there is some evidence to suggest that the marriage was not valid – the CE may have to gather sufficient evidence to make a determination as to whether the parties established a common-law marriage in a state or other territory which authorizes such marriages. As a general rule, in those states that legally permit it, the existence of a common-law marriage is determined by the law of the state where the alleged common-law marriage was allegedly entered into and that has the most significant relationship to both spouses and to the alleged marriage. If full development of the claim results in evidence that the alleged common law marriage occurred in a state that does not allow the creation of such marriages within its borders – and no other state is involved – the inquiry may end there.

(1) The CE must develop evidence sufficient to establish that any claimed (or potential) common-law marriage meets two threshold issues. The first is when the common-law marriage was entered into, and the second is where it was entered into.

(2) Once the "when and where" elements have been established, the CE proceeds with additional development to document the five standard elements of a common-law marriage outlined in the DEEOIC Common-Law Marriage Handbook.

(3) Evidence which may be used to document a common-law marriage may consist of the following items, as delineated in the handbook: affidavits, marriage and divorce documents, death certificates, children's records, real estate documents, tax records, banking and loan documents, contracts including insurance documents, employment documents, medical records, tribal documents, wills, trusts, POA documents, utility bills, letters, and/or other significant formal or informal documents.

(4) The burden to produce all necessary evidence and to establish each element of their eligibility by a preponderance of the evidence rests with the claimant(s). The purpose of development regarding a claimed common-law marriage is to obtain sufficient information and probative evidence to support a determination regarding whether a common-law marriage was ever created, and if so, its duration. If the evidence is sufficient to reach a decision, the CE proceeds with adjudication. If the legality of the common-law marriage is not clear, or is in dispute, the case file, along with a memorandum of explanation, is referred to the NO Policy Branch for guidance.

8. Surviving Child. A "child" of an individual under both Parts B and E of the EEOICPA can only be a biological child, a stepchild, or an adopted child of that individual. A person who is or was a dependent of the employee but does not fit within the definition of a qualifying "child" is not an eligible survivor. In the vast majority of situations, a birth certificate showing the employee as the parent of a child is sufficient to establish survivorship.

Where the claimant claims to be a child of the deceased employee and the birth certificate does not list the deceased employee as the father or mother of the claimant, the CE must undertake development to ascertain the circumstances of the claim. In those situations where evidence is received that contradicts the paternity of the child or his or her connection to the employee, the CE must proceed with development. The CE must use discretion when evaluating evidence in support of a survivorship claim and weigh all evidence received in its totality.

a. Categories of eligible children.

(1) Biological Child. The term "biological child" is broad and refers to all persons with either a presumed or established genetic link to a deceased employee. Because a recognized natural child is presumed to have a genetic link to a deceased employee, a recognized natural child is one type

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

(2) Stepchildren. Claims for eligibility as a stepchild will be decided by the DO unless there is an issue that cannot be determined by the CE. In circumstances where the status of a stepchild as a potentially eligible survivor cannot be determined, the matter is referred to the NO Policy Branch.

(a) A stepchild is defined as any individual who establishes a parent-child relationship with the employee through the marriage of their parent to the employee. This determination is made once the CE receives documentation from the stepchild in support of their claimed relationship. This must include evidence of the marriage between the employee and the parent of the stepchild.

(b) Documentation supporting a regular parent-child relationship may include school records (e.g., report card) listing the employee as having a familial relationship to the stepchild, employment or tax returns showing that the covered employee claimed the stepchild as a dependent, photographs taken at family gatherings, newspaper articles, obituaries, insurance policies listing the stepchild as the son or daughter of the covered employee, wills, affidavits from biological children of the employee, and/or any other documents that refer to the stepchild and the deceased employee in a familial way.

(c) Under Part B, where a stepchild was an adult at the time of the deceased employee's marriage, the evidence will be considered on a case-by-case basis. Evidence that may document eligibility includes records that the stepchild was the primary contact in medical dealings with the deceased employee, that the stepchild provided financial support for the deceased employee, and/or provided housing for the deceased employee, etc. Evidence consisting of medical reports, letters from the physician, or receipts showing that the stepchild purchased medical equipment, supplies or medication for the employee may be helpful. These items of evidence will be considered on a case-by-case basis and each is weighed together to fully evaluate the eligibility of the survivorship claim.

(d) There is no minimum time requirement for a stepchild to have lived in the same household as the covered employee or for their parent to have been married to the employee, merely that a parent-child relationship existed. To determine if a parent-child relationship existed, the CE or FAB representative must consider the above information in conjunction with the following: Did the stepchild visit the employee during the holidays?; Did the stepchild take care of the employee for days at a time?; and is it logical that the stepchild and employee stayed at one another's home at any given time? As long as a reasonable basis exists to show that a parent-child relationship existed, the CE can make an affirmative finding.

(e) For claims involving a divorce between the biological parent and the stepparent, the dissolution of the marriage does not terminate the parent-child relationship for eligibility purposes. As such, because a parent-child relationship did exist at one time, the child is considered an eligible stepchild. An ongoing parent-child relationship following divorce is not necessary.

(f) The CE or FAB representative must consider the totality of the evidence when determining whether the stepchild qualifies, and must provide the rationale supporting whatever outcome in the RD and/or FD.

(3) Adopted Child. An adopted child is defined as a child that is not biologically related to the employee, but whose parental responsibilities have been permanently transferred by a legal mechanism to the employee. The CE obtains the relevant legal document(s), whether state, tribal, or otherwise, confirming the transfer of responsibility to the employee.

(4) Posthumously Conceived Children. Advances in medicine and science have enabled the storage of human reproductive material (egg, sperm or embryo) as to allow for posthumous conception of children. DEEOIC considers a posthumously conceived child of the employee to be an eligible survivor to the extent permitted by local or state law. In those survivor claims involving a posthumously conceived child, the assigned CE refers the case to the NO Policy Branch so it can obtain a legal opinion from the SOL of applicable local or state law in deciding the status of the child as an eligible survivor under the Act.

b. Qualifications for eligibility under Part B vs. E.

(1) All Surviving Children. A surviving child is a biological, stepchild, or adopted child of the employee regardless of age.

(2) Part E Surviving Child Only. Under Part E, a "covered child" must also have been, as of the date of the employee's death: either under the age of

18 years, under the age of 23 years and a full-time student who was continuously enrolled in one or more educational institutions since attaining the age of 18 years, or any age and incapable of self-support regardless of their marital status.

(a) Student Status. To be considered a full-time student at the time of the employee's death, the child must have been continuously enrolled as a full-time student in one or more educational institutions since attaining the age of 18 years and must not have reached the age of 23 years, regardless of marital status or dependency on the employee for support.

(i) Enrollment as a full-time student generally consists of a 12-month period, with a break of no more than four months, during each year of post high school education.

(ii) If the child's status as a full-time student is uncertain, the CE consults the academic institution to determine what was considered to be the minimum number of hours required to qualify as "full-time" (versus part-time), at the time of the child's enrollment, as this may vary from one institution to another.

(iii) With certain programs such as co-op, intern, or graduate school programs, while the student might not actually be enrolled in any courses for a particular term, he/she could still be "registered" as a full-time student while fulfilling other requirements of the program.

(iv) If a student is prevented by reasons beyond his or her control from continuing education for a period of reasonable duration, (such as a brief but incapacitating illness) the CE has discretion to determine whether the student's status as a continuously enrolled full-time student should be preserved. A suspension from school for a limited period should not affect the child's status as a continuously enrolled full-time student.

(v) Leaving school to care for a sick parent/employee, lack of funds to pay for school as a result of a parent/employee's illness, or dropping/failing out of school is not a sufficient basis to maintain the child's status as a continuously enrolled full-time student.

(vi) Documentation to support eligibility includes transcripts from the accredited educational institution(s), school records, and affidavits.

(b) Incapable of Self-Support. To establish eligibility for benefits as a covered child who was incapable of self-support at the time of the employee's death, the child must have been physically or mentally incapable of self-support, regardless of marital status or dependency on the employee for support, regardless of the temporary or permanent nature of the incapacity.

(i) A child is incapable of self-support if, at the time of the employee's death, his/her physical or mental condition was such that he/she was unable to obtain and retain a job or engage in self-employment that could provide him/her with a sustainable living wage.

(ii) Medical evidence must show that the child was diagnosed with a medical condition establishing that he/she was physically/mentally incapable of self-support at the time of the employee's death.

(iii) Documentation to support the incapability of self-support can include medical records, social security disability records, tax returns showing that the covered child was claimed as a dependent, state guardianship documents, and affidavits.

SSA or State disability records alone, showing lack of self-support, should not be used to establish that the child is incapable of self-support. The CE must consider the evidence as a whole to determine if it demonstrates that the person was/is incapable of self-support for purposes of the EEOICPA.

(iv) When medical evidence demonstrates incapacity for self-support, this determination will stand unless refuted by sustained work performance or other conflicting evidence.

(v) A child is not incapable of self-support merely because of an inability to obtain employment due to economic conditions, lack of job skills, incarceration, etc.

(vi) There is no specific timeframe required to establish that a child was incapable of self-support prior to the death of the employee (e.g., accident). It is only necessary to establish that the child was incapable of self-support on the day the employee died.

(c) Non-spousal children. In certain situations, a special provision of the EEOICPA allows for the division of benefits between an

eligible spouse and an employee's child who is not related to the spouse.

(i) Under Part B only. If there is at least one child of the employee who is a minor at the time of payment, and who is not a recognized natural child or adopted child of the spouse, half of the payment is made to the covered spouse and the other half is made in equal shares to each child of the employee who is a minor at the time of payment, without regard to whether the child is a spousal child, or non-spousal child. A recognized natural child is a child acknowledged by the employee as their own during their lifetime. The RD and FD must fully explain the distribution of compensation to the spouse and all children who have filed a claim.

(ii) Under Part E only. If there is at least one child of the employee who is living at the time of payment, who qualifies as a "covered child" (i.e., under the age of 18 at the time of the employee's death, between the ages of 18 and 23 and continuously enrolled as a full-time student since attaining the age of 18 at the time of the employee's death, or any age and incapable of self-support at the time of the employee's death) and who is not a recognized natural or adopted child of the spouse, half of the payment is made to the covered spouse, and the other half is made in equal shares to each "covered child" of the employee, who is living at the time of payment, without regard to whether the child is a spousal child or non-spousal child. Refer to the definition of a recognized natural child found under Part B above. The RD and FD must fully explain the distribution of compensation to the spouse and all children who have filed a claim.

9. Parents, Grandchildren and Grandparents. Under Part B only, parents, grandchildren (including biological, adopted and step-grandchildren), and grandparents may be eligible for survivor benefits, provided there is no surviving spouse or living child who is eligible to receive compensation. When adjudicating a survivorship claim for a parent, grandchild, or grandparent, documentation must establish the relationship of the survivor to the deceased employee (i.e., employee's birth certificate listing parent's name, parent's birth certificate showing grandparent's name, etc.). As DEEOIC issues payment of lump-sum survivor benefits equally between eligible survivors, the CE must obtain evidence that establishes the status of all potential survivors in each category (parent, grandchild or grandparent). Parents, grandchildren and grandparents are not eligible for Part E survivor benefits.

10. Potential for Additional Survivors. When an additional potential survivor is identified on Form EE-2 or through some other development action, the CE contacts the individual by letter explaining their right to file a survivor claim (Exhibit 20-1).

a. Letter to Survivor. The letter to the survivor does not indicate whether the individual is qualified to receive benefits, as this is a function of the claims process. Rather, the letter outlines the general requirements for survivor eligibility. The CE explains that filing a claim does not guarantee that benefits will be payable, as both statutory and regulatory requirements must still be met before compensation can be awarded.

b. Form EE-2. The CE encloses a blank Form EE-2 with the correspondence. The potential survivor is asked to complete and submit the form within 30 days. Additional information on handling non-filing claimants can be found in Chapter 24 - Recommended Decisions.

c. Additional Documentation. To ensure that compensation is paid to eligible survivors of the deceased employee, the CE may require the survivor(s) to provide documents, affidavits, or records sufficient to substantiate the veracity of their claim.

11. Claims Involving Multiple Claimants. When a claim is filed, it is created in the ECS based on claimed employment and claimed illness(es). In some cases, multiple claimants will file a claim for one or more illnesses. And in some of these cases, not all claimants will claim the same illness(es). Therefore, in cases involving multiple claimants, an illness claimed by one claimant will be considered claimed by all parties to the case [unless the claimant specifically states they do not wish to claim the additional illness(es)] and should be documented accordingly in ECS for each claimant. This means that all illnesses will be addressed for all claimants without the request for additional claim forms.

a. Findings for Each Survivor. Once appropriate development is completed and review of evidence undertaken, one comprehensive RD addressing the claims of all filing parties is to be issued. Each party to the claim must receive an individual finding in the decision with respect to his or her eligibility. The decision references each survivor who has filed a claim and specifies whether they are entitled to receive compensation, the amount of compensation payable to each eligible survivor, and the basis for the conclusions reached.

b. Reopening After a FD. Given the procedure requiring each individual in a multi-claimant case be party to a decision on entitlement of benefits, all claims associated with the case must be reopened before a new decision can be issued (Refer to Chapter 27 - Reopening Process).

c. Individual Addresses. The RD does not include the addresses of the various claimants. Instead, an address sheet is prepared for each claimant and a copy of the decision is sent to all filing parties.

d. Lack of Form EE-2. The CE may encounter a situation where a survivor has made a claim for benefits in writing but has not filed Form EE-2. Alternatively, the CE may have evidence indicating the existence of a potentially eligible survivor, but is unable to contact the survivor to obtain a completed Form EE-2.

Under these circumstances, the CE issues a RD (See Chapter 24 - Recommended Decisions).

12. Issues During the Payment Process.

a. Death Before Payment. If the employee/survivor is alive when the FD is issued but dies before payment is received, the employee's/survivor's claim must be administratively closed. Receipt of payment is defined as the date the payee's bank receives the Electronic Funds Transfer (EFT) or the date the payee or someone legally able to act for the employee in receiving the payment receives the paper check.

Any compensation payment (whether check or EFT) received after the employee/survivor's death must be returned to the Treasury Department, and the payment must be cancelled in ECS. (Refer to Chapter 32 - Compensation Payments, for the payment cancellation steps.)

The CE appropriately develops any survivor claims and issues a new RD to all survivors who have filed a claim.

b. Death Due to Non-Covered Illness, Part E. If a covered Part E employee dies after filing a claim, but before the monetary benefits are paid, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received had he/she not died prior to payment. This would be in lieu of the survivor lump-sum compensation payable under Part E.

It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment benefits for the election option to be available to the survivor(s). As long as the employee filed a Part E claim, claims for wage-loss and impairment benefits are presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any remaining balance of Part E lump-sum compensation available to a survivor under Part E should they make an election. Once a survivor makes an election to receive a payment that the covered Part E employee would have received, the survivor is treated the same as the employee in determining whether the payment is subject to SWC coordination. For example, if the employee received SWC benefits for asbestosis and the survivor elected to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the amount payable to the survivor with the amount of those SWC benefits. (See PM Chapter 32, Coordinating State Workers' Compensation Benefits).

(1) When an election of benefits is available, the CE contacts the survivor via telephone or letter advising the survivor of the option to receive the benefits that the employee would have received had he/she not died prior to receiving payment. One a claimant makes his or her election in writing, the CE proceeds with a review of the claim. If interacting by phone, the

CE obtains a verbal response and follows with written confirmation of the survivor's option.

(2) Once the claimant's election is documented in the case record, the CE proceeds to award the survivor the impairment and/or wage-loss benefit the employee would have received. In assessing any payable lump-sum compensation to the survivor, the CE has to assess an impairment or wage-loss claim using established procedures.

(3) Under the election, lump-sum compensation is payable to a qualifying survivor up to the aggregate maximum amount of compensation payable under Part E.

(4) A survivor cannot exercise the election of benefit option unless the evidence establishes that the employee's death occurred solely because of a non-covered illness.

(5) The survivor is not entitled to the $125,000 lump-sum payment because death was not caused by the employee's covered illness(es).

c. Change in Child Status. Under Part B, a non-spousal child who is a minor at the time of filing may be advised in the FD that he or she be approved for compensation. While DEEOIC makes every effort to make lump-sum payment in a timely manner, if at the time of payment a child no longer meets the state law definition of a minor, the CE may not award. Under this unique situation, the CE takes action to vacate the FD so that a new decision may be issued finding that the non-spousal child is an ineligible survivor. DEEOIC staff is to take all necessary and appropriate steps to avoid this scenario.

d. Survivor's Death. An eligible survivor must be alive to receive any payment awarded under the Act. If one eligible survivor in a multiple survivor claim dies before payment is received, the CE administratively closes the deceased survivor's claim and issues a new RD reapportioning compensation among the remaining eligible survivors.

e. Survivor Compensation Part B. A survivor may receive one lump-sum payment under Part B for each employee for whom he/she qualifies as an eligible survivor. If a survivor files a claim for benefits and DEEOIC already awarded the maximum lump sum payment of compensation to the employee, the CE issues a RD addressing whether the claimant qualifies as an eligible survivor; however, makes no award of lump compensation due to the previous payment to the employee.

f. Survivor Compensation, Part E. An eligible survivor is entitled to the basic lump-sum survivor compensation of $125,000 if it is determined that an accepted illness caused, contributed to, or aggravated the death of the employee. In the case of a claim with multiple eligible survivor payees, the CE must allocate the lump-sum survivor compensation based on who qualifies as a survivor.

A survivor may receive more than the basic $125,000 survivor benefit if the deceased, covered Part E employee experienced compensable wage-loss as a result of any covered illness prior to his or her attainment of normal Social Security retirement age as defined by the Social Security Act. The additional benefit of $25,000 or $50,000 is dependent upon the number of years for which the employee experienced wage-loss (Refer to Chapter 22 - Wage-Loss Determinations). The maximum lump-sum survivor compensation under Part E is $175,000.

g. Aggregate Compensation Payable under Part E. The total amount of compensation payable, excluding medical benefits, may not exceed $250,000 per covered employee. The CE does not develop for additional medical conditions in a survivor claim once the aggregate compensation amount is reached, unless the potential for covering medical expenses exists. If a survivor files a claim for benefits and the aggregate compensation amount has been reached, the CE must deny the survivor's claim.

13. Alternative to Filing a Survivor Claim Under Part E. A non-covered spouse or child of a deceased DOE contractor employee or RECA Section 5 uranium worker may submit a written request for an informal evaluation of whether the employee contracted a covered illness as a result of employment at a covered facility. Once the alternative filing review is complete, the CE issues a determination letter to the claimant. No RD or FD is required.

a. Written Notice. An individual seeking a determination regarding the cause of an employee's illness must send a letter to the DEEOIC requesting an alternative filing determination.

(1) Alternative filing requests may be submitted to the RCs or the DOs.

(2) Only individuals listed in Subtitle E of the EEOICPA as potential survivors (i.e., spouses or children of an employee) may seek a determination letter regarding an employee.

(3) The survivor seeking a determination letter must provide evidence of a familial relationship with the employee.

b. Acknowledgement Letter. The CE sends each requester a letter acknowledging receipt of their request to receive an alternative determination letter, upon submission of their filing. The acknowledgement letter serves to explain the alternative filing process and offers the requester the opportunity to pursue full adjudication of the claim.

(1) The requester is notified that the alternative filing will result in the issuance of a determination letter, following development of the claim. The CE explains what will be contained in the determination letter and discusses the steps necessary to reach a determination on an alternative filing.

(2) If the requester has not already received a FD denying his or her claim, the acknowledgement letter gives the requester the opportunity to opt out of the alternative filing process and to pursue full adjudication of the claim leading to a RD/FD. Upon receipt of a requester's decision requesting a RD/FD, the CE sends a follow-up letter informing the requester that full development will be completed and outlines the evidence required to adjudicate the claim. If full adjudication of the claim is requested, the requester is to submit a completed form EE-2.

(3) The "Alternative Filing Acknowledgement Letter" must contain guidance to the requestor explaining that a decision by DEEOIC under the alternative filing rule does not serve as evidence that the named employee's illness was caused by his or her employment for the purposes of any lawsuit or workers' compensation program, including the EEOICPA.

c. Review of the Evidence. In accordance with the instructions contained in the EEOICPA PM, the CE undertakes full development of the alternative filing. The CE gathers any evidence necessary to arrive at a determination on the claim, including sending the case file to a CMC or NO Health Specialist for resolution of a question of exposure, diagnosis, or causation.

d. Determination Letter. Upon completion of development on the alternative filing, the CE sends a determination letter to the requester (Exhibit 20-2.)

(1) The CE prepares the written determination using clear language that the reader can easily understand. In the narrative of the decision, the CE provides sufficient discussion of the case evidence to describe the justification of the decisional outcome. The letter does not take the format of a RD, and no appeal rights or waiver is required.

(2) The determination letter must reach a conclusion about whether the employee contracted an illness as a result of exposure while employed at a covered facility.

(3) The letter must state that the requester is not afforded any appeal or review rights as a result of the conclusion reached.

(4) The CE reiterates that the determination cannot be used as evidence in a claim for benefits under EEOICPA.

(5) The CE explains that the requester may seek full adjudication on the claim, including issuance of a RD and FD, at any time.

(6) A SrCE or supervisor reviews the determination and prepares it for the DD's signature.

e. Receipt of Form EE-2. If the survivor files a Form EE-2, the CE renders a RD on eligibility, which is then reviewed by the FAB for issuance of a FD.

CHAPTER 21 – IMPAIRMENT RATINGS

1. Purpose and Scope. This chapter provides procedures for evaluating a claim for permanent impairment. It explains the responsibilities of the CE in awarding a covered Part E employee impairment attributable to a covered illness. The chapter provides guidance on how to evaluate medical evidence relating to impairment and the evidence necessary to establish a ratable permanent impairment. The chapter includes a discussion on calculating an impairment award if the impairment award is subject to tort offset and/or SWC coordination.

2. Policy. DEEOIC staff is responsible for processing impairment claims and ensuring that benefits are appropriately paid. In impairment decisions, DEEOIC staff explains the general requirements for impairment and provides a clear explanation of the calculations used to compute the impairment award. The assigned CE is responsible for bronzing into OIS all case-related correspondence or other documentation generated or received during the development of an impairment rating.

3. Definition of Impairment. The American Medical Association's Guides to the Evaluation of Permanent Impairment (AMA's Guides), 5th Edition, defines impairment as "a loss, loss of use or derangement of any body part, organ system or organ function." Furthermore, "Impairment percentages or ratings developed by medical specialists are consensus-derived estimates that reflect the severity of the medical condition and the degree to which the impairment decreases an individual's ability to perform common Activities of Daily Living (ADL), excluding work." (Emphasis in original) The AMA's Guides organize ratable organ or body function by chapter e.g., respiratory, cardiovascular, nervous, endocrine etc.

4. General Requirements for Impairment Ratings.

a. Covered Employees. The employee is a covered DOE contractor or subcontractor employee, or RECA Section 5 employee found to have contracted a covered illness through exposure to a toxic substance at a DOE facility or RECA section 5 facility.

b. Claiming Impairment. The employee has to claim impairment in writing.

c. MMI. An impairment rating is to encompass each covered illness that has reached MMI according to the rating physician. MMI means the condition is unlikely to improve substantially with or without medical treatment. A CE may consider conditions that are progressive in nature and worsen over time, such as CBD, to have reached MMI when the condition is not likely to improve.

(1) Terminal Employees. An exception to the MMI requirement exists for terminal employees undergoing treatment for an illness that has not reached MMI. In these situations, the terminal employee could die before the end of treatment and eligibility for an impairment award would be extinguished. Therefore, if the CE finds probative medical evidence that the employee is terminal, the CE includes the covered illness in the impairment rating even if the covered illness has not reached MMI.

(2) MMI Has Not Been Reached. If the rating physician or the treating physician states that a condition is not at MMI, and the employee is not terminal, the CE cannot make an impairment determination.

(a) If the CE does not make an impairment determination due to the employee not being at MMI, the CE sends a letter informing the employee that an impairment determination is not possible because the employee's condition has not reached MMI and that the impairment claim is closed administratively. The letter includes a statement instructing the employee to contact the DO once he or she receives medical evidence that describes the condition is at MMI (Exhibit 21-1.)

(b) Once the CE receives notice from the employee and medical evidence indicating that the employee is at MMI, the CE resumes development.

(3) Multiple Covered Illnesses. In a case of multiple covered illnesses, where one condition is at MMI and another is not, the CE proceeds with a determination regarding impairment for the condition at MMI. If different covered illnesses affect the same organ or body function, and one condition is not at MMI, the CE cannot proceed with an impairment rating until all conditions in that organ or body function have reached MMI.

d. Impairment Rating. An impairment evaluation performed by a qualified physician is the basis for the CE's determination of impairment benefit entitlement. Therefore, the physician's impairment rating report is to include narrative text that clearly communicates the physician's opinion, and that provides a convincingly descriptive rationale in support of the stated impairment rating.

(1) Evaluation. An impairment evaluation of the employee must be based upon the 5th Edition of the AMA's Guides.

(2) Rating Physician Qualification. A physician who performs an impairment evaluation must satisfy certain criteria. In order for a CE to accept an impairment rating, the rating physician must hold a valid medical license and Board certification/eligibility in his/her field of expertise (e.g., toxicology, pulmonary, neurology, occupational medicine, etc.). In addition, the physician must meet at least one of the following criteria: certified by the American Board of Independent Medical Examiners (ABIME); certified by the American Academy of Disability Evaluating Physicians (AADEP); possess knowledge and experience in using the AMA's Guides; or possess the requisite professional background and work experience to conduct such ratings.

(a) A CE may determine the qualifications of the physician upon receipt of a letter or a resume demonstrating that the physician has

a medical license and meets the requisite program requirements. There is no need to submit copies of his/her medical license or other certification.

(b) If a physician does not possess ABIME or AADEP certification, the physician must submit a statement certifying and explaining his/her familiarity and years of experience in using the AMA's Guides.

(3) Rating Percentage. The impairment rating is a percentage that represents the extent of a whole person impairment of the employee, based on the organ or body function affected by a covered illness or illnesses. A qualifying impairment rating must account for all Part E accepted covered illnesses claimed by the employee and must include all pre-existing conditions present in the claimed organ or body function at the time of the impairment evaluation.

(4) Whole Person Impairment. The physician must specify the percentage points of whole person impairment resulting from all covered illnesses. This includes accepted consequential conditions.

(a) In some instances, there are diseases or life style choices (e.g., smoking), in addition to the covered illness, that affect organ or body function. The DEEOIC does not apportion damage within the same organ or body function, thus the impairment rating should assess the functionality of the whole organ or body function regardless of other non-occupational factors that might cause impairment.

(b) If an employee's covered illness affects more than one organ or body function, the physician must specify the percentage points of impairment for each organ or body function affected by the employee's covered illness. The physician references a combined value chart in the AMA's Guides to calculate the aggregation of multiple organ or body function impairments into whole person impairment.

(c) If the employee contracted more than one covered illness that affects the same organ or body function, the physician does not need to provide separate ratings for each covered illness since DEEOIC does not apportion damage within the same organ or body function.

(d) An impairment that is the result of any accepted covered illness that cannot be assigned a numerical impairment percentage using the 5th Edition of the AMA's Guides will not be included in the employee's impairment rating, and the physician performing the impairment evaluation must explain why a numerical impairment

percentage cannot be assigned.

e. Triggering Impairment. There first must be impairment to an organ or body function that is clearly due to a covered illness before the CE can give any consideration for additional impairment to that organ or body function resulting from any unaccepted illness or condition. For example, if the employee has an accepted Part E claim for COPD only, and the rating physician opined that the employee's respiratory system has 0% impairment due to COPD, but 9% due to asthma (which has not been accepted), the CE is to deny the employee's impairment claim for COPD.

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

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

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

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

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

(3) Timeframe. The CE allots 60 days for the employee to respond to Form EE-11A/EN-11A, with a follow up request sent to the employee at the first 30-day interval. The CE uses Form EE-11A/EN-11A for the follow up request, but the form must be marked "Second Request." The CE does not develop the impairment issue until he or she receives a completed Form EN-11A.

(a) If the employee does not respond to Form EE-11A/EN-11A within

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

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

(c) If the employee does not indicate on the EN-11A form who he or she would like to perform the impairment evaluation, the CE calls the employee for this information. The CE advises the employee to document his or her choice in a written statement submitted to the DEEOIC CMR address.

6. Impairment Ratings by the Employee's Choice Physician. If the employee elects to have the physician of his/her choice perform the impairment rating, the CE must obtain evidence necessary to document that the physician is qualified as explained in Section 4.

a. Letter to Selected Physician. The CE sends a letter (Exhibit 21-2) to the physician selected by the employee. In the letter, the CE notifies the physician of the employee's eligibility, and the covered illness or illnesses with respective ICD-9/10 code(s). The CE also explains in the letter that for the DEEOIC to pay for an impairment evaluation, the physician must perform the evaluation within one year of the report's receipt by the DEEOIC. The letter includes reference to the requirement that the impairment evaluation is to be performed in accordance with the 5th Edition of the AMA's Guides, and that the rating physician must cite the appropriate page numbers and tables applied from the AMA's Guides. The letter explains that the physician must submit supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) with the impairment report. The letter includes instructions for the physician to contact the DO if they need medical evidence from the case file. Lastly, the CE provides URL links to the medical bill pay agent enrollment forms, which is to include: an OWCP-1500, Health Insurance Claim Form, OWCP-1168, the EEOICP Provider Enrollment Form, and a SF Form 3381. The OWCP-1168 contains a written explanation of how a physician enrolls with the medical bill pay agent.

If a physician has previously enrolled with the DEEOIC, there is no need to enroll again. If the employee opts to select his/her physician to perform the impairment rating but does not know of one, the CE may direct the employee to the

appropriate RC or the DEEOIC bill pay agent website for a list of physicians who are enrolled in the program.

b. Scheduling an Appointment with the Selected Physician. Upon receipt of the employee's written choice of physician, the CE sends a letter explaining that the employee is to schedule the impairment appointment within 30 days and the appointment is to occur within three months. The CE advises that the employee may request that the DO provide the rating physician with medical evidence in the case file to perform the impairment evaluation. The CE also explains that any appointment scheduled to occur later than three months may lead to denial of the impairment claim, unless there is a valid reason for the delay (for example, the earliest appointment available for a specialist was over three months).

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

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

7. Impairment Ratings by a CMC. If the employee chooses the CMC option, the CE reviews the medical evidence in the case file to determine if the evidence is sufficient for a CMC to perform the impairment evaluation.

a. Required Medical Evidence. Since the CMC will not conduct a physical examination, the employee's ADL or equivalent information is required. The CMC or the employee's physician can collect ADL information from a variety of sources, including the use of ADL worksheet (Exhibit 21-3), patient interview, or other techniques. The ADL or equivalent information should be completed within the last 12 months before the impairment evaluation. The CE also checks Xerox's Stored Image Retrieval (SIR) system to provide the most current medical record to the CMC. If the employee is under nursing care, the CE provides all nursing notes from the past 30 days to the CMC for review. In addition to the ADL or its equivalent, some conditions require specific medical evidence before a CMC can complete the impairment evaluation (Exhibit 21-4.) If Exhibit 21-4 does not identify the condition to be rated, the CE is to consult with a CMC to determine what medical information is required as outlined in the AMA's Guides.

After receipt of the notice that the employee has chosen the CMC option, the CE

sends a letter to the employee attaching a sample blank ADL or an ADL for breast cancer or skin cancer. The CE also includes the information regarding the required medical evidence for the covered illness(es). If the CE determines that additional evidence and/or diagnostic test(s) is required to conduct an impairment evaluation, the CE explains the requirement in this letter. The letter includes instruction for the employee to return the required evidence within 30 days. If after 30 days, the claimant does not submit the required evidence, the CE makes a phone call to determine the status of the evidence. The CE advises the employee verbally of the need to obtain this evidence. The CE explains that if the employee does not return the required evidence within 30 days, a RD to deny the impairment claim may be issued. The CE records this discussion in the phone calls section of ECS. After this phone call, the CE sends a second letter to the employee and includes a written summary of the phone call, blank ADL and information regarding the required medical evidence needed to conduct an impairment evaluation.

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

b. Insufficient Evidence. If the CE determines that the submitted medical evidence is insufficient, the CE sends a follow-up development letter to the employee explaining the deficiency and the additional evidence and/or diagnostic test(s) required to conduct an impairment evaluation.

c. Unavailability of Records. If the employee is unable to provide the necessary medical records, the CMC must decide if an impairment evaluation is possible in accordance with AMA's Guides given the available evidence. The CE may proceed with a CMC referral to determine if the available records are sufficient to perform a rating. If the CMC is able to perform a rating based on the available medical evidence but states that additional testing could potentially increase the rating, the CE notifies the employee that additional testing may result in a higher rating and that the DEEOIC will pay for the additional testing. The CE sends the employee a letter and gives the employee the option of obtaining the necessary testing paid by DEEOIC, or notifying the CE in writing that a decision may proceed based on the available medical evidence. If the employee does not respond, the CE proceeds with the impairment evaluation based on the available medical evidence.

d. Outdated Evidence. If the CE has provided the employee the opportunity to obtain current medical evidence but the claimant has not responded adequately, the CE may use medical evidence in the file that is older than 12 months to obtain an impairment rating from a CMC. In some instances, the CMC may not be able to render an opinion with older or missing medical records.

8. Impairment Ratings for Certain Conditions.

a. Mental Disorders.

(1) Upon receipt of a claim for a mental impairment, the CE must determine whether the claimed impairment originates from a documented physical dysfunction of the nervous system.

(2) Once it has been established that an employee's mental impairment is related to a documented physical dysfunction of the nervous system, the employee obtains an impairment evaluation from the physician based on Table 13-8 of Chapter 13 in the 5th Edition of the AMA's Guides.

(3) If the mental impairment is not related to a documented physical dysfunction of the nervous system, it cannot be rated using the 5th Edition of the AMA's Guides. The CE explains this to the employee and provides the employee 30 days to submit documentation from a physician to establish a link between the exposure to a toxic substance at a covered facility and the development of a mental impairment. The report from the employee's physician must contain rationalized medical analysis establishing that the mental impairment has a relationship to neurological damage due to a named toxic exposure. Speculation or unequivocal statements from the physician reduce the probative value of a physician's report, and, in such situations, the CE may refer the case to an occupational CMC.

b. Breast Cancer.

(1) Upon receipt of a claim for impairment for the breast in either a male or female, the CE submits a request to the physician undertaking the evaluation, explaining all the criteria that are to be considered and referenced in the impairment report (Exhibit 21-5.) For the purposes of considering impairment due to breast cancer in a female, childbearing age will not be a determining factor when issuing an impairment rating, as the AMA's Guides do not define "child- bearing age."

(2) When the physician returns a completed impairment evaluation, the CE is to review it to ensure that the physician has comprehensively addressed each of the factors necessary for an acceptable rating. The impairment evaluation is to contain written information to show that the physician has considered:

(a) The presence or absence of the breast(s);

(b) The loss of function of the upper extremity (or extremities if there is absence of both breasts due to cancer), including range of motion, neurological abnormalities and pain, lymphedema, etc.;

(c) Skin disfigurement (may include notes older than a year and/or photos) and

(d) Other physical impairments resulting from the breast cancer. The

total percentage of permanent impairment of the whole person must be supported by medical rationale and references to the appropriate sections and tables (with page numbers) of the AMA's Guides.

(3) If the CE determines that the physician has not provided a complete rating for a claimed impairment of the breast, the CE sends a follow-up letter to the physician. The CE explains in the letter the noted deficiency in the assessment, and explains that a complete response ensures that the employee receives the maximum allowable rating provided by the AMA's Guides.

c. Pleural Plaques/Beryllium Sensitivity.

(1) The CE may accept an impairment claim for pleural plaques/beryllium sensitivity if the rating physician provides medical rationale and references to the appropriate sections and tables (with page numbers) of the AMA's Guides to justify the impairment rating.

d. Metastatic Bone Cancer.

(1) In situations where the CE accepts a case under the SEC provision based on metastatic (secondary) cancer, i.e. metastatic bone or metastatic renal cancer, often the primary source of the metastatic cancer will prove to be the prostate. If the CE does not accept the prostate cancer due to a lack of a causative link and because prostate cancer is not an SEC-specified cancer, it is important that the CE ensure that a physician does not apply the non-covered prostate cancer in an impairment rating. A physician or CMC may only consider the accepted condition of SEC metastatic cancer for the impairment rating.

9. Receipt of the Impairment Evaluation. Upon completion of the impairment evaluation by a physician, the CE reviews the report to assure that it contains all the information necessary to meet DEEOIC's criteria for a valid impairment. The CE reviews the impairment evaluation to determine the following: whether the opining physician possesses the requisite skills and requirements to provide a rating as set out in paragraph 4d(2); whether the evaluation was conducted within one year of receipt by the DEEOIC; whether the report addresses the covered illness or illnesses; whether the whole person percentage of impairment is explained with a clearly rationalized medical opinion as to its relationship to the covered illness or illnesses, and whether the medical opinion is supported by medical evidence in the case file.

a. Incomplete Ratings. If the impairment rating report is unclear or lacks rationalized medical analysis in support of the offered conclusion, additional clarification is required. In such instances, the CE returns the impairment rating evaluation to the rating physician with a request for clarification, explaining what areas are in need of remedy. If the employee's choice physician submitted the insufficient report and no response is received, or it is returned without sufficient clarification, the CE notifies the physician and the employee of the need for

additional justification. If a response is not forthcoming, the CE may issue a RD to deny the impairment claim for an insufficient impairment report. If the CMC submits an incomplete report, the CE notifies the CMC of the deficiency and requests a more comprehensive report.

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

a. Determining Probative Value. If the impairment reports appear to be of equal value and the ratings are not within 10% of each other, the CE must obtain an evaluation from a second opinion physician.

11. Impairment Award. To calculate the impairment award, the CE multiplies the percentage points of the impairment rating of the employee's covered illness or illnesses by $2,500.00. For example, if a physician assigns an impairment rating of 40% or 40 points, the CE multiplies 40 by $2,500.00, to equal a $100,000.00 impairment award.

a. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000.00. The CE considers any previous compensation awarded under Part E for impairment and/or wage-loss to determine if a subsequent award needs to be reduced to ensure that it does not exceed the $250,000.00 maximum aggregate compensation. In determining the aggregate compensation, the CE does not take into consideration the reduction of compensation based on SWC coordination or tort offset. For example, if the employee was previously awarded benefits for impairment in the amount of $100,000.00 but his compensation was reduced because of tort offset to $60,000.00, the amount of compensation used to determine the maximum aggregate compensation is $100,000.00 not $60.000.00.

12. Impairment and Tort Offset/SWC Coordination. If there are impairment benefits due to multiple covered illnesses, and at least one of those illnesses is subject to a tort offset or coordination of SWC award, the CE must determine the impairment award by following the steps in this section. Since DEEOIC does not apportion impairment within the same organ or body function, if there are several covered illnesses affecting the same organ or body function and one illness from the same organ or body function is subject to coordination or offset, the entire rating for that affected organ or body function is subject to coordination or offset.

a. Determine that coordination and/or offset is required.

(1) SWC Coordination. In an impairment case with multiple covered illnesses, the CE confirms that at least one covered illness from the impairment award is the same illness that serves as the basis for SWC payment.

(2) Tort Offset. In an impairment case based upon multiple covered illnesses, the CE confirms that at least one covered illness from the impairment award is associated with the same exposure to a toxic substance that a tort settlement references as causing illness.

b. Identify the combined impairment rating and calculate the dollar amount. For example, John Doe has a 20% impairment due to his asbestosis and 7% impairment due to his skin cancer. The combined impairment rating according to the Combined Values Chart is 26%, and the potential impairment award is $65,000.00 (26% X $2,500.00 = $65,000.00).

c. Determine the percentage of the combined impairment rating that each separate impairment represents (apportionment) using these steps:

(1) Determine the sum of the individual impairment rating. In the John Doe example case, the individual ratings are 20% due to his asbestosis (lung) and 7% due to his skin cancer, so the sum of his individual impairment ratings is 27% (20% + 7% = 27%)

(2) Calculate the relative percentage of impairment for each organ or body function.

For asbestosis - Divide 20% by 27% to determine that 74.07% of the sum of the individual rating is attributable to asbestosis.

For skin cancer – Divide 7% by 27% to determine that 25.93% of the sum of the individual impairment rating is attributable to skin cancer.

d. Calculate the dollar amount attributable for each organ or body function. In the John Doe example case, the calculation is as follows:

For asbestosis – Multiply 74.07% (the percentage attributable to asbestosis) by the dollar amount of the combined impairment award of $65,000.00 to determine that $48,145.50 is the dollar amount attributable to asbestosis.
For skin cancer – Multiply 25.93% (the percentage of impairment rating attributable to skin cancer) by $65,000.00 to determine that $16,854.50 is the dollar amount attributable to skin cancer.

e. Subtract Offset/Coordination amount from the dollar amount attributable to the organ or body function subject to offset and/or coordination.

Example 1: If the dollar amount attributable to John Doe's lung impairment has to be reduced by $10,000.00 due to coordination (the eligible amount paid from a SWC claim), $10,000.00 is subtracted from $48,145.50 (the dollar amount attributable to asbestosis), which leaves $38,145.50 payable due to asbestosis after coordination of SWC benefits.

Example 2: If the dollar amount attributable to John Doe's lung impairment has to be reduced by $50,000.00 due to coordination, $50,000.00 must be subtracted from $48,145.50 (the dollar amount attributable to asbestosis), which leaves $1,854.50 as a surplus after coordination of SWC benefits. His surplus due to asbestosis will not affect his entitlement to benefits for skin cancer.

f. Calculate the Payable Impairment Award. Add the dollar amounts for each organ or body function (after coordination and/or offset) to determine the amount of the impairment award.

Example 1: Add $38,145.50 for asbestosis (after subtracting the coordination amount of $10,000.00) to $16,854.50 for skin cancer for a total impairment award of $55,000.00.

Example 2: If the coordination amount to asbestosis is $50,000.00, the amount of the total impairment award is $16,854.50 from the skin portion of the combined impairment award if skin cancer is not subject to offset or coordination. The surplus of $1,854.50 after coordination of SWC benefits for asbestosis is NOT subtracted from the skin cancer award. The CE absorbs this surplus from medical benefits for asbestosis and future compensation benefits for asbestosis.

13. How to Calculate Increased Impairment Award with Tort Offset/SWC Coordination. For an increased impairment claim involving tort offset and/or SWC coordination, the calculation must be based on the current impairment rating/award and not on the net increased impairment award.

For example, John Doe had previously been awarded impairment for asbestosis and skin cancer for 26%. The current combined impairment rating is 40%, which is comprised of 33% due to asbestosis and 10% due to skin cancer. Using the current impairment rating, follow the calculation in Section 12c to determine the relative percentage of impairment for each organ or body function and Section 12d to determine the dollar amount attributable for each organ or body function. The dollar amount attributable to each organ or body function must be based on the current impairment award of 40% or $100,000.00 and not on the net increase of 14% (40% - 26% = 14%) or $35,000.00. As such, the increased impairment calculation is as follows:

For asbestosis – Multiply 76.74% (the percentage attributable to asbestosis based on the current impairment rating) by the current impairment award of $100,000.00 to determine that $76,740.00 is the dollar amount attributable to asbestosis.

For skin cancer – Multiply 23.26% (the percentage of current impairment rating attributable to skin cancer) by $100,000.00 to determine that $23,260.00 is the dollar amount attributable to skin cancer.

Since the CE calculates the increased impairment award based on the current impairment rating and not on the net increase, the total of all SWC coordination/tort offset for that organ or body function must be subtracted from the current dollar amount attributable to that organ or body function that is available for SWC coordination/tort offset.

Example: In the previous impairment decision issued to John Doe, the CE concluded that a surplus of $1,854.50 remained for asbestosis after coordination of SWC benefits for asbestosis in the amount of $50,000.00. The total impairment award was $16,854.50 from the skin portion of the combined impairment award. Since the previous impairment decision, the CE concluded that John Doe received an additional SWC coordination for asbestosis in the amount of $10,000.00 for a total coordination amount of $60,000.00.

To calculate the dollar amount of the new impairment award, first subtract the total coordination amount of $60,000.00 for asbestosis ($50,000.00 calculated at the time of the prior award + the additional amount of $10,000.00 = $60,000.00) from the new dollar amount attributable to asbestosis ($76,740.00), which leaves $16,740.00. Add the new amount attributable to skin cancer ($23,260.00) to this figure for asbestosis, and the result is $40,000.00 ($23,260.00 + $16,740.00 = $40,000.00).

Finally, from this amount of $40,000.00, subtract the total amount of impairment benefits previously paid ($16,854.50), and the resulting figure of $23,145.50 is the amount payable as increased impairment benefits ($40,000.00 - $16,854.50 paid on the prior award = $23,145.50), with no outstanding surplus.

In any unique or challenging circumstance involving how best to apply SWC coordination or tort offset to a payable impairment, the CE consults with the NO Policy Branch.

14. Issuance of a RD. The RD for impairment must contain a CE's discussion of the relevant impairment evidence submitted in deciding the claim. Moreover, the CE must explain the sufficiency (or insufficiency) of the evidence justifying the decision outcome. For example, the CE discusses the qualification of the physician to perform an impairment rating. In addition, the CE includes a description of the medical evidence that satisfy the necessary procedural requirements for a valid impairment including MMI, use of AMA's Guides, calculation of rating, citation of AMA tables, etc. For any lump-sum award, the CE explains clearly the calculation of the award, including subtractions due to prior lump-sum impairment payments. If coordination and/or offset is required, the CE explains the steps and calculations performed to derive at the award.

If a decision recommends denial of an impairment claim based upon an insufficient evaluation, or if the CE relies on one evaluation over another evaluation(s) in the file, the CE provides a detailed discussion regarding the probative value of the evaluation(s). In the case of competing medical opinions, the CE discusses the weight of medical evidence as to why one report is insufficient, and/or why one report offers more probative value. In other words, the CE has to explain how he or she selected one physician's opinion over another. This is necessary in the event that the employee submits additional impairment evidence to FAB, as any additional impairment evidence submitted has to overcome the weight of medical evidence as assigned by the CE.

15. FAB Development. Once the CE issues RD on impairment and the CE forwards it to FAB, the employee may submit new medical evidence and/or additional impairment evaluations to challenge the impairment determination discussed in the RD.

a. Reviewing Ratings. The employee bears the burden of providing additional impairment evidence that shows an error of procedural application or that provides a probative medical argument to overcome the CE's assignment of weight of medical evidence as discussed in the RD. However, if the evidence is not from a qualified physician who meets the requirements of paragraph 4d(2) of this chapter, the FAB HR or FAB CE will not consider it probative.

b. FAB Review. The FAB CE or HR reviewing the case is to take into consideration the list of factors in section 9 when weighing impairment evaluations for probative value. In addition to the impairment rating(s), the FAB reviews all the relevant evidence of impairment in the case record and determines which evidence is most probative. If the employee's file contains multiple impairment evaluations, the FAB CE or HR reviews each report to determine which provides the most probative value given the totality of the evidence. Any analysis by a FAB CE or HR relating to a contested impairment rating must include a careful consideration of the weight of medical evidence. The mere presentation of new medical evidence does not serve as a singular basis to invalidate the weight of medical evidence as assigned in a RD. The FAB may not remand impairment solely on the basis of receipt of new evidence.

c. Development. When evaluating objection or new evidence in response to a recommendation relating to impairment, the FAB CE or HR must undertake any reasonable development to resolve disputes. This includes submitting medical evidence received after the issuance of a RD to a CMC to determine the effect, if any, it has on an assigned impairment rating.

d. FD. The FD must contain sufficient narrative to describe whether the FAB CE or HR feels that the recommended findings comply with the procedural requirements of the DEEOIC for a valid impairment award and that the findings derive reasonably from the medical evidence of record. The FAB CE or HR must independently validate any calculations of impairment, including any applicable SWC coordination or tort offsets.

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

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

a new claim.

a. Timeframe. The employee may not submit a claim form for an increased impairment rating earlier than two years from the date of the last FD on impairment.

(1) Waiver of the Two-Year Waiting Period. The CE has discretion to ascertain the circumstance warranting the waiver of the two-year waiting period. The CE may consider waivers under the following circumstances.

(i) The CE accepts a new covered illness since a previous FD awarding impairment and the condition relates to an organ system (in accordance with the AMA's Guides to the Evaluation of Permanent Impairment, 5th Edition) that was not included in a prior rating. For example, an employee was already rated for a pulmonary condition, but now has an approval for a newly diagnosed skin cancer.

(ii) The claimant requests a waiver of the two-year rule and submits medical evidence, documenting since the last impairment rating, that the accepted condition(s) has caused a substantial detrimental effect to the claimant's living circumstances, one or more ADLs, or medical status. The effect should represent a change unlikely to improve. For example, an employee previously rated for lung cancer, who was mobile and able to perform most ADLS, has a sudden degradation of their accepted condition to the point where they are rendered bedbound. No other treatment modalities are available. Under this circumstance, the CE could grant a waiver of the two-year waiting period for a new impairment, if requested. Alternatively, an employee who has had an impairment rating performed for multiple skin cancers receives approval for two new skin cancers. There is no documented change to the employee's lifestyle or ADLs. Under this circumstance, a waiver is inappropriate because the new conditions relate to the organ system previously rated and there is no evidence of a substantial detrimental effect to the claimant's living circumstance. 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.

(2) New Consequential Illness. The CE waives the two-year time period requirement if the consequential condition affects an organ or body function that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. The FAB issued a FD one year ago to award a 50% impairment due to whole person impairment rating to the respiratory system. A consequential illness is accepted for stomach ulcers because of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the

consequential illness affects an organ or body function (digestive) that was not included in the prior impairment assessment.

However, if the consequential illness involves an organ or body function previously included in an impairment assessment, the two-year time period requirement is not waived.

(3) Terminal Employees. If medical evidence or other information clearly establishes that the employee is terminal, the CE has the discretion to waive the two-year period requirement.

(4) 0% Rating. If FAB issues a 0% impairment rating FD and subsequently it or the DO obtains a new impairment rating greater than 0%, the two-year wait period does not apply. The new evidence for increased impairment is to be reviewed and either a DD with authority to do so or the Director should consider reopening the FD with the 0% impairment. However, if the two-year wait period has elapsed between the 0% rating and a request for increased impairment, a reopening is not required since a CE can treat the request as a new claim.

The two-year wait period still applies if the employee is denied an impairment award because there is no increase in the impairment rating. For example, the FD denied the impairment claim because the rating of 15% did not increase from the previous FD. In this situation, the employee must comply with the two-year wait period from the last FD that denied the impairment claim because of no increase in rating.

b. Untimely Requests for Re-evaluation. If the two-year date is within three months or less of the two-year mark, the CE may initiate development of the impairment claim. However, a RD cannot be issued until the two-year mark. In this circumstance, the CE informs the employee in writing that he/she is not eligible for an impairment decision until at least the two-year mark. The language can be included with the development letter or as a separate letter if all development is completed.

If the employee submits an untimely request for re-evaluation more than three months prior to the two-year mark, the CE administratively closes the impairment claim. This two-year wait period applies even if the employee submits a new impairment report with a rating that is higher than the previous impairment award. The CE sends a letter to the employee explaining the administrative closure and the two-year wait requirement. The letter informs the employee to resubmit a new claim at or after the two-year mark.

17. Issues Involving Survivor Election. Issues Involving Survivor Election. If a covered Part E employee dies after submitting a Part E claim, but before that claimed payment is received, and if the employee's death was caused solely by a non-covered illness or illnesses, the survivor may elect to receive the compensation that would have been payable to the employee (known as election of benefits), including impairment (refer to Chapter 20 – Establishing Survivorship). It

is not necessary for the employee to have filed a claim specifically for impairment benefits to have the election of benefits option available. As long as the employee filed a claim for Part E benefits, the CE presumes that claims for impairment and wage-loss were filed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any subsequent amount of monetary benefits claimed by the survivor up to the aggregate maximum amount of compensation payable under Part E.

a. Instances Where Impairment is Not Available to a Survivor. In some cases, an impairment rating is not possible in accordance with the AMA's Guides because the necessary diagnostic or medical evidence is unavailable. If new information cannot be collected following the death of the employee, the CE advises the survivor of the deficiency in a letter. The CE should also advise the survivor that he/she may be eligible to receive compensation for wage-loss. If the CE is uncertain as to whether there is sufficient medical evidence to perform an impairment rating following the death of the employee, the CE can refer the case to a CMC for consideration. The CE notifies the claimant of any deficiency that prevents the CMC from opining on the employee's impairment and allow for the submission of supportive evidence. If an impairment rating cannot be performed due to lack of sufficient medical evidence, the CE denies the impairment claim.

CHAPTER 22 – WAGE-LOSS DETERMINATIONS

1. Purpose and Scope. This chapter provides procedures for evaluating a wage-loss claim under Part E and describes relevant terminology and definitions related to wage-loss. In addition, the chapter provides guidance on how to evaluate wage and medical evidence to determine if wage-loss compensation can be awarded. The chapter also explains how compensable wage-loss is calculated.

a. OIS. Anyone undertaking development action with regard to a claim for wage-loss is to ensure that documents generated or received during the evaluation process are properly bronzed/scanned into the OIS. This guidance applies to any of the procedures described throughout this chapter.

2. Policy. DEEOIC staff is responsible for processing wage-loss determinations and ensuring that benefits are appropriately paid. Wage-loss decisions issued by DEEOIC staff are to explain each finding relevant to the applicable wage-loss decision, along with a clear description of the calculations used to compute any possible wage-loss benefit.

3. Definitions.

a. Average Annual Wage (AAW) refers to four times the average quarterly wages for the twelve quarters that preceded the quarter during which the covered Part E employee first experienced wage-loss due to a covered illness that was caused by exposure to a toxic substance at a DOE facility or RECA section 5 facility, excluding any quarter during which the employee was unemployed (See subparagraph f below). The calculated AAW is the baseline wage against which the CE measures a subsequent calendar year wage earned by a covered Part E employee.

b. A calendar year is defined as the twelve-month period from January through December.

c. The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The CPI is the most widely used measure of inflation. The CPI is often used to adjust benefit payments (for example, Social Security and Federal Employees' Compensation Act payments) and income eligibility levels for government assistance, and to automatically provide cost-of-living wage adjustments.

d. Normal Social Security Retirement Age is the age at which an employee receives unreduced Social Security retirement benefits. This age varies by date of birth and is set by §216(1) of the Social Security Act, 42 U.S.C. §416(1).

In general, persons born during or before 1937 are eligible for unreduced Social Security retirement benefits at age 65. The eligibility age increases in two-month increments for persons born between 1937 and 1960 until it reaches 67, which is the age at which persons born during or after 1960 become eligible for unreduced

Social Security retirement benefits (Exhibit 22.1.)

e. A quarter is defined as the three-month period of January through March, April through June, July through September, or October through December.

f. A quarter during which the employee was unemployed (for purposes of determining AAW) is a quarter during which $700 (in constant 2005 dollars) or less in wages were earned by the employee, unless the quarter is one where the employee was retired. If the CE determines that the adjusted value is $700 or less, then the employee is considered to have been unemployed during that quarter and it will not be included in the calculation of the AAW.

g. A quarter during which the employee was employed (for purposes of determining AAW) is a quarter in which the adjusted value of the employee's wages for the quarter exceeds $700 in constant 2005 dollar values. For example, $700.01 in adjusted value is considered to be a quarter of employment. A quarter in which the employee was employed will be included in the AAW calculation.

h. A year of wage-loss is defined as a calendar year in which the employee's wages were less than the employee's AAW, as a result of the covered illness that is due to the employee's exposure to a toxic substance at a covered facility. Prior to making this finding, the CE adjusts the yearly wages for inflation to determine their values during the calendar year in which the employee first experienced wage-loss due to a covered illness.

4. General Requirements for Wage-Loss. There are some general requirements that a CE has to establish before a case can be accepted for wage-loss:

a. Covered Part E Employee. The employee is, or was, an employee of a covered DOE contractor or subcontractor; and

b. Covered Illness. The employee developed a covered illness as a result of exposure to a toxic substance at a covered DOE facility or RECA section 5 facility; and

c. Trigger Month. A particular year and month (trigger month) that the employee first experienced wage-loss as a result of the covered illness prior to his or her normal Social Security retirement age; and

d. Causal Relationship. Wage-loss in the trigger month was causally related to the employee's covered illness; and

e. Wage-Loss: Wage-loss occurred due to the covered illness. Wage-loss determinations are based upon the calendar years of wage-loss occurring up to and including either the calendar year the employee reaches normal Social Security retirement age or the last calendar year of wage-loss prior to the submission of the wage-loss claim, whichever occurs first.

5. When Wage-Loss Is Not Covered: Wage-loss benefit is to be denied in the following circumstances:

a. Employee is not a covered Part E employee: If the employee worked for an AWE or for a beryllium vendor (unless the employee was employed during a period in which the facility was designated as a DOE facility for remediation and the employee was employed by a remediation contractor) he/she is not considered a covered Part E employee and is not entitled to wage-loss benefits.

b. Wage-loss is not due to a covered illness: For example, if the employee was not earning wages because of a Reduction-In-Force at his job before the trigger month, wage-loss cannot be awarded because the wage-loss was due to a Reduction-In-Force and not due to a covered illness.

c. Employee experiences wage-loss (as a result of a covered illness) after his or her normal Social Security retirement age.

d. Employee's death occurs less than ten years before his or her normal Social Security retirement age and does not experience any wage-loss prior to his or her death (for survivor claims).

e. Employee did not earn wages before the trigger month. For example, if the employee did not work and was not earning wages before the trigger month, wage-loss is to be denied because the employee did not earn wages prior to the trigger month to be able to establish a reduction in wages.

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

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

b. Timeframe: The CE is to allot 60 days for the claimant to respond to Form EE-11B/EN-11B, with a follow up request sent to the claimant at the first 30-day interval. The CE uses Form EE-11B/EN-11B for the follow up request, but marks

the form "Second Request." The CE does not develop for wage-loss until a completed Form EN-11B is received.

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

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

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

7. How to File Subsequent Wage-Loss Claims. An employee who has been previously awarded compensation for wage-loss may file a Form EN-10 for subsequent calendar years of wage-loss. The employee may file a Form EN-10 on a yearly basis, or for an aggregate of calendar years in which wage-loss is alleged. With the filing of an EN-10, the claimant is to submit sufficient employment and medical evidence to establish that the claimant is entitled to additional wage-loss benefits.

8. Development of Wage-Loss Claims. Upon receipt of a signed Form EN-11B or Form EN-10 claiming wage-loss or subsequent wage- loss, respectively, the CE determines if there is sufficient medical and earnings evidence to support a claim for wage-loss. If not, the CE sends a letter requesting the required evidence from the claimant. If there is no response within 30 days, the CE contacts the claimant by telephone to assist the claimant with obtaining the required evidence. The CE advises the claimant verbally of the need to obtain this evidence. The CE explains that if the required evidence is not submitted within 30 days, a RD to deny the wage-loss claim may be issued. It is important that the CE record this discussion carefully in the phone calls section of ECS. After this phone call, the CE sends a written summary of the call to the claimant.

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

9. Medical Evidence to Establish Wage-Loss. The claimant is required to submit medical evidence of sufficient probative value to establish that the period of wage-loss claimed is causally related to the employee's covered illness.

There are instances when the medical evidence shows multiple conditions contributing to the wage-loss. As long as the evidence establishes that a covered illness contributed to the

employee's wage-loss, then the medical evidence is sufficient to prove causal relationship.

An acceptance of Social Security Disability benefits alone is not sufficient evidence to establish a causal relationship, unless accompanied by supporting medical evidence.

If a secondary cancer is the accepted covered illness but the primary is not accepted(e.g., secondary bone cancer is accepted but the primary prostate cancer is not accepted), the medical evidence needs to support that the wage-loss is causally related to the secondary cancer, because the causation requirement has not been met for the primary cancer.

The CE develops the case for a causal relationship between the claimed years of wage-loss and the employee's covered illness by requesting medical evidence from the claimant and/or medical provider. Medical evidence can include the following:

a. Narrative Report from a Physician. A physician's narrative report is to contain an explanation about the causal relationship between the covered illness and the period(s) of wage-loss and reference medical evidence that is contemporaneous to the claimed period(s) of wage-loss. A narrative report that is speculative in nature, or is not well-rationalized is not considered to be of sufficient probative value.

b. Return to Work Slips Signed by a Physician. The work slip is to indicate that the return to work was from a covered illness.

c. Physician's Office Notes. Physician notes are to indicate that the employee had stopped working, reduced his work hours or missed work due to the covered illness.

d. CMC Opinion. The CE is to use discretion when determining if a CMC referral is warranted. For example, a referral to a CMC is not warranted when there is insufficient wage evidence to prove wage-loss. Additionally, the CE does not refer a case file to a CMC if the claimant and/or treating physician have not been contacted first for the requisite medical information.

   The CE is to request the opinion of a CMC on causal relationship between the covered illness and wage-loss if the evidence is inconclusive. The CMC may also provide an opinion regarding the period of illness-related wage-loss. In most instances, wage-loss questions are best handled by a CMC who specializes in occupational medicine. In the CMC referral, the CE specifies the period of wage-loss in question and identifies the accepted covered illness. The CE instructs the CMC to provide a detailed rationale for his or her opinion. The CE submits both medical and employment evidence for CMC evaluation.

   Example of a wage-loss question to CMC: *Please review the case records to determine if the employee's wage-loss for the period from June 1975 to August 1999 is causally related to the accepted illness of asbestosis. If the available medical evidence is insufficient to make a wage-loss determination for a certain period, indicate the dates. Provide your rationale to support your conclusion.*

10. Wage Evidence to Establish Wage-Loss. Wages are defined as all monetary payments that the employee earns from employment or services that are taxed as income by the Internal Revenue Service. Salaries, overtime compensation, sick leave, vacation leave, tips, buyouts and bonuses received for employment services are considered wages. However, capital gains, IRA distributions, pensions, annuities, unemployment compensation, SWC benefits, medical retirement benefits, and Social Security benefits are not considered wages.

The CE obtains evidence of the employee's wages for the calendar year(s) during the claimed period(s) of wage-loss and for the twelve quarters immediately preceding the first quarter of claimed wage-loss. These twelve quarters of wages immediately preceding the first quarter of claimed wage-loss are used to determine the AAW. (See paragraph 12)

The CE generally relies upon the earnings information that has been reported to the SSA, but can also rely upon additional wage information submitted by the claimant.

a. SSA earnings records are received from the claimant if available or the CE digitally faxes a completed Form SSA-581 to SSA to obtain this information. The form is located on the shared drive in the Forms folder under Policies and Procedures). The process to obtain earnings records using Form SSA-581 is as follows:

(1) The CE is to complete the top portion of the Number Holder's Information section on the SSA-581. This includes the following information: name; SSN; date of birth of employee; date of death of employee (if applicable); and other name(s) used. The CE completes the form with the years deemed necessary to verify employment and/or establish wage-loss on the "Periods Requested" line. In the box entitled, "Requesting Organization's Information," the CE types his or her name and identifies the DO under, "Signature of Organization Official." The CE dates the form and lists his or her direct phone number, along with the DO fax number. The CE is to capitalize all entries on the SSA-581.

(2) The completed SSA-581 must be digitally faxed to SSA using fax number 877-278-7067. A cover letter is not required, nor is it necessary to fax the second page of the SSA-581 that contains the Privacy Act Statement. The CE is responsible for bronzing into OIS the completed SSA-581 and fax receipt.

(3) If the faxed SSA-581 is deficient, the SSA contacts the CE directly to explain the deficiency, or the SSA emails the DEEOIC designated POC with a list of rejected SSA-581s for each DO. This email will include the name of the employee, the employee's SSN, SSA reference number, and the reason(s) for the rejected SSA-581.

(4) The POC forwards the email of a rejected SSA-581 to the assigned CE. After making the necessary corrections, the CE digitally faxes the corrected SSA-581 with a cover sheet (Exhibit 22-2) to FAX number (410) 594-2054. The cover sheet must include the SSA reference number.

The CE is responsible for bronzing into OIS any document received or created in response to a rejected SSA-581.

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

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

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

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

(b) Name of your organization.

(c) A copy of the SSA-581 or earnings statement in question.

(d) The full SSN of the number holder (employee), or the control number from the earnings statement.

(8) Upon receipt of a completed SSA-L460, the CE documents receipt of the SSA response in ECS. Should the SSA fail to submit an SSA-L460 after following up within the established procedures, the CE is to proceed with claim adjudication based upon the evidence contained in the case record or request other forms of wage information as noted below:

b. Tax Returns and W2 Forms provide proof of the employee's wages in instances where the employer did not report accurate and/or complete earnings to SSA, when the employee worked for an employer where there was no reporting of income to SSA, or where SSA earnings records indicates that the employee earned more than the maximum amount of taxable earnings (see paragraph 12c). If a W2 Form is submitted, the claimant is to submit an affidavit attesting that he or she has submitted all W2 Forms for that calendar year;

c. Pay Stubs that provide proof of the employee's wages;

d. Union records that provide proof of the employee's wages;

e. Pension records that provide proof of the employee's wages; and

f. DAR for Pay and Salary Records that provide an employee's pay, salary, any workers' compensation claim or other documents affecting wage. Examples of records from the DOE database include, but are not limited to, Official Personnel Files of Contractor Employees, Contractor Job Classification, Employee Awards Files, Notification of Personnel Actions, Classification Appraisals, Wage Survey Files, and Unemployment Compensation Records.

11. Wage-Loss Calculator. The Wage-Loss Calculator in ECS is used to calculate wage-loss benefits. The CE enters the employee's wages for all claimed years of wage-loss and the twelve quarters immediately prior to the first quarter of experienced wage-loss into the Wage-Loss Calculator. The Wage-Loss Calculator calculates the AAW, determines the wage-loss percentage and calculates the wage-loss award.

12. Calculation of AAW. The AAW is the baseline wage against which the Wage-Loss Calculator measures each claimed year of wage-loss to determine the wage-loss percentage. To determine the AAW, the Wage-Loss Calculator adds the wages from the quarters (up to twelve quarters) immediately prior to, but not including, the quarter where the employee first experiences wage-loss due to a covered illness. The sum of the total wages is divided by the number of quarters included in the sum to get the average quarterly wage. The Wage-Loss Calculator then multiplies the average quarterly wage by four to determine the AAW.

The Wage-Loss Calculator will identify any quarter in which the employee earned $700 or less in constant 2005 dollars. The Wage-Loss Calculator determines the dollar value of any wages for any given year to reflect their value (buying power/worth) to 2005 dollar by using the CPI Inflation Calculator on the Bureau of Labor Statistics' website: https://www.bls.gov/data/inflation_calculator.htm

Example: If the CE enters that the employee earned $100 in a quarter of employment in 1963, the Wage-Loss Calculator, using the CPI Inflation Calculator, determines that $100 in 1963 has the same adjusted value as $638.24 in 2005 dollars. Since the adjusted value of $638.24 is less than $700 in constant 2005 dollars, the Wage-Loss Calculator identifies this quarter for further review by the CE. The CE must identify the quarter as either unemployed or retired depending on the employee status for that quarter.

a. Unemployed: If the CE considers the employee to have been unemployed for a particular quarter that quarter is excluded in the calculation of the AAW.

Example: If an employee is unemployed for three quarters during the AAW period; the Wage-Loss Calculator adds the wages from the nine quarters of employment (excluding the wages from the three quarters of unemployment) and divides by nine rather than twelve to get the average quarterly wages. The Wage-Loss Calculator then multiplies the average quarterly wages by four to obtain the AAW.

It should be noted that a wage-loss claim is denied if the employee did not earn any wages before the trigger month. To establish a claim for wage-loss, the

employee first had to earn wages before the trigger month.

b. Retired. If an employee is retired prior to his or her normal Social Security retirement age due to his covered condition, he/she is not considered unemployed under Part E. Even though the retired employee has no wages reported to SSA or the wages are less than $700 in constant 2005 dollars, this time period is not excluded from the calculation of the AAW.

Example: If the CE determines that the employee was retired (prior to his or her normal Social Security retirement age), during the entire twelve quarters immediately preceding the quarter during which he or she first experienced wage-loss due to a covered illness, the AAW is $0.

If the employee earned wages during any of the twelve quarters and then retired before the of the twelve quarters, those earned wages are included in the AAW calculation.

Example: If the Wage-Loss Calculator identified two quarters as quarters with earnings less than $700 in constant 2005 dollars and the CE identified these two quarters were due to retirement, the Wage-Loss Calculator adds the wages for the twelve quarters including the two quarters of retirement and divides the sum by twelve to get the average quarterly wages. The CE then multiplies the average quarterly wages by four to obtain the AAW.

c. Maximum Amount of Taxable Earnings. If the employee's earnings meet SSA's maximum amount of taxable earnings for that year, those earnings that exceed the maximum limit are not reflected in the SSA statement. The CE is to find the maximum amount of taxable earnings under the SSA for a specific year at the SSA website: http://www.ssa.gov/OACT/COLA/cbb.html.

(1) Multiple Employers. For any year in which the employee is employed by multiple employers, according to SSA, each of the employers withholds Social Security taxes on the wages without regard to what the other employers may have withheld. Therefore, the employee can potentially meet the maximum amount of taxable earnings under SSA from each employer for the same year in question.

To determine if any additional wages have been unaccounted for in the SSA earnings summary, the CE contacts the claimant by telephone and requests evidence to support additional wages (see paragraph 10 for different types of wage evidence). The CE memorializes the claimant's response in ECS. The CE follows up with a letter notifying the claimant of the earnings information included in the SSA earnings summary for the applicable year(s). In the letter, the CE requests that the claimant submit evidence of wages that may have been unaccounted for as a result of reaching the maximum amount of taxable earnings under the SSA. If the claimant does not submit additional evidence within 30 days of the letter, the CE is to proceed with claim adjudication based upon the evidence

contained in the case record.

d. Additional Wages. If there is evidence of wages based on records other than SSA, the CE adds any additional wages earned by the employee during those same quarters as supported by the submitted evidence.

e. Annual SSA Earnings Report. In the late 1970's, SSA began reporting yearly earnings summary instead of quarterly earnings summary. In instances when only a detailed SSA yearly earnings summary is available, the CE divides the yearly earnings by four (representing four quarters in a year) to estimate the quarterly earnings for each year.

13. Determination of Wage-Loss Percentage. The Wage-Loss Calculator compares the AAW of an employee with his or her adjusted (for inflation) wages in later calendar years to determine the wage-loss percentage. The Wage-Loss Calculator begins with the calendar year that includes the quarter in which the claimed wage-loss commenced, and concludes with the last calendar year of claimed wage-loss, the calendar year in which the employee reached normal Social Security retirement age or the calendar year in which the employee would have reached his normal Social Security retirement age but for his covered illness-related death.

a. Adjustment of Wages for Inflation. Wages are adjusted for inflation for each calendar year that wage-loss is claimed. The wages are adjusted for inflation to reflect the value (buy power/worth) during the calendar year in which the employee first experienced wage-loss due to a covered illness. The Wage-Loss Calculator performs this calculation by using the CPI Inflation Calculator. Example: The employee claims wage-loss first commencing in 1993 and ending in 2002 when the employee reaches normal Social Security retirement age. The Wage-Loss Calculator adjusts the yearly wages for inflation to reflect the value of the wages for the calendar year in which the wage-loss first commenced (which in this example is 1993). If the employee earned $38,000 in 1995, this wage is adjusted for inflation using the CPI Inflation Calculator to $36,030.18 to reflect the value in 1993 dollars.

b. Comparison with the AAW. The Wage-Loss Calculator compares the AAW of the employee with his or her adjusted wages in later calendar years to ascertain the wage-loss percentage for each claimed year of wage-loss. For example, $36,030.18 (Adjusted Wage) ÷ $46,000 (AAW) = 78% (Wage-Loss Percentage).

14. Employee Wage-Loss Compensation. The Wage-Loss Calculator uses the wage-loss percentage to determine the amount of the employee's wage-loss compensation.

a. If the employee's adjusted wages during a claimed calendar year is greater than 75% (X > 75%) of the AAW, then the employee is not considered to have wage-loss for that calendar year and the employee is not awarded wage-loss benefits for that calendar year.

Example #1: AAW = $46,000.00
Adjusted wages = $36,030.18
Percentage of AAW = 78%

b. $10,000 is awarded for each year in which the employee's adjusted wages during a claimed calendar year is greater than 50% but less than or equal to 75% (50% < X < 75%) of the AAW.

Example #1: AAW = $46,000.00
Adjusted wages = $34,662.00
Percentage of AAW = 75%

Example #2: AAW = $46,000.00
Adjusted wages = $23,661.80
Percentage of AAW = 51%

c. $15,000 is awarded for each year in which the employee's adjusted wages during a claimed calendar year is equal to or less than 50% (X ≤ 50%) of the AAW.

Example #1: AAW = $46,000.00
Adjusted wages = $23,076.00
Percentage of AAW = 50%

Example #2: AAW = $46,000.00
Adjusted wages = $11,646.75
Percentage of AAW = 25%

The following is an example of a Wage-Loss Calculation:

AVERAGE ANNUAL WAGE: $46,000.00

Year	Reported Earnings	Adjusted Earnings	Percentage	Compensation
1993	$44,000.00	$44,000.00	96%	$0
1994	$40,000.00	$39,001.30	85%	$0
1995	$38,000.00	$36,030.20	78%	$0
1996	$35,000.00	$32,233.90	70%	$10,000.00
1997	$38,500.00	$34,662.00	75%	$10,000.00
1998	$30,000.00	$26,595.10	58%	$10,000.00
1999	$26,000.00	$22,551.00	49%	$15,000.00
2000	$27,500.00	$23,076.00	50%	$15,000.00
2001	$29,000.00	$23,661.80	51%	$10,000.00
2002	$14,500.00	$11,646.75	25%	$15,000.00
Wage-Loss Payable Compensation				$85,000.00

15. Survivor Wage-Loss Compensation. The CE first determines whether the survivor is entitled to benefits under Part E of the EEOICPA. If the survivor is found to be entitled to survivor benefits, he/she may also be entitled to additional compensation for wages lost by the

employee as a result of the covered illness. The CE undertakes the same medical and employment development and AAW calculation as if the employee had filed a claim. The difference is that the monetary benefit provided to a survivor is limited to an additional $25,000 or $50,000 based on the number of years in which the employee's adjusted wages during a claimed calendar year is equal to or less than 50% (X ≤ 50%) of his or her AAW.

a. Percentage of Loss: If the employee dies as a result of the covered illness prior to his or her normal Social Security retirement age, the Wage-Loss Calculator performs the same inflation adjustment calculation as an employee claim for each calendar year of wage-loss claimed through and including the calendar year of death to determine the percentage of loss.

For the years after the employee's death, the Wage-Loss Calculator assumes that the employee had no wages and therefore the adjusted wages were less than or equal to 50% of the AAW for each year after the year of the employee's death up to and including the calendar year of his or her normal Social Security retirement age.

In some instances, the employee may have lost wages due to a covered illness prior to his or her death. In this situation, the CE ensures that the Wage-Loss Calculator includes the period of wage-loss (prior to and including the calendar year of the employee's death) and adds any calendar years in which adjusted wages were less than or equal to 50% of the employee's AAW to the number of calendar years after the year of the employee's death up to and including the calendar year of his or her normal Social Security retirement age (based on the assumption that the employee did not earn any wages after his or her death) in order to determine the survivor's entitlement.

(1) $25,000.00 Award. For the survivor to be awarded an additional $25,000.00, the employee must have 10 to 19 years in which the employee's adjusted wage is equal to or less than 50% (X ≤ 50%) of his or her AAW.

(2) $50,000.00 Award. For the survivor to be awarded an additional $50,000.00, the employee must have 20 or more years in which the employee's adjusted wage is equal to or less than 50% of his or her AAW.

b. Survivor Election. If a covered Part E employee dies after filing a Part E claim but before the claimed payment is received, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received, had he/she not died prior to payment, rather than survivor benefits. It is not necessary for the employee to have filed a claim specifically for wage-loss benefits for the election option to be available to the survivor(s). As long as the employee filed a claim for Part E benefits, claims for impairment and wage-loss benefits are presumed by the CE. The earlier receipt by the employee of monetary benefits under Part E for impairment or wage-loss does not negate the availability of this election for any subsequent amount of monetary benefits claimed by the survivor.

16. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000.00. The CE considers any previous compensation awarded under Part E for impairment and/or wage-loss to determine if a subsequent award needs to be reduced to ensure that it does not exceed the $250,000.00 maximum aggregate compensation. In determining the aggregate compensation, reduction of compensation based on SWC coordination or tort offset is not taken into consideration. For example, if the employee was previously awarded benefits for impairment in the amount of $100,000.00 but his compensation was reduced because of tort offset to $60,000.00, the amount of compensation used to determine the maximum aggregate compensation is $100,000.00.

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

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

In a RD denying wage-loss benefits, the CE is to explain which specific requirement(s) was not established to justify the wage-loss denial.

For finalizing a wage-loss RD, the FAB Representative independently evaluates the CE findings and wage-loss calculations for accuracy. The FAB Representative ensures that a copy of the DO calculations is in OIS. Printouts of the calculation performed by the FAB Representative are also bronzed in OIS. If the FAB Representative cannot determine the basis for a wage-loss decision, the case file is remanded.

CHAPTER 23 – CONSEQUENTIAL CONDITIONS

1. Purpose and Scope. This chapter discusses the CE's role when developing claims for consequential conditions. It also discusses the types of injuries, illnesses, impairments, or diseases that may be considered as consequential conditions.

a. OIS. Anyone undertaking development action with regard to a claim for consequential conditions is to ensure that documents generated or received during the evaluation process for consequential conditions are properly bronzed/scanned into the OIS. This guidance applies to any of the procedures described throughout this chapter.

2. Defining a Consequential Condition. 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 CE is to accept as compensable any claimed consequential condition(s) that is documented properly by substantive, well-rationalized medical evidence.

Consequential conditions can arise for any reason established as being medically linked to a previously accepted work-related illness. In some instances, a "chain of causation" can result in a series of injuries, illnesses, impairments, or diseases, which are a direct consequence of an accepted work-related illness. When medical evidence is present to establish such a scenario, the resulting consequential condition(s) in the causal chain are all compensable under the EEOICPA. The acceptance of a consequential condition(s) results in medical coverage for that condition(s) under Part B and/or Part E as appropriate. Additionally, under Part E, any diagnosed illness, injury, impairment, or disease shown by medical evidence to be a consequence of a covered Part E condition may affect the calculation of an impairment rating and/or wage-loss.

3. Claims for Consequential Conditions. The claimant must file a claim for all consequential condition(s) in writing and may use any method of written notification, so long as the claimant signs the submission. However, while documents containing written words of claim for a consequential condition(s) are acceptable, the CE is to obtain a completed and claimant signed Form EE-1/2 associated with the consequential claim before issuing a decision. A signed claim form is also required for all metastatic cancers. Ideally, the claimant should concurrently send a written statement identifying the specific nature of the consequential condition claimed, along with a signed EE-1/2. A signed EE-1/2 is required, because it provides notice to the claimant of his or her responsibilities in filing for benefits under the Act.

a. For each distinct medical condition claimed as a consequence of a previously accepted condition, the CE undertakes a careful examination of the evidence presented in support of the claim. If the evidence demonstrates the existence of a diagnosed consequential illness and the CE decides that the medical justification is sufficient to link reasonably the condition to a previously accepted condition, he or she proceeds with issuing a letter decision of acceptance (refer to 10a on acceptances). In those claims situations where insufficient evidence exists, after development, to establish a consequential claim, the CE issues a RD of denial. There may be instances where a claimant files words of claim or an EE-1/2 for a condition but it is not clear whether the claimant's intent was to file the condition

as resulting from toxic substance exposure or as a consequential condition. In most cases, the condition will be processed as a primary diagnosed condition resulting from toxic substance exposure. However, if the medical or factual information provided with the words of claim or the EE-1/2 alludes to the fact that the condition may be a consequence of a previously approved condition, the CE is to contact the claimant to obtain clarification on whether he or she wants the claim to be processed as a primary condition or as a consequential condition. Once the CE obtains clarification, he or she documents the claimant's intent in ECS and begins appropriate development for that condition.

In those cases where only words of claim was filed, the CE requests that the claimant submit a completed and signed EE-1/2 clearly indicating that the condition is consequential, prior to issuing any decision. (Note: if a completed and signed EE-1/2 was already submitted and the CE just needed to seek clarification of the claimant's intent, a new updated EE-1/2 is not needed).

(1) For any consequential condition(s) where the CE has requested a completed and signed Form EE-1/2, the CE allows a period of 30 days for the claimant to submit the required documentation. After 30 days, the CE administratively closes the claim if the claimant has not submitted a signed EE-1/2 claim form. The CE is to mail a notice to the claimant(s) that no further action will occur on the claim for that medical condition until receipt of a completed and signed claim form.

b. In some situations, the CE may find evidence contained in a case record that suggests that an unclaimed medical condition is consequential to an accepted condition. If there is sufficient reason to discern that the evidence of record communicates the existence of a likely consequential condition, the CE is to contact the claimant to ascertain whether he or she wants to claim that condition as consequential to a previously accepted illness. If the claimant states that he or she wants to file a claim for that condition, the CE instructs the claimant to submit a completed and signed EE-1/2 form. The mere fact that the CE identifies an unclaimed condition in the medical evidence is not sufficient reason to seek a new claim. Evidence has to be present in the case record to lead the CE to a reasonable conclusion that the condition is consequential to an approved primary condition.

c. Where a claimant previously filed Form EE-1/2 for a condition due to toxic substance exposure that was denied, but later claims that the denied condition is consequential to an accepted condition, the claimant is to file a new Form EE-1/2 claiming the condition as a consequential illness. In this scenario, the CE treats it as new claim filed under the EEOICPA. As this is a new claim filed under the EEOICPA, a Director's Order vacating the prior denial of the same condition based on toxic substance exposure is unnecessary.

4. Claim Development. When assessing a claim for a consequential condition, medical evidence is required to document clearly the relationship that creates the nexus between a consequential condition and an accepted work related illness. The medical documentation is to

contain information identifying the diagnosis of the consequential condition. In addition, the medical evidence is to include a physician's opinion that presents a convincing and well-rationalized conclusion linking the consequential condition to a previously accepted illness. The opinion of the physician regarding a consequential condition is to be sufficiently probative and compelling to allow the CE to assign the weight of medical evidence to the conclusion offered. Physicians offering vague, equivocal, speculative positions on the relationship between a consequential condition and a work-related illness require additional investigation by the CE. Additional development is also required when a physician offers opinions that the CE considers to be unsupported by any reasonable medical justification.

a. Exhibit 23-1 provides a sample listing of secondary medical conditions that are known to result from CBD (and treatment), silicosis, prednisone treatment, and other conditions. This list is not all-inclusive but serves as a guide for identifying some commonly known consequential illnesses. While Exhibit 23-1 serves as a guide and lists potential secondary illnesses, the CE is to exercise discretion when developing for these conditions. The fact that a condition appears as "secondary" in this appendix in no way establishes that the condition truly resulted from the claimant's approved underlying condition. The CE is to ensure that the claimant submits sufficient medical evidence to substantiate the relationship between the underlying condition and the claimed consequential condition.

5. Metastasized Cancer(s). Metastasized cancer(s) is a type of cancer that originates from a primary cancer site but spreads or invades other organ systems. Metastatic cancer has the same name and the same type of cancer cells as the original, or primary, cancer (under a microscope metastatic cancer cells generally look the same as cells of the original cancer). For example, breast cancer that spreads to the lung and forms a tumor is metastatic breast cancer, not lung cancer. In many situations, there will be evidence in the form of pathology or other diagnostic evidence that identifies a cancer as "metastatic" or "secondary" to a primary cancer type. A CE may accept a claimed metastatic cancer as a consequential condition if the diagnostic or other medical evidence is sufficiently descriptive to identify it as being caused by another primary cancer accepted as work-related. If the evidence is unclear or does not establish a relationship between the cancers, the CE undertakes additional development to include collecting the opinion of a treating physician or an assessment of the record by a CMC.

a. The evidence relating to a metastatic cancer is to include the following:

(1) The diagnosis of each secondary cancer; and

(2) The date of diagnosis for each secondary cancer(s).

If the medical evidence is inconclusive and the CE is unable to determine if the cancer is a metastasis, the CE seeks clarification from the treating physician and/or a CMC.

b. Examples of Metastasized Cancers. It is widely accepted that certain carcinomas and/or sarcomas metastasize from a primary site. For example:

(1) Carcinomas of the lung, breast, kidney, thyroid, and prostate tend to metastasize to the lungs, bone, and brain.

(2) Carcinomas of the gastrointestinal tract, reproductive system, and abdomen tend to metastasize to the abdominal lymph nodes, liver, and lungs. Later in their course, these carcinomas can metastasize to the brain and other organs.

(3) Sarcomas often first metastasize to the lungs and brain.

(4) Primary malignant tumors of the brain seldom metastasize to other organs, but they can spread to the spinal cord.

6. Conditions Resulting from Medical Treatment. Consequential conditions can arise from treatment modalities imposed on an employee because of an accepted work-related illness. This can include any injury, illness, impairment or disease arising from any form of medical treatment, including effects from prescription medication.

a. Consequential Conditions Resulting from Medical Treatment for Accepted Conditions. As part of a patient's medical treatment or protocol, a patient may undergo treatment and/or other drug therapy that will produce side effects that can be considered as common consequential conditions.

Examples of such conditions are:

(1) Radiation pneumonitis as a result of radiation treatment;

(2) Skin rashes and radiation burns because of radiation treatment;

(3) Osteoporosis (which causes weakening of the bones and injuries such as spontaneous hip fractures) as a result of steroid treatment.

b. Developing evidence for conditions resulting from medical treatment. When the CE receives a claim for a consequential condition caused by medical treatment of the accepted condition (also known as iatrogenic), the CE investigates the submitted documentation to ensure that the medical evidence supports the claim.

(1) Medical evidence is to identify the medical diagnosis of an illness or injury that is due to the treatment of an accepted work-related illness.

(2) A physician opinion or narrative is to be present that discusses the causal relationship between the consequential condition and a treatment modality made necessary because of the accepted condition. The physician's opinion should present a reasonable chronology of the onset of a consequential condition following a treatment regimen. In addition, the physician is to offer a well-rationalized position on the relationship that exists between a newly diagnosed problem and the treatment of an accepted illness. Vague, speculative or unsubstantiated positions taken by

a physician require additional development including a review of the situation by a CMC, if necessary.

7. Independent Intervening Causes. Consequential conditions can arise from an injury arising from an action or event that is reasonably linked to the accepted work-related illness. An example would be an injury sustained by the claimant as a result of a slip and fall on his or her way to or from a medical appointment for the accepted work-related illness. Other examples include injuries to the claimant resulting from accidents involving wheelchairs or scooters, improper DME use, medical transport, etc. When assessing claims of this sort, the CE is to collect documentation that describes the circumstances of the injury, along with the medical evidence that diagnoses a medical condition linked to the event.

a. The CE is to obtain a signed written statement from the claimant that describes the circumstances of the event that resulted in an injury. For example, "I tripped down the stairs when exiting the doctor's office and broke my arm." The claimant's statement is to be sufficiently descriptive to explain the circumstances of the event or accident, along with an explanation as to how it is linked to the accepted work-related illness.

b. A physician opinion or narrative is to be present that discusses the causal relationship between the event or accident that is somehow linked to the accepted work-related illness and the onset of a new diagnosed medical condition. The physician is to explain the sequence of events that led to the consequential condition, along with his or her explanation as to how the event or accident is related to the accepted work-related illness. If the physician is unable to provide a rational explanation, or there are other contradictions in the evidence that lead the CE to question the sufficiency of the claim, additional development should occur, including a review of the situation by a CMC. In situations where the claimant sustains an injury on his or her way to a medical appointment, it may be necessary to confirm the date, time and location of the appointment to assist with determining that the claimant was in fact on his or her way to an appointment related to the accepted condition.

(1) An independent intervening incident caused by, or attributed to, the employee's own conduct. Injuries, illnesses, impairments or diseases suffered as a result of the employee's own actions will not be accepted as consequential conditions. For example, if an employee is involved in an automobile accident on his or her way to a doctor's appointment for treatment of an accepted condition, but it is determined through medical evidence/police report that the claimant was under the influence of drugs or alcohol at the time of the accident, then the results of the accident could not be considered as a consequential illness or injury.

8. Pre-existing Conditions. Pre-existing conditions are conditions that pre-exist the diagnosis date of an accepted work-related condition. If medical evidence supports that the pre-existing condition became aggravated or worsened by the accepted condition, it is considered a consequential condition. To accept a claimed pre-existing condition as a consequential illness, a medical report is required that includes the diagnosis of the pre-existing condition and a well-

rationalized explanation of how the condition was worsened or aggravated by the accepted condition. The medical evidence has to support an increase in the symptoms or disability that would not have otherwise occurred, or treatment that would not have been necessary, but for the accepted condition. An example of a pre-existing condition affected by a covered condition includes COPD that aggravates a pre-existing heart disease such as Coronary Artery Disease. The "Eligibility Begin" date is the filing date of the underlying accepted condition.

9. Psychological Conditions. Psychological conditions can arise as a consequence of the accepted illness and/or treatment of that condition. They can also arise with no physiological basis. Depression, anxiety, and/or chemical imbalance are a few examples of psychological conditions that may have no physiological basis. In addition to a specific diagnosis, these conditions may be described as "psychogenic pain disorder," "conversion disorder," or "psychological syndrome." However described, the symptom or pain is quite real to the individual involved although there is no demonstrable physical disorder.

To accept a claimed psychological condition, the claimant must provide diagnostic evidence and a well-rationalized medical opinion from a qualified physician supporting a causal connection between the psychological condition and the covered condition. A qualified physician must be a clinical psychologist or psychiatrist. In situations where clarification on the causal relationship between the psychological condition and an accepted condition cannot be obtained from a qualified physician, the CE forwards the claimant's case file to a CMC or refers the claimant to a qualified second opinion physician for evaluation and opinion concerning causal relationship.

A CE may authorize social worker services for the treatment of a consequential psychological condition when prescribed under the supervision of a qualified physician. However, the physician is to specify the justification for such services, along with the submission of a narrative report that describes the plan of care with regard to the extent and duration of social services.

10. Accepting or Denying the Consequential Condition. The CE is responsible for taking the appropriate steps in developing any claimed consequential condition. This includes notifying the claimant of any deficiencies in the evidence and allowing him or her the opportunity to respond and submit additional evidence.

a. Acceptances. If the consequential condition is going to be accepted, the CE accepts the consequential condition under Parts B and E, if the primary underlying condition is also accepted under both Parts. The CE notifies the claimant in a letter decision. All letter decisions should contain two signature blocks; one for the CE who drafted the letter, and one for his or her supervisor (or another management official designated by the DD), who will certify the sufficiency of the decisional outcome. Exhibit 23-2 provides a sample decision letter for approvals of consequential conditions.

The CE should be aware that once he or she accepts a consequential condition by letter decision, any pending claim for that same condition being affiliated with a toxic substance exposure can be administratively closed. For example, when a letter accepting glaucoma as a consequential condition occurs, there is no need to then issue a recommended accept/deny for glaucoma based on toxic substance

exposure. The "Eligibility Begin" date for consequential conditions is the filing date of the underlying accepted condition.

b. Denials. If the CE has determined that insufficient medical evidence exists to accept a claim for consequential condition, and the CE provided the claimant the opportunity to submit supportive evidence, he or she issues a RD specifically denying the claim for a consequential illness. The CE does not issue a letter decision denying a consequential condition. A RD issued to deny a consequential condition must contain a clear explanation to the claimant of the deficiencies in the medical evidence, including any interpretation of medical opinion from a physician, which is not considered sufficiently well-rationalized to support the claim.

c. Issuing the Decision. A CE cannot issue a letter decision accepting a consequential condition or a RD denying a consequential condition without a preceding FD accepting a primary covered condition. In those situations where a case is in posture for the CE to accept a primary covered condition and a potential consequential condition exists, the CE proceeds with the immediate release of a RD for the primary condition. A CE does not delay issuance of a RD accepting a primary covered condition while development occurs for a consequential condition. However, if the case is in posture for concurrent acceptance of both a primary and a consequential illness, the CE includes both in the RD.

11. Impairment and Wage-Loss. Consequential conditions may cause additional impairment or wage-loss under Part E, but do not result in an additional lump-sum award under Part B.

a. Impairment rating. An impairment rating assesses the functionality of the whole organ or system. The DEEOIC does not apportion impairment by disease (see Chapter 21 – Impairment Ratings, for further discussion of impairment ratings). The effect of this methodology means that an impairment rating encompasses all illnesses causing damage to an organ system, so long as one is an accepted work-related illness. For conditions accepted as consequential, the CE determines if the acceptance of a new consequential illness requires action to initiate an impairment rating under Part E. If the CE is reviewing case evidence to make a decision on an initial claim for impairment, he or she includes all accepted primary or consequential claims in the assessment of impairment.

(1) The acceptance of a consequential illness that involves an organ system previously included in an impairment rating will not trigger a new impairment evaluation if it is less than two years from the date of the FD awarding impairment benefits.

(2) For situations where a new consequential illness is accepted after an initial impairment rating has occurred, the CE proceeds with a new impairment rating if the consequential condition affects an organ system that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. FAB issued a FD one year ago to award a 50%

impairment due to whole person impairment rating to the pulmonary system.

A consequential illness is accepted for stomach ulcers as a result of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the consequential illness effects an organ system (digestive) that was not included in the prior impairment assessment.

If the claimant's treating physician or a CMC identifies a consequential illness during an impairment evaluation that is not included in the SOAF as an accepted condition (regardless of whether or not it is included in the impairment), the CE contacts the claimant and asks if he or she wants to file a claim for the condition (refer to paragraph 3). If the claimant answers in the affirmative, the CE instructs him/her to submit a completed and signed Form EE-1/2. The processing of the impairment claim should not be delayed if the condition is for the same organ/body system.

b. Wage-Loss. With the acceptance of a new consequential illness the CE has to determine if sufficient evidence is present to undertake development for wage-loss. CEs calculate wage-loss using the first day that the employee lost wages due to the covered illness and/or consequential illness (see Chapter 22 – Wage-Loss Determinations for further discussion of wage-loss).

In certain instances, the consequential condition may be the initial cause of the employee's wage-loss. For example, a claimant is approved for CBD due to beryllium exposure under Parts B and E. A year later, the claimant files a claim for pulmonary hypertension as a result of CBD. The medical evidence supports this finding and the assigned CE accepts the pulmonary hypertension as a consequential condition to the approved condition of CBD. The CE obtains evidence showing that the employee has had to stop work due to breathing and cardiac difficulties. The claimant is now entitled to wage-loss benefits under Part E for any lost wages due to pulmonary hypertension.

12. SWC Claims, Lawsuits and Fraud. For each consequential injury that is to be accepted, the CE must obtain a newly signed Form EN-16 SWC/Tort/Fraud affidavit from the claimant.

CHAPTER 24 – RECOMMENDED DECISIONS

1. Purpose and Scope. The DO issues RDs for claims filed under the EEOICPA. A RD is a written decision made by the CE regarding the eligibility of a claimant to receive compensation benefits available under the EEOICPA. As a recommendation, it does not represent the final program determination on claim compensability. It is a preliminary determination made by the CE that is subject to challenge by any claimant party to the decision. The FAB independently assesses each RD for finalization. This chapter describes the procedures for issuing a RD.

2. Authority. 20 C.F.R. § 30.300 grants the DO authority to make determinations with regard to compensability and issue RDs with respect to EEOICPA claims. Under this section, the DO is to recommend the acceptance or denial of a claim for benefits under the EEOICPA. The DO forwards all RDs to the FAB for review.

3. When a RD is Required. A RD is required in situations where a claimant seeks an entitlement benefit provided for under either Part B or E of the EEOICPA. Entitlement benefits include medical benefits under Part B and/or E; lump-sum compensation under Part B; impairment or wage-loss awards under Part E; and lump-sum survivor compensation under Part E. In certain situations, as explained later in this chapter, exceptions to this guidance apply to decisions involving new cancer claims after a prior finding of PoC of 50% or greater, consequential illnesses, or approval or denial for medical procedures, equipment or other medically indicated necessities.

Claims made under Part B or E of the EEOICPA can involve multifaceted elements, filed at varying points in time, involving a multitude of medical conditions, or periodic claims for monetary lump-sum benefits, i.e. recurring wage-loss and impairment. The question of when a case element is in posture to be decided and a RD issued is dependent on several factors that the CE must consider. First, the CE must identify the parties seeking benefits, i.e., employee vs. survivor claims. This includes individuals who have filed claims or potential claimants who have not filed, but may be eligible. Secondly, the CE is to identify the actual claimed entitlement benefit for which a decision is required. In some instances, a claimant may be seeking multiple benefits under Part B and/or E, especially if the claimant is claiming more than one illness.

Based on examination of the evidence of record, development occurs to overcome any defect in the case evidence that does not satisfy the eligibility criteria for a claimed benefit. Once development is completed, the CE then performs an examination of the case evidence to determine if it is sufficient to accept or deny a claim for benefit entitlement.

a. When a Claim is Submitted. Documents containing words of claim are acceptable to begin the adjudication process and set the effective date for the date of filing; however, the CE is to obtain a Form EE-1/2, as applicable, before issuing a RD. The CE notifies the claimant of the need to submit the required form. A period of 30 days is allotted for the claimant to submit the required documentation. If the appropriate form is not forthcoming, the CE administratively closes the claim. The CE is to provide notice to the claimant(s) that no further action will be taken on their claim until the proper claim form is submitted.

(1) The CE has the discretion to conclude that a new claim has been adjudicated in a prior determination under the EEOICPA. For example, a claim for "lung disease" is filed and denied lacking any diagnosed condition. Subsequent filing is made for "lung problems." While the exact wording of the claimed condition is dissimilar, the nature of the claim is the same and, in this situation, would not require new adjudication, unless the claimant provides evidence of a more specific diagnosis.

Additionally, no RD is needed if a FD has previously addressed a newly claimed condition. In such instances, the claimant is notified that the condition has previously been decided and no further action will be taken without a request from the claimant to reopen the prior FD.

b. On the Initiative of the Director of the Division of the DEEOIC. Upon the issuance of a Director's Order, the Director may instruct the DO to issue a new RD to address new evidence.

c. At the Request of a Claimant. The claimant may request issuance of a RD either after or in lieu of a letter decision. This may occur in any of the letter decision situations discussed later in this chapter.

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

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

5. Who Receives a RD. Each individual who files a claim under a case, and has not had their claim administratively closed, is required to be a party to a RD that decides a benefit entitlement.

Given the variant benefit filings that may exist in a single case, the CE may divide benefit entitlement claims to be addressed by separate RDs. This will occur when the CE is able to decide one or more entitlement benefits based on the evidence of record, while concurrent development occurs on outstanding claimed components. For example, the CE may issue

separate decisions awarding medical benefits for a cancer under Part E, and a subsequent decision for any impairment linked to that cancer.

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

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

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

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

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

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

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

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

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

6. Writing a RD. When the CE has completed development to allow for a decision involving an entitlement benefit, the CE issues a RD. The decision recommends acceptance or denial of entitlement benefits in accordance with the legal criteria set out under the EEOICPA. The CE is to defer on any outstanding claims.

The CE ensures that any decision issued is well written, uses appropriate language to clearly communicate information, and addresses all facets of the evidence that led to the conclusion, including evidence the claimant submitted. The CE is to provide a robust, descriptive explanation of how the evidence satisfied or failed to satisfy the eligibility requirements of the EEOICPA, including any interpretive analysis the CE relied upon to justify the decision. Moreover, the discussion should address the actions taken to assist with the development of the case.

a. Use Simple Words and Short Sentences. Avoid technical terms and bureaucratic "jargon", and explain the first time any abbreviation that is used in the text.

b. Divide Lengthy Discussions into Short Paragraphs. The progression of the text is to follow a logical and chronological pattern.

c. Confine the Discussion to Relevant Issues. These are the issues before the CE that need to be resolved. It may be necessary to state an issue is being deferred pending further development, but there is no need to discuss it in detail. Extensive case history, which is inconsequential to the issue being decided, does not need to be discussed.

d. Address All Matters Raised by the Claimant. This includes any issue or medical condition relevant to the decision, whether raised in the initial report of the claim or during adjudication. Make certain to address all claimed conditions being decided in the introduction, discussion and conclusion. If the CE recommends acceptance of a covered condition, and the claimant has also claimed other conditions that are not covered, the non-covered conditions are to be denied. The CE also recommends denial of claimed conditions in survivor claims that have previously reached the maximum allowable benefit entitlement and no further compensation is payable.

e. Mailing Addresses. For mailing purposes, the CE is to print a separate mailing sheet for each claimant who is to receive a copy of the RD. The mailing sheet is to include only the mailing address of the claimant, and when applicable, his/her

AR. The CE is to image each mailing sheet in OIS, along with the final version of the RD and accompanying documents (as a consolidated document) to record the transmission of the RD to all claimants named as a party of the decision.

7. Content and Format. A RD is comprised of a written decision and a Notice of Recommended Decision provided to a claimant explaining his or her right to challenge the recommendation. With the Notice of Recommended Decision, the DEEOIC provides a waiver for claimant to complete if they agree with the decision entirely or in part. The CE is to attach to the decision any Medical Health Science (HP, IH, TOX or CMC) input that provides justification or support for a claim denial. The CE is responsible for preparing the RD and all its component parts. The format and content of a RD is as follows:

a. Written Decision. The written decision is comprised of an introductory statement, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.

(1) Introductory Statement. This is a statement written following the title "Recommended Decision" that summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E.

(2) Statement of the Case. The Statement of the Case is a clear, chronological, and concise narrative of the relevant factual evidence leading up to the decision. It describes the steps taken by the CE to develop evidence, the outcome of any development, and any other relevant information derived from examination of the case records. The Statement of the Case should not be overly technical covering every minute detail of the case evidence, nor should it include interpretation of the evidence; as this is to be covered in the "Explanation of Findings" outlined below. Essentially, the Statement of the Case tells the relevant history of the case leading up to the present decision and includes basic information such as the relevant evidence submitted, development actions taken, and any other relevant information that correlates to the discussion and analysis in the Explanation of Findings. Basic information that may be covered in the Statement of the Case, when relevant, includes:

(a) Name of the claimant or survivor, name of employee, and when the claim was filed;

(b) Benefit(s) the claimant is seeking. In the case of a survivor claim, the relationship of the claimant to the employee and documentation submitted in support of the relationship, if any;

(c) Claimed employment and evidence submitted to establish covered employment, if any;

(d) Claimed medical condition and the pertinent medical evidence submitted to establish a diagnosed illness;

(e) In a recommended acceptance, pertinent issues may include specific medical documents received from the claimant or other sources, which confirm the diagnosis of the claimed condition, and evidence establishing the claimed employment and exposure. Also important for inclusion are the results of any searches conducted or documentation generated from the SEM, OHQ, records from the DOE FWP, and DAR records. The evidence and development actions discussed in the Statement of the Case should correlate with the discussion and analysis, which follows in the Explanation of Findings.

In a recommended denial, the CE discusses what evidence he or she sought, how the CE advised the claimant of the deficiencies, any assistance provided to overcome a defect, and the claimant's response.

(3) Explanation of Findings. This section of the RD explains the CE's analysis of the case evidence used to arrive at the various factual findings necessary to substantiate a conclusion on benefit entitlement. It is critical that the CE writing the decision include a compelling, robust justification of his or her decision to accept or deny a claim. CE findings made without any explanatory justification, or communicated in vague or overly broad language is not appropriate. A poorly written decision increases the likelihood that a claimant will not understand the outcome of the claim and the probability of objection. Moreover, it serves to increase the potential objection by the claimant, or remand by the FAB.

In writing the content of the Explanation of Findings, the CE follows a logical and sequential presentation of findings and explains the relevant legal, regulatory or procedural guidelines of DEEOIC claims adjudication, the relevant evidence, and how the evidence does or does not satisfy the referenced criteria. In this manner, the CE communicates to the claimant his or her interpretive analysis of available evidence in satisfying the legal requirement for claim acceptance or denial. Moreover, it provides the narrative content, which allows the FAB to properly conduct its role of independently assessing the sufficiency of the CE's recommendation.

Given the various types of benefit entitlements that may be involved, the content of this section will vary depending on the context of the matter under review. However, the CE is to communicate information pertinent to the issue for determination in a logical, comprehensive manner. For example, the logical presentation of findings for a new Part E claim for causation will follow this general order – diagnosis, employment, relation to employee (in survivor claims), exposure, and causation. However, a different presentation of findings is needed depending on the circumstances of the claim; such as with impairment, where the presentation of findings would follow a different order – accepted

condition, evaluation for impairment, and outcome of evaluation with award or denial of impairment benefit.

Given the disparate types of evidence that may exist in a claim record, there may be instances where the discussion is based exclusively on the presentation of undisputed evidence that clearly affirms findings leading to a conclusion. In other instances, there will be a need to use inference or extrapolation to support a finding. In either situation, the CE is to provide a compelling argument as to how the evidence is interpreted to support the various findings leading to acceptance or denial of benefit entitlement. This is particularly important in situations involving toxic chemical exposure analysis under Part E, conflicting medical opinion, or other complex procedural applications. The assessment will rest on various factors, such as the probative value of documentation, relevance to the issue under contention, weight of medical opinion, or the reliability of testimony, affidavits, or other circumstantial evidence.

In instances where the claim is being denied, the discussion should focus on the first logical element that failed to meet the eligibility criteria. However, in multi-claimant cases, the reason for denial may differ for each claimant. In such instances, the CE should explain the basis of denial for each individual party to the claim.

Within the context of decision analysis, the CE is to maintain a claimant-oriented perspective. This can be defined as decisions made within the scope of the law that have the effect or potential to produce a positive benefit to the claimant(s).

(a) Contested Factual Items and Other Claim Disputes. Written analysis is particularly important when reaching judgment on a claim issue that differs from the position of the claimant or has negative consequences to the claim. The CE is to identify the differences, clearly note the decision made, and the evidence or argument that supports such a decision. This is frequently the case where there is disagreement over medical diagnosis, dates or location of employment, health effects of toxic exposure, interpretation of program procedure, or medical opinion on causation. In any instance where a dispute involves a decision based on the weight of medical evidence, the CE is to describe completely the weighing methodology in support of the chosen medical opinion.

(b) Complex subject matter and other complicated evidentiary situations. Evidence presented in support of DEEOIC claims can often be open to a variety of interpretations, especially in situations involving complicated subject matter or in situations where evidence is vague. Whenever a CE is presented with a situation involving a complex set of issues for which a finding is necessary;

e.g. establishing intermittent covered employment at multiple facilities, it is essential that the CE provide sufficient explanation as to how he or she chose to apply the evidence in arriving at a finding. Simply making a factual statement in these situations without providing the underlying rationale for making such a finding will not suffice.

(c) Mathematical Calculations. In any decision involving a mathematical calculation, the CE fully explains the figures used to arrive at the finding listed. Situations where calculations need to be described include impairment or wage-loss, division of benefits between multiple claimants or Part B vs. Part E claims, aggregated workdays for SEC classes, latency periods for diseases, and offsets for SWC or tort settlements.

For example, when accepting a claim for wage-loss, the CE is expected to provide a narrative explanation of how he or she arrived at the various components of the decision. Specifically, how the first date of wage-loss was determined, the evidence of wages used to calculate AAW, how the AAW was compared to future calendar years of wage-loss, and any explanation of how the wage-loss benefit is calculated to arrive at the amount being awarded.

(d) Application of Written Program Policy, Regulations, Procedure or case precedent. A CE may have to explain the use of policy guidance from various program resources in support of a decision being made in a claim. In these situations, the CE must clearly reference the resource being used, and if necessary, make a specific citation or reference. The program policy must pertain to the issue at hand and the CE must explain how it provides guidance in resolving a particular claim issue.

(i) Case precedent. A CE is permitted to use only those case decisions that are specifically authorized and recognized as setting precedent. These can be found on the DEEOIC main web page and are updated periodically. It is not appropriate for a CE to generalize information or findings from a non-precedent setting case to address a separate case under review.

(4) Conclusions of Law. This portion of the RD summarizes the determination of eligibility reached based on the discussion and analysis contained in the Explanation of Findings. The CE's conclusion either accepts or rejects the claim in its entirety, or it may address a portion of the claim presented. The conclusions should be limited to a simple recommendation of acceptance or denial of the claim(s) under consideration under Part B and/or Part E.

As a RD does not represent the final program determination regarding eligibility under the EEOICPA, it is not necessary to cite sections of the EEOICPA or its governing regulations in support of the conclusions reached.

(a) When the conclusion is to accept a claim, the CE must include the amount of payable lump-sum compensation or award of medical benefits effective the date of filing, and under what Part of the Act the benefit is being awarded.

(b) In a conclusion that results in a denial of benefits, the CE is to identify the denied claimed condition. The CE is not to state the lump-sum amount to be denied.

(6) Signatory Line. The signature line must include the name and title of the person who prepared the recommendation and the name and title of the person who reviewed and certified the decision, when applicable. When a decision is certified by a SrCE/Supervisor, this means that the reviewer has assessed the overall accuracy and readability of the decision to ensure quality.

(7) Notice of Recommended Decision. Provides information about the claimant's right to file specific objections to the RD and to request either a review of the written record or an oral hearing before the FAB. The notice also outlines the claimant's SWC and Tort reporting requirements in the case of recommended acceptances. A sample Notice of Recommended Decision is included as part of Exhibit 24-3.

(a) Waiver of Rights. A waiver is included within the Notice of Recommended Decision and the CE is to list the case ID number, name of the employee, name of the claimant, and the date of the decision in the upper right hand corner. With the completion of the waiver, the claimant may waive his or her right to a hearing or review of the written record and request that the FAB issue a FD. The claimant may waive any objection to the decision in its entirety or in part. A claimant has 60 days from the date a CE issues the RD to file an objection, and may waive this right at any time.

8. Types of RDs. Due to the wide variety of possible benefit entitlements available under Part B and Part E, various claim elements may be in different stages of development and adjudication at any given time. Following are examples of several types of RDs that may be necessary:

a. Acceptance. Where the entire case is in posture for acceptance and no outstanding claim elements (e.g., wage-loss, impairment, additional claimed illness, or a cancer claim pending dose reconstruction at the NIOSH) need further development, the CE issues a RD to accept in full. The narrative included in the

decision should be sufficient to justify each element of the decision process that factored into the acceptance.

b. Denial. If after development, criteria for a compensable claim have not been met, the CE issues a RD to deny the claim as a whole. The narrative justification for the recommended denial should communicate the singular basis serving as the first logical element that does not meet the necessary EEOICPA criteria. However, the CE may also relay other critical information in his or her decision that will serve to assist the claimant in understanding other components of the case file that, while not directly tied to basis of claim denial, describe other potential shortcomings in the case evidence. For example, a claimant submits a claim for asthma, but provides no medical evidence of the diagnosis. The CE prepares a denial on the singular basis of insufficient medical evidence to support the claimed medical condition, but may also communicates that the claimed employment does not correspond to the information received from the employer, which would also need to be overcome in order for eventual claim acceptance.

(1) Addressing all claimed elements. Once development has occurred, the CE is to proceed with the issuance of a RD that addresses as many claimed elements as can be addressed in the RD. Each specific claimed element that does not satisfy the requirements of the EEOICPA are to be consolidated into one RD and reasons supporting the recommendation to deny each element clearly explained. Elements that the CE cannot address are to be deferred for later action.

c. Partial Accept/Partial Deny. If the CE determines that no further development is necessary on a case file and concludes that some claim elements should be recommended for acceptance and some for denial, the CE issues a RD that clearly sets forth those recommendations.

For instance, if an illness that can be covered under both Part B and Part E of the EEOICPA (cancer, beryllium illness, chronic silicosis) is claimed and meets the evidentiary requirements only under Part E but not under Part B, the CE states that the Part E benefits are being accepted and the Part B benefits are being denied.

(1) Example. A claimant files a claim for CBD and submits medical evidence that contains a medical diagnosis of CBD that is sufficient to meet the Part E causation burden, but not the statutory criteria under Part B; the CE issues a RD awarding benefits under Part E and denying benefits under Part B. In the denial under Part B, the CE should clearly outline the relevant Part B CBD criteria; explain what evidence was lacking and why the case is being denied. The CE clearly delineates the benefits being awarded and denied under Part B and Part E.

d. Partial Accept/Partial Develop. When a claim element is fully developed and ready for acceptance, but other elements remain for further development (e.g., wage-loss, impairment, another claimed illness, or a cancer pending NIOSH dose

reconstruction), the CE issues a RD accepting the claimed illness and specifies all associated benefits awarded under the EEOICPA as a whole. With regard to other claim elements requiring further development, in the Introduction the CE advises that these elements are deferred until they are fully developed and adjudication is possible. Partial adjudication of a claim should be avoided whenever possible. In any instance where a part of a claim is deferred, it is the CE's responsibility to ensure that action is ultimately taken to address the outstanding claim by way of a RD or administrative closure, when appropriate. Development for a deferred claim may be required while other components of the claim are addressed by the FAB.

e. Partial Accept/Partial Deny/Partial Develop. If one portion of the claim is in posture for acceptance and another portion is in posture for denial, while yet a third portion requires additional development, the CE addresses all claim elements in one comprehensive RD. Where one or more claim elements are accepted and other elements are either denied or deferred for additional development, the CE must clearly outline the status of each element that is accepted, denied and deferred.

9. Decision Issuance. After preparing a RD, the CE routes the decision and case file to the appropriate signatory for review, signature, date, and release.

a. Clearing the RD for Release. The appropriate signatory reviews all RDs.

(1) Deficiency Identified. If the appropriate signatory discovers a deficiency or other problem, the RD is returned to the CE with a detailed explanation of why the decision is not in posture for release. When the appropriate signatory has provided comments or has extensively edited the RD, the CE is to revise the decision accordingly.

(2) Decision Approved. If the signatory agrees with the decision, he or she signs and dates the RD. The date shown on the RD must be the actual date on which the decision is mailed.

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

(1) A signed and dated copy of the RD is imaged into the electronic case file.

(2) The decision issuance is to be appropriately recorded in ECS.

(3) The CE then forwards the case record to the appropriate FAB office.

10. Letter Decisions. In certain situations, an entitlement determination is addressed in a simple letter to the claimant. If a CE makes a decision in this format, the CE communicates the nature of the claim that was made, evaluates the evidence supporting the outcome and the conclusion.

A formal RD is not necessary, unless the claimant submits a written request for one or objects to a letter decision. In some situations, including contentious or otherwise complicated issues for which the claimant is likely to contest a decisional outcome, the CE may exercise his or her judgment in deciding to issue a RD in lieu of a letter decision without specific request for such by the claimant. Circumstances where a letter decision is permitted include:

a. Approval of additional claims for medical benefits for cancer:

(1) Once a PoC value has been calculated at 50% or greater and a FD accepting the cancer has been issued, any subsequent new claim for cancer will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

(2) Once a FD accepting a specified cancer under an SEC class has been issued, any subsequent new claim for a specified cancer will be presumed linked to occupational exposure to radiation under either Parts B or E of the EEOICPA.

b. Consequential illness acceptance (including reverse consequential illness acceptance.)

c. Acceptance of medical care or treatment, including HHC.

d. Acceptance of DME or housing/vehicle modification.

e. Alternative filing determination (see Chapter 20 – Establishing Survivorship for further guidance.)

f. Acceptance of additional cancers under Parts B and E following a NIOSH POC equal to or greater than 50% by letter decision.

g. For any primary skin cancer that is accepted under Part E for toxic substance exposure other than radiation (e.g. chemical or biological exposure), DEEOIC may accept by letter decision any subsequent claim of the same type of primary skin cancer diagnosed at a different anatomical location.

11. Special Circumstances. As noted previously, there are disparate issues that confront the CE during the process of making a RD. This section provides guidance in certain unique situations that the CE may encounter.

a. Cases Where the Maximum Aggregate Lump-Sum Compensation Has Been Attained. The maximum lump-sum compensation payable under Part B is $150,000, and $250,000 under Part E. Once the maximum aggregate compensation has been awarded, claims for any new medical condition(s) are to be addressed for medical benefit coverage only. Under Part E, once the maximum lump-sum figure has been reached, any new claim for impairment or wage-loss benefit is denied.

(1) If the employee dies after receiving the maximum lump-sum compensation available to him or her, any subsequent claim by a survivor is denied as no additional compensation is payable. For guidance concerning Part E claims in which an employee dies subsequent to receiving a lump-sum payment less than the maximum aggregate allowable, refer to Chapter 20 – Establishing Survivorship.

b. Death of Employee Prior to Claim Adjudication. In a scenario involving an employee who files for benefits, but dies prior to claim adjudication, the CE administratively closes the claim and no RD is issued. If a survivor claim is later presented, the CE is to proceed with claim adjudication based on the condition(s) claimed only by the survivor. In this scenario, the CE is not to resume development for conditions previously claimed by the employee. Instead, the CE is to contact the survivor to discuss any potential benefit that may be derived from filing a claim for a condition previously filed by the employee, but for which the survivor has not claimed; e.g., such as a potentially compensable condition that may have contributed to the death of the employee.

c. Forfeiture Due to Fraud. When a claimant pleads guilty to, or is found guilty of fraud, in connection with an application for or receipt of federal or state workers ‘compensation, that claimant forfeits any entitlement to further benefits under the EEOICPA. In cases where there are other eligible claimants, the CE is to reallocate the forfeited amount to the remaining eligible claimants without holding the forfeited amount in abeyance.

d. Issuing a RD After the Maximum Aggregate Compensation Has Been Paid in a Part B or E Survivor Claim. Once the maximum available compensation has been awarded in a survivor claim, i.e., $150,000 under Part B or $175,000 under Part E, and a new survivor presents a valid claim, the CE is to develop the claim to determine the new survivor’s eligibility. Should the survivor be deemed eligible, it will be necessary to vacate any prior decision to other survivors to allow for a new decision to all claimants. In the decision, the CE explains the circumstances of the new claim, the eligibility of the new survivor to receive benefits, and the reallocated award based on the number of qualifying survivors. The new survivor is awarded his or her share of payable compensation, regardless of the fact that the maximum payable compensation was previously paid. Once a FD has been issued with regard to this matter, the CE takes action to assess any survivor in the case who has a potential overpayment.

e. Issuing a RD When There is a Previously Established Outstanding Overpayment. When there is an overpayment in a case, and the CE needs to issue a new RD, the case file is transferred to the Policy Branch at NO before the RD is issued. The NO will send the claimant(s) an initial overpayment notice advising them of the overpayment. The claimant then has 30 days to dispute the overpayment or request a waiver. After the NO sends the FD on the overpayment to the claimant(s), it will return the case to the DO for issuance of the RD. The NO will provide instruction on how to address the overpayment in the RD.

CHAPTER 25 – FAB REVIEW PROCESS

1. Purpose and Scope. This chapter describes the functions of the FAB, focusing on the administrative and preparatory aspects of its work under the EEOICPA.

2. Authority. The regulations governing the administration of EEOICPA specify at 20 C.F.R. § 30.300 that each RD is to be forwarded to the FAB for issuance of a FD. Section 30.310 allows a claimant to object, in writing, to all or part of the RD within 60 calendar days from the date the RD is issued. If a claimant requests a hearing within the 60 day time period, a FAB HR will conduct a hearing, pursuant to 20 C.F.R. § 30.314. Otherwise, the objections will be responded to by a review of the written record, pursuant to 20 C.F.R. § 30.312.

Whether or not an objection is filed, the FAB reviews all RDs, all arguments and evidence of record, and issues a FD pursuant to 20 C.F.R. § 30.316 or a Remand Order returning the case to the DO for additional development, pursuant to 20 C.F.R. § 30.317. Also, the FAB reviews claimant requests for reconsideration of a FD under 20 C.F.R. § 30.319. FAB can also issue a FD reversing the findings and conclusions of the RD in certain circumstances.

3. Organization. The FAB is a NO organization with DO locations (FAB-DOs) in: Jacksonville, Florida; Cleveland, Ohio; Denver, Colorado; and Seattle, Washington. The FAB-DO is a distinct entity with a separate operational and management structure. In addition to the FAB-DOs, a NO FAB (FAB-NO) is located in Washington, D.C. The FAB Chief is located in the Washington, D.C., office and oversees the operations of the FAB-NO and the four FAB-DOs.

a. The FAB Chief and Assistant Branch Chiefs:

(1) Coordinate the administration of the four FAB-DOs and the FAB-NO. Oversee policy implementation, manage adjudication timeliness, and ensure general compliance with FAB procedures.

Hearing requests received by FAB-DOs are sent to the FAB-NO for assignment. A hearing coordinator, as designated by the FAB Chief, manages the assignment of hearings nationwide.

Reconsideration requests are forwarded to FAB-NO, Attn: FAB Ops, and are assigned to an office different from that which issued the FD.

(2) Can redistribute certain case files at their discretion to ensure balanced caseloads among the four FAB-DOs and the FAB-NO.

b. FAB Offices:

(1) Review RDs, conduct hearings, reviews of the written record, and issue FDs or Remand Orders on reviewed cases. The cases reviewed by FAB, and the cases for which FAB conducts hearings, can originate from any DO. A FAB HR can be assigned a hearing anywhere in the nation; not just in his or her FAB office's jurisdiction.

(2) Processes requests for reconsideration of FDs.

4. Processing, Monitoring, and Transferring Case Files. When a DO issues a RD, it will forward the entire case file to its affiliated FAB-DO or the FAB-NO, as directed, for review and issuance of a FD. Because each FAB office, including the FAB-NO, is separate and distinct from the DOs, each maintains a separate mail and file operation.

Initial Screening/Review. A case file received from the DO is assigned and delivered to the responsible FAB CE or HR for initial review. The CE or HR timely reviews the RD for accuracy. The CE or HR reviews the evidence of record to ensure that all evidence and documentation referenced in the RD accurately describes what is in the file. The CE or HR also determines whether the claimant has filed a waiver, a written objection(s), or a request for a hearing. If some deficiency or defect is found which requires the case be remanded to the DO, the case is to be remanded immediately.

a. FAB Docketing. Upon receipt of an initial claim for FAB review, ECS assigns a unique docket number to each RD that is pending a final determination. The assignment of a docket number allows FAB to track RDs undergoing review for a final determination. The assignment of a document number also protects claimant privacy. The docket number is the year/month/date-case ID-RD version (i.e., 20161025-50008054-2). ECS creates a separate docket number for each pending final determination, regardless of the number of claimants involved in the RD.

5. Waivers. A waiver gives a claimant(s) the opportunity to voluntarily relinquish their right to object to the findings and conclusions of law contained in a RD, either in part or in full. The FAB may issue a FD at any point after receiving a written notice of waiver. To expedite the FAB review process, the DO must immediately forward all signed waivers to FAB upon receipt.

a. Signed Waivers. A claimant may waive his or her rights to object and to request a hearing by submitting a signed waiver form to the DO or the FAB within 60 calendar days of the RD issuance date. The submission of a signed waiver denotes the claimant's willingness to accept the findings of fact and conclusions of law reached by the DO in the RD. If FAB receives a waiver that is unclear, or does not specify to which portion of the decision the claimant objects, FAB contacts the claimant for clarification prior to conducting its review and issuing its decision.

6. Objections and Review of the Written Record. The regulations allow a claimant to file written objections to all or part of a RD. When the claimant has submitted a timely written objection to a RD, but has not requested a hearing, FAB conducts a review of the written record.

a. Timeliness. A claimant has 60 calendar days from the date of the RD to file an objection in writing. The claimant does not need to specify the basis for the objection for it to be considered, but can merely state that he or she disagrees with a finding of fact, a conclusion of law, or the RD in general.

A written objection is considered timely if the envelope containing it is postmarked no later than the 60th calendar day after the RD issuance date (the

date of the RD is not included in the 60 calendar days). If the 60th day falls on a non-business day, the envelope must be postmarked by the next business day for the objection to be considered timely filed. If no postmark is available, the date of the objection is considered to be the earliest date it is received, as determined by the date stamp. As long as at least one objection is timely filed by a claimant, the FAB must consider ALL objections filed by that claimant, even objections raised after the 60-day period has expired. Any objection filed after the 60-day objection period has passed is reviewed by FAB to determine if it is material to the outcome of the claim.

b. Review of the Written Record. A review of the written record is an analysis of the documentation contained in the case file to determine if the conclusions reached in the RD are accurate in light of the objections filed and the requirements of the EEOICPA.

If the claimant objects to one portion of the RD and agrees with the other portion, the FAB may issue a FD on the accepted portion and issue a separate "FD Following a Review of the Written Record" on the objected portion. RDs addressing multiple claimants generally should be issued under one FD.

(1) Acknowledgement. The FAB acknowledges receipt of the objection in writing. The letter to the claimant indicates that the claimant has an additional 20 calendar days from the date of the acknowledgement letter to submit new evidence in support of the objection. For claims involving multiple claimants, a single objection from any one claimant is sufficient to warrant a review of the entire written record. Upon receipt of an objection in a case with multiple claimants, individual acknowledgments are sent to each claimant explaining the course of action to be undertaken. It is the policy of the DEEOIC that the acknowledgment letter to the claimant(s) that did not submit the objection should indicate that an objection was received, but should not indicate the basis of the objection. Each claimant's response to any objections is reflected in ECS.

(2) Conduct of Review of the Written Record. Guidelines for conducting a review of the written record are set out in 20 C.F.R. § 30.313. The FAB representative considers the written record forwarded by the DO and any additional evidence and/or argument submitted by the claimant.

After the review of the written record, FAB issues a FD, remands all or part of the case to the DO, or reverses all or a portion of the RD if advantageous to the claimant. A FD following a review of the written record contains a narrative summation of the claimant's objections, and the HR/CEs assessment of the evidence in response to those objections. The HR/CE ensures that any decision is based on an objective analysis of the evidence; and applies well-reasoned judgment, sound exercise of discretion, and correct application of law, regulations, and DEEOIC policy and procedures.

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

a. Initial Handling of Hearing Requests. When a timely request for an oral hearing is received in the DO, action is immediately taken to forward the request to the FAB-NO. The referring office makes note of any special requests or needs of the claimant. The hearing scheduler tracks incoming requests for oral hearings and assigns the hearing to an HR in one of the five FAB offices.

b. Acknowledgement. Following the assignment of a hearing request to a FAB hearing scheduler, the hearing scheduler sends an acknowledgement letter to the claimant and any AR confirming receipt of the hearing request. Each claimant party to the FD is to be sent an acknowledgment. The acknowledgement must be sent 30 days prior to the date of the hearing and includes the following notifications:

(1) The hearing will be conducted within 200 miles roundtrip of the claimant's residence, absent compelling reasons to the contrary.

(2) All sworn testimony offered during the hearing will be transcribed for inclusion into the case file.

(3) The FAB, at its discretion, may schedule a telephone or video conference hearing. See paragraph d(2) below.

(4) If the claim involves multiple claimants, each is allowed to participate in the hearing.

c. Hearing Assignments. The hearing scheduler may assign a hearing to an HR from any one of the five FAB offices. The hearing scheduler sends a hearing acknowledgment letter, schedules a date and time for the hearing, reserves the physical space for the proceedings, arranges for a court reporter to record the proceedings, and transmits the entire case file to the assigned HR. All pertinent information relating to the hearing and related correspondence is captured in ECS.

d. Scheduling. Each claimant is provided written notice of the hearing at least 30 days prior to the scheduled date (unless waived by the claimant); advised that a one week notice must be provided to the FAB should he or she desire a person(s) other than himself or herself and his or her AR to attend the hearing; and advised that no independent video or audio recording of the hearing is allowed. See Exhibit 25-1 and Exhibit 25-2 for Sample Hearing Notice letters.

(1) Travel to Hearing. While the FAB will try to set the hearing within a reasonable distance of the claimant, the claimant may be required to travel up to 200 miles roundtrip to attend the hearing. There is no reimbursement to the claimant for the expense of this travel. However, if an unusual circumstance causes the FAB to schedule a hearing that requires the claimant to travel more than 200 miles roundtrip, OWCP will

reimburse him or her for reasonable and necessary travel expenses as outlined in 20 C.F.R 30.314(2).

In instances when multiple claimants request a hearing, the hearing is scheduled nearest the first claimant who requested a hearing. The remaining claimants are given the option to attend the hearing in person or participate via telephone.

(2) Telephonic and Video Conference Hearings. A hearing may be conducted by telephone or video conference at the FAB's discretion, or by claimant request. Only the hearing scheduler can schedule such a hearing, which will include all the aspects of an in-person hearing.

(3) Scheduling Changes. The FAB will entertain any reasonable request for scheduling the time and place of a hearing, but such requests should be made when the hearing is requested. The hearing scheduler will make every effort to accommodate the scheduling request of the claimant. An in-person hearing may be changed to a telephone hearing if a claimant or AR so requests. This change must be coordinated through the hearing scheduler.

Once the hearing has been scheduled and written notice has been mailed, it cannot be postponed at the claimant's request for any reason except as indicated in paragraph 4 below. However, the hearing scheduler may accommodate minor scheduling changes requested by a claimant or AR. HRs may not independently make changes to the scheduled hearing time or place without supervisory approval. The change request must be made to the HRs supervisor and the supervisor will contact the hearing scheduling unit supervisor.

The HR contacts the claimant(s) by telephone prior to the hearing to confirm they are planning to attend the hearing at the arranged date, time and location.

(4) Postponing a Hearing. The FAB may grant a postponement of a hearing when the claimant or his or her AR has a medical reason that prevents attendance or when the death of the claimant's parent, spouse or child prevents attendance. The claimant or AR should provide at least a 24 hour notice. The FAB will make every effort to accommodate timely requests to postpone a hearing.

In such cases, a new hearing will be set for the next hearing trip. Hearing scheduling unit supervisor approval is needed to postpone a hearing.

(5) Failure to Attend. If a claimant does not attend the hearing at the designated time and place, and makes no effort to contact the HR to request a rescheduling based on one of the reasons outlined in paragraph d(4) above, the claimant will not be allowed to reschedule his or her

hearing. In such instances, the claimant will be considered to have withdrawn the hearing request, and a review of the written record will be undertaken. If new evidence or argument accompanied the objection, it will be reviewed in the review of the written record.

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

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

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

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

f. Multiple RDs. Since more than one RD can be issued prior to a hearing and additional objections and hearing requests may result, measures are needed to streamline the hearing process.

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

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

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

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

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

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

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

objections and the objections discussed at the hearing will be addressed in one FD.

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

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

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

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

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

a. Convening. At the scheduled time and place, the HR will meet with the court reporter, the claimant, and any AR.

(1) If any other individual(s) is in attendance, the HR will request the identity of this individual(s) and have the claimant(s) sign a "Waiver of Right to Confidentiality" (Exhibit 25-3) before convening the hearing. The claimant(s) sign a separate waiver (Exhibit 25-4) if he or she requests that a member of the media be present.

(2) If there are multiple claimants present, each is required to sign a waiver of confidentiality.

(3) At the start of the hearing, the HR indicates to the court reporter that he or she wishes to open the record of the hearing. He or she will note the date and time, identify all persons present by name, and enter a brief narrative into the record describing the events leading to the hearing, including the specific objection(s) raised by the claimant. If no specific objections have been raised, the HR should indicate this.

For hearings addressing NIOSH Dose Reconstruction issues, the HR strictly follows the hearing script shown as Exhibit 25-5. The HR advises participants that he or she can discuss issues of a factual nature about the information provided to NIOSH and the application of methodology (see example below), but is not permitted to consider in the FD objections to the methodology employed by NIOSH in preparing the dose reconstruction report.

APPLICATION OF METHODOLOGY

A claimant may present argument to the FAB that NIOSH made an error in the application of methodology such as applying the radiation dose estimate methods to his or her individual circumstances, or that NIOSH did not address a specific incident discussed in the phone interview.

Another application issue might involve the use of "worst case" approach (which is a NIOSH method). The application aspect of this issue might be whether the "worst case" selected was the worst case (e.g., there were 20 more people working there that were not monitored and the worst case was based only on monitored individuals).

Example of Application of Methodology. *The objection alleges that NIOSH did not properly consider the "proximity to the source." The NIOSH exposure matrix considers that the worker was one foot away from uranium billets/rods for six hours and one meter away for four hours. NIOSH considers this to adequately account for times when the worker would touch the uranium rods/billets, since there would also be times when the worker was at a much greater distance. This exposure matrix is drawn as the example of highest possible exposure, as no individual exposure records are available. The objection indicates that the worker handled the uranium metal more often than NIOSH allowed in the exposure matrix. This is a challenge to the application of the dose reconstruction methodology and can be addressed as part of the hearing process.*

METHODOLOGY

20 CFR 30.318(b) provides that the "methodology" NIOSH uses in making radiation dose estimates is binding on the FAB. The "methodology" NIOSH uses is the way NIOSH performs the dose reconstruction, which is addressed in the statute and 42 CFR Part 82. "Methodology" is dictated by sections 7384n(c) and (d) of the statute. For example, those methods must be based on the radiation dose received by the employee (or a group of employees performing similar work) and the upper 99 percent confidence interval of the probability of causation in the radioepidemiological tables published under the Orphan Drug Act. The Act also requires

NIOSH to consider the type of cancer, past health-related activities (such as smoking), and information on the risk of developing a radiation-related cancer from workplace exposure.

The "methods" of dose reconstruction are set out in 42 CFR Part 82 and include: analyzing specific characteristics of the monitoring procedures in a given work setting; identifying events or processes that were unmonitored; identifying the types and quantities of radioactive materials involved; evaluating production processes and safety procedures; applying certain assumptions that err reasonably on the side of overestimating exposures while achieving efficiency; and using current models for calculating internal dose published by the International Commission on Radiological Protection (ICRP). The NIOSH "efficiency" process of using overestimates and underestimates in dose reconstruction is another example of a methodology. It is these "methods" that cannot be addressed by FAB. Any questions related to the content of NIOSH-IREP software are also related to methodology, whereas questions related to the Department of Labor's probability of causation calculation (which relies on NIOSH-IREP software) can be considered.

Example of Objections to Methodology. *The radiation dose to the claimant's gall bladder was calculated using the highest recorded doses from other co-workers at the facility as the basis for the claimant's dose estimate. This was noted in the text of the dose reconstruction report as being "the highest reasonably possible radiation dose." No uncertainty values were assigned to the claimant's estimate because it was considered that the claimant's "dose was no higher than this estimate."*

b. Testimony and Evidence. The HR will administer an oath to each person giving testimony. The HR should make clear at the outset that he or she cannot receive testimony from participants who are not under oath. If a witness arrives late, he or she must be sworn in before testifying. An attorney must not be sworn in since he or she simply presents arguments, objections or evidence but not testimony.

(1) A court reporter shall record oral testimony and place it into the record. A court reporter may use only audio (not video) equipment. Moreover, neither the claimant(s), any AR nor anyone else present at the hearing may bring audio or video equipment to obtain an independent record of the hearing.

(2) Any evidence or testimony a claimant wishes to enter into the record is entered, even if it pertains to a RD that was previously issued and the 60-day post-decision timeframe to object has expired. The HR will accept all testimony and evidence presented at the hearing.

(3) During the claimant's testimony, the HR should note any additional questions or areas for exploration and make appropriate inquiries. The claimant can raise additional objections at this time. The HR should ask questions or request the claimant to elaborate so the objections are clearly understood.

(4) Each exhibit is marked separately and identified on the record by name and number with a brief description of its content. The HR will state on the record that the exhibit is being entered into the evidence of record.

(5) During the testimony the HR states whether there is a need to interrupt testimony and go off the record. When it is time to return on the record, the HR indicates this and, once back on record, provides a brief description of why it was necessary to go off the record. Time and issues discussed off the record should be kept to a minimum.

The HR is responsible for maintaining order during the hearing. The HR should keep testimony on point. Should any of the hearing attendees cause a disruption or unreasonable delay in the proceedings, the HR will warn the disruptive attendee and terminate the hearing if the warning goes unheeded.

(6) The HR spells unfamiliar words or names to help the court reporter maintain an accurate record of the hearing.

c. Conclusion. When all testimony has been given and all the exhibits marked and clarifications made, the HR explains that the record will remain open 30 days after the date of the hearing to permit the submission of additional written evidence or argument on the issue(s) in question.

The HR also advises that the claimant will receive a copy of the transcript and will have 20 days from the date of mailing to request changes in writing to the record. The HR then closes the proceedings by noting the time and date.

9. Post-Hearing Actions. After the hearing, the HR obtains a copy of the transcript from the reporting service. FAB must timely send the claimant a copy of the hearing transcript.

A cover letter accompanies the transcript, reminding the claimant that he or she has 20 days from the date of the letter to comment on the accuracy of the transcript in writing. The claimant is also advised that the record will remain open 30 days from the hearing date for the submission of additional evidence.

a. Collecting Comments and Additional Evidence. The HR keeps the hearing record open for 30 calendar days after the hearing. At his or her discretion, the HR may choose to grant the claimant an extension for the submission of new evidence. However, the HR may only grant one extension not to exceed another 30 calendar days.

(1) If the claimant submits additional evidence within 30 days after the date of the hearing, or comments on the transcript, the HR will enter such evidence into the record and weigh it when issuing the decision.

(2) If the claimant does not submit additional evidence within 30 days after the date of the hearing, and does not comment on the transcript, the HR reaches a decision based on examination of the evidence of record. However, the HR must consider all evidence submitted, even if it arrives after the 30 day period, prior to issuing a FD.

b. FD. After examining the documents associated with the hearing, the HR independently assesses the evidence, analyzes the conclusions of the RD for appropriate application of law, regulations and procedures, and evaluates the objections. If a determination can be made without further development, the HR issues a FD.

c. Disposition of Case File. Once the HR issues the FD, the case file is returned to the DO that issued the contested decision, unless additional FAB review is needed on an outstanding RD.

10. Receipt of New Claim or New Medical Evidence. If the DO receives new medical evidence or a new claim while the case file is at FAB, the DO promptly transfers the documents to the FAB office where the case file is located.

a. New Medical Evidence Received. If FAB has the case file, receives new medical evidence, and has not issued the FD, the CE or HR reviews the new medical evidence and determines if the evidence pertains to a claimed condition or to a new, as-yet-unclaimed condition.

(1) New Medical Evidence Pertaining to Claimed Condition. If the evidence pertains to a previously claimed condition and the RD recommends denial of benefits based on insufficient evidence relating to that condition, FAB has the discretion to determine if the new evidence, when reasonably considered with the totality of the evidence, is likely to support a reversal of the RD in favor of the claimant.

(a) If FAB concludes that the new medical evidence of the claimed condition supports a reversal of the RD to deny the condition, and no further development is needed, FAB reverses the decision in favor of the claimant and accepts the claim.

(b) If FAB concludes that the new medical evidence does not support a reversal of the RD to deny, FAB upholds the denial.

(c) If FAB concludes that the new medical evidence does not support a reversal of the RD, but that further development is needed, FAB remands the case to the DO.

(2) New Medical Evidence of an Unclaimed Condition. If new evidence is of a condition that has not yet been claimed, FAB notifies the responsible DO CE who issues a letter to the claimant addressing receipt of the new evidence and explaining the ability to file a new claim form. FAB then proceeds with its review of the case and issues the FD on the claimed conditions.

b. New Claim Filed. If FAB has the case file, receives a new claim from a current claimant, and has not issued the FD, the CE or HR reviews the new claim and determines if any medical condition is being claimed for the first time.

If the conditions are determined to be duplicative, FAB acknowledges receipt of the new claim in writing and advises that it will not lead to further development as no new medical conditions were claimed. However, in certain instances, a subsequent claim for a condition such as skin cancer may lead to the need for further development.

In the event the claim is for a condition which has not previously been claimed, the FAB notifies the responsible DO CE to add a new claim or a new medical condition to an existing claim and to develop the claim if necessary.

(1) New Condition Claimed, Case in Posture for Denial. If a claim for a new medical condition is filed while the case is at FAB for denial of benefits, FAB has the discretion to determine if the new claimed condition, when considered with the totality of the evidence, is likely to lead to acceptance of benefits for the condition presently before FAB.

(a) If FAB determines that coverage is likely, FAB remands the case to the DO without issuing a FD.

(b) If FAB determines that coverage is not likely, the issue is forwarded to the DO for development. FAB then issues a FD on the matter adjudicated in the RD and notes in the opening of the FD that the development of the new claim is pending by the DO.

(2) New Condition Claimed, Case in Posture for Acceptance. If a claim for a new medical condition is filed while the case is at FAB for a review of a RD awarding benefits, the case is forwarded to the responsible DO CE to acknowledge receipt of the new claim and to advise that the DO will develop the newly claimed condition. FAB then proceeds to issue a FD on the conditions adjudicated in the RD.

(3) New Claimant. In multi-claimant cases, if a new claim is received while the case is at FAB, and the claimant had not previously filed a claim, FAB remands the case to the DO for development of the new claim.

11. One Year Requirement. To prevent undue delays in adjudication, 20 C.F.R. § 30.316(c) imposes a one-year limit on the amount of time a RD can be pending at the FAB before it automatically becomes a FD. Once the one year time frame has elapsed, there is essentially a regulatory/administrative FD. FAB CEs and HRs must ensure that a FD is issued prior to the expiration of a one-year deadline. FAB managers ensure that cases are assigned or re-assigned so as to prevent the expiration of a one-year deadline.

a. No Objection or Hearing Request Filed. If the claimant did not object to the RD and did not request a hearing, and the RD has been pending at FAB for more than one year from the last date on which the claimant was allowed to file an objection or request a hearing, the RD becomes final on the one-year anniversary of that date. This would be 425 days [60 days to object + 365 days (one year)] after the RD date.

b. Objection or Hearing Request Filed. A RD awaiting either a hearing or a review of the written record at the FAB will automatically become a FD on the one-year anniversary of the date the objection or request for a hearing was received in the FAB (as indicated by the date stamp).

c. DEEOIC Director Reopened the Claim. A RD awaiting a FD following an order by the DEEOIC Director reopening the claim for a new FD shall be considered a FD on the one-year anniversary of the date of the Director's reopening order.

d. One-Year Event Occurs. If the one-year time limit has expired, the RD automatically becomes a FD, and the case shall be transferred to the FAB-NO for review.

The FAB CE/HR ensures the case file is sent to the FAB-NO to the attention of the FAB Operations Specialist. A memo from the district FAB Manager, through the FAB Chief, dated and signed by the FAB Chief, to the Director must be included with the case file. The FAB Operations Specialist ensures that the case file is sent to the NO to the attention of the Office of the Director. The memo requests that the regulatory/administrative FD (based on the one-year rule) be vacated so a formal FD can be issued.

Once the case file is received in the NO, an assessment will be undertaken to determine whether it is necessary to vacate the regulatory/administrative FD. The Director may choose to allow an administratively finalized decision to stand and not issue a Director's Order. However, if a Director's Order is deemed necessary, it will specify whether the case file needs to be returned to FAB for a FD or to the DO for a new RD based on the evidence of record. Once the file is received back in the FAB or DO, the DO or FAB proceeds as instructed by the Director's Order.

e. Jurisdiction. Upon expiration of the one-year time period described above, FAB has no jurisdiction to remand the case for further development or to take any action other than that described above.

12. Decisions Returned by Postal Service. In those instances where a case file is at the FAB for review of a RD, and the Postal Service returns a RD sent to a claimant as undeliverable, the assigned FAB CE or HR should ascertain whether a simple mailing mistake (e.g., typographical error, unprocessed address change request) occurred that is easily rectified, or whether the claimant's mailing address is no longer valid. If there was an administrative error on the part of the DO in mailing a RD, FAB must coordinate with the DO to have it reissue the decision to all claimants with an effective date that corresponds with the new mailing date. Should the FAB CE or HR determine that the claimant's mailing address is not valid, he or she evaluates the case evidence to identify any information that could help locate the claimant. The investigation should include making a reasonable effort to obtain new information that may assist in identifying the claimant's valid mailing address. For example, the FAB should request a forwarding address from the Post Office closest to the claimant's last known address (Exhibit 25-6.) Once FAB has undertaken development, but is unable to obtain the claimant's current address, it places a memorandum in the file listing the actions taken to locate the claimant. It then administratively closes the effected claim. In a single claimant case, FAB returns the file to

the jurisdictional office responsible for case management. For a multiple claimant case, FAB must proceed to finalize the recommendation to any remaining claimants for which a valid mailing address exists. FAB is to reference the administrative closure of any claim with an invalid mailing address. For compensable claims, FAB must also explain that the allocation of any payable compensation to a claimant for which the FAB does not have a valid address is held in abeyance until the claimant provides written confirmation of his or her correct mailing address.

a. In the event the DO obtains information on the claimant's current address after FAB administratively closes the claim, the assigned CE must ensure that the claimant submits a written notice of his or her address change (Exhibit 25-7.) Once received, the CE resumes development of the claim.

(1) In a claim with a single claimant, the CE notifies the claimant in writing that the claimant did not provide proper notification of an address change, and that for this reason, FAB administratively closed its review of a pending RD. The CE explains that action on the claimant's file is resuming based on the status of the claim at the time of administrative closure. The CE is to reissue the previously undeliverable RD. The CE then forwards the claim to FAB, for it to proceed with finalization of the RD.

(2) For a claim with multiple claimants, if resumption of development occurs on an ineligible claimant, the CE is to issue a new recommendation to the claimant denying his or her claim. However, in the circumstance where resumption of development occurs involving a claimant who is eligible for compensation benefit, it is necessary to first reopen all claims to allow for a newly issued recommendation that comprehensively addresses the entitlement for all claimants with an interest in the claim.

b. FD Returned by Postal Service. If the FAB has issued a FD and the Postal Services returns it as undeliverable, the responsible FAB staff person is to ascertain the correct mailing address for the effected claimant. In such instances, the DO is to transfer the case back to FAB so that the responsible FAB staff may complete these actions. If the assigned FAB staff person obtains written confirmation of a new address from the claimant, he or she is to mail a copy of the FD to the claimant's new address. In the event that the assigned staff person is unable to obtain a written confirmation of a new address, he or she is to refer the claim to the appropriate DO contact to initiate an administrative reopening. The assigned DO staff will draft a Director's Order for the file explaining that the mailing address of the claimant is invalid, attempts to obtain a valid address were unsuccessful, and that a reopening is necessary to allow for an administrative closure. In a multiple claimant situation, reopening and administrative closure will apply only to those claims where the DO cannot confirm an address. However, later, if the DO receives written confirmation of a valid address on an administratively closed claim, it may then become necessary to reopen the other claims to permit for a reissuance of a unified FD.

CHAPTER 26 – FAB DECISIONS

1. Purpose and Scope. The Act and its implementing regulations provide for administrative review of all RDs. This Chapter describes the process by which the FAB performs that review and issues a FD or Remand Order on claims filed pursuant to the EEOICPA. This chapter also describes the FAB process following a claimant's request for reconsideration of a FD.

2. FDs. The FAB CE/HR reviews all evidence of record and the RD. Based upon that review, the FAB CE/HR issues an independent written decision addressing the appropriateness of the RD outcome. A FD of FAB may accept the findings presented in the RD, whether the RD awards or denies benefits, or reverse the RD if it denies the claim and the FAB CE/HR determines that the claim should be accepted. If FAB disagrees with the outcome of the RD, but there is insufficient basis to warrant a reversal, it issues a separate type of decision called a Remand Order. Guidance relating to the issuance of Remand Orders comes later in the chapter. As part of the content of a FD, the FAB CE/HR makes findings of fact and conclusions of law that support his or her position.

There are several types of FDs:

a. Acceptances. When FAB receives a RD accepting a claim for benefits, the assigned CE/HR evaluates the evidence, and the written content of the RD to validate that the RD outcome is appropriate given the circumstances of the claim. In particular, the assigned FAB CE/HR is to determine whether the conclusion described in the RD is based on the proper application of EEOICPA legal, regulatory, or procedural standards to the facts of the case. Once the FAB CE/HR has determined the RD to accept was decided properly, he or she is to prepare a FD listing the findings of fact and conclusions of law that permit the final approval of the claim.

(1) If the DO issued a RD accepting the claim in full and independent review by FAB concludes the acceptance is correct, FAB issues the FD awarding benefits in full.

(2) If the DO has issued a RD accepting one or more claim element(s) while denying and/or deferring other elements, the FAB issues the FD on the accepted portion of the claim as soon as possible to expedite the claimant's receipt of benefits. The FAB does not wait to issue the FD until the elements under development at the DO, or under contention due to denial, are decided.

b. Denials. When FAB receives a RD in which the DO denies the claim in full or in part, FAB reviews the RD and independently reviews the case to ensure that appropriate development has occurred, the case has been adjudicated consistent with the law, regulations, policies and procedures and that the assessment of evidence has been interpreted reasonably to allow for a negative outcome. Provided no technical or procedural errors exist, FAB issues a FD to deny the claim.

If the RD denies one claim element and defers another claim element pending further development, the assigned DO CE continues to develop the claim element that is not before the FAB.

(1) For non-contested denials, absent any technical or procedural error, the FAB issues a FD accepting the RD findings and denying the claim for benefits in cases where no timely objection is filed or a waiver is received.

(2) For contested denials, the FAB considers the timely filed written objection by either conducting a hearing, if requested, or a review of the written record before a FD is issued, as appropriate.

c. Decisions Issued in Response to an Objection. After considering a timely filed written objection by conducting a hearing that has been requested or, in those cases in which no hearing has been requested, by reviewing the written record, FAB issues a decision based upon its review of the record, consideration of the objections, and any new evidence. The FAB can issue a FD, a remand order returning the case file to the DO for further development or some other action, or a FD reversing a RD denying benefits.

Remand orders and FD reversals are discussed below and can be issued on both contested and non-contested claims.

(1) A review of the written record (RWR) is performed after a claimant has objected to the findings of a RD without requesting an oral hearing. The FAB will review the written record, the claimant's objection, and any additional evidence submitted to determine whether the RD findings can be adopted, reversed to accept the claim or remanded for further development. The FAB CE/HR must review all objections raised in the RWR objection letter and respond to each objection clearly and comprehensively. Once this review is complete, the FAB issues a decision based on its independent review.

(2) If the FAB conducts a hearing and satisfies all of the requirements of the hearing process (see Chapter 25, FAB Review Process), a decision is issued. While the HR may entertain objections raised from several RDs at the hearing itself, one FAB decision will be issued that addresses each contested RD after the resolution of the entire hearing process.

(3) In the decision following a hearing, the HR outlines the facts of the case, lists and comprehensively addresses all of the objection(s)(whether raised in the hearing request letter, subsequent letters, hearing testimony, or hearing exhibits) and thoroughly discusses the findings and/or conclusions of the FAB.

d. Reversal. A reversal is a FD issued when the evidence shows that either the RD denied benefits in error or new and compelling evidence warrants overturning a RD denial and accepting a claim for benefits.

If there is evidence in the case that warrants a reversal, the FAB CE/HR reverses the decision with approval from the FAB Chief and issues a decision to the claimant without delay. If the claimant submits additional evidence, the FAB CE/HR reviews such evidence and determines whether it is sufficient to accept the case. If it is sufficient, and there are no outstanding development issues (such as SWC/Tort information), the FAB CE/HR may reverse the decision immediately and accept the case. If the evidence is sufficient to warrant further development, FAB remands the case.

(1) A reversal can be issued when a case is denied in full or in part. In partial denials, the FAB may reverse to accept if the portion of the claim denied by the RD is found to be in posture for acceptance, a DO error is identified, or new evidence is received that warrants a reversal.

(2) A decision reversing the RD is used only where a denial is reversed to accept benefits. The FAB may not issue a reversal to deny benefits. The rationale for reversals must be clearly stated in the body of the decision and forwarded with the case file to the FAB Chief for review and approval. A reversal cannot be issued without such approval.

(3) When considering a reversal, FAB must be mindful of tort offset/SWC coordination and determine whether anyone received a settlement that might reduce the EEOICPA benefit.

3. Preparation of FDs. As with RDs, multiple FAB decisions are possible on one case. Given the requirement that any RD in which the DO decides the eligibility of any one claimant to receive benefits must include all claimants' party to the decision, a FD cannot be issued deciding any one claimant's eligibility to receive benefits without including all claimants with an interest in the claim as party to the decision. Accordingly, it is the responsibility of the FAB to remand any RD which does not comply with these procedures and instruct the DO to issue a new RD to address the eligibility of each party to the claim. This may require the reopening of certain claims, except in certain limited circumstances (see Chapter 27 – Reopening Process).

FAB decisions are plainly written and provide the claimant with a descriptive explanation regarding the basis for the outcome. This ensures that the decision-making process is transparent. The FAB clearly identifies the Part of the Act under which benefits are awarded or denied so that the claimant clearly understands the decision. They include statutory/regulatory language in the conclusions of law when outlining the benefits being awarded or denied.

a. Three Components. The FAB representative must prepare three components before issuing a FD (a sample of a complete FD is shown as Exhibit 26-1):

(1) A cover letter explaining that a FD has been reached. The cover letter must clearly identify what is being accepted, denied and/or deferred, and under what Part of the Act. This letter provides general information about the FD process and the administrative review available to the claimant.

(2) The FD. The FD contains a Notice of Final Decision (Introduction), Statement of the Case, Findings of Fact and Conclusions of Law.

(3) Certificates of Service certify that each listed claimant and his or her AR was mailed a copy of the FD and the date it was placed in the U.S. mail. A separate certificate of service is created for each claimant, but a claimant and his or her AR may appear on the same certificate of service.

An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 26-2); and/or (2) two Acceptance of Payment forms (EN-20), which is required before payment can be issued.

b. Formatting and Content, FD for Acceptances, Contested Decisions, Denials, and Reversals. Where a FD is prepared for an acceptance, contested decision, denial or reversal, it must contain the following sections in the following sequence:

(1) Notice of Final Decision (Introduction). This portion of a FD succinctly summarizes what benefit entitlement is being accepted, denied or deferred. Distinction is made between benefits addressed under Part B vs. Part E.

(2) Statement of the Case. This section sets out the case history, relevant to the issue for determination, up to the point of the issuance of the FD, including FAB actions and other pertinent information in a clear, concise narrative. No analysis of the facts or law and no citations should appear in this section.

(3) Findings of Fact. This section is a recitation of all facts needed to reach the conclusions of law and the ultimate decision rendered by the FAB. The findings of fact are the most significant findings from the Statement of the Case that are needed to support the FD ruling. Each finding is numbered sequentially. The findings should draw conclusions from the evidence of record, and must not simply recite the statement of the case.

(4) Objections. This section contains a summary of any timely objection brought up by the claimant or AR in connection with the RD(s) before FAB, as well as FAB's response to these objections. The summary should mention all timely objections in a clear and orderly manner, but the summary does not need to be numbered and it may combine similar objections. All summarized objections must be responded to, with a discussion of FAB's analysis of the objections in respect to entitlement requirements and an explanation of whether the objections have an impact on the adjudication of the claim. In most situations, to fully respond to the objections, the Objections section will need to make reference to the Act, regulations, or procedures. Therefore, citations are necessary and appropriate in this section.

(a) Objections to NIOSH Dose Reconstruction Decisions. Detailed procedures for assessment of objections to the NIOSH process are found in Chapter 25, FAB Review Process.

(i) Factual objections in FD. If the claimant submits a factual objection and the factual findings reported to NIOSH are supported by the evidence of record, the FAB CE/HR addresses the objections in the FD. No referral to the DEEOIC HP is necessary. If the factual findings reported to NIOSH do not appear to be supported by the evidence of record the FAB CE/HR refers the case to the HP for review. If the HP determines that a rework of the dose reconstruction is not necessary, the FAB CE/HR addresses the objection in the FD by outlining the findings of the HP. However, if the HP determines that a rework of the dose reconstruction is necessary, the FAB CE/HR remands the case to the DO.

(ii) Technical Objections in FD. A technical objection involving either methodology or application must be referred to the DEEOIC HP. If the DEEOIC HP deems none of the technical objections plausible, the FAB CE/HR incorporates the findings on these technical issues into the FD.

However, if the DEEOIC HP determines that there is substantial factual evidence that NIOSH had not previously considered and/or that NIOSH should consider an issue relating to application of methodology, he or she notifies the FAB CE/HR, who then remands the case, after supervisory approval, to the DO with instructions to refer the case back to NIOSH. In most cases, NIOSH will perform a new dose reconstruction based on circumstances of the remand.

(iii) Objections to Methodology in FD. When an objection is directed at NIOSH's methodology, the FAB CE/HR states in the decision that the objection cannot be addressed based on 20 CFR § 30.318(b) (methodology that NIOSH uses in arriving at reasonable estimates of radiation doses is binding on the FAB). The FAB CE/HR makes this statement only if so advised by the DEEOIC HP. Objections related to the content of NIOSH-IREP software are also related to methodology. However, the calculation of the probability of causation using the IREP software is the responsibility of the DEEOIC; therefore, FAB must address these objections in the FD.

(5) Conclusions of Law. This section contains the statutory and regulatory analysis used by the FAB reviewer to support his or her decision, referencing the findings of facts that support the conclusions of law. This section must be well-reasoned and provide appropriate legal citations. It should not, however, consist of a list of statutory and regulatory references without any explanation. This section also discusses any objection raised by the claimant in writing or through an oral hearing and includes FAB's response to the objection based on FAB's analysis of the objections and evidence of file. Finally, an overall legal conclusion supporting the decision must be reached. The conclusions of law must specifically identify whether or not benefits are being awarded or denied and under which Part of the Act.

c. Return of FD by Postal Service. Should FAB receive a returned FD, the FAB CE/HR will attempt to obtain the new or updated address for the claimant and re-mail the decision. More details regarding the handling of a returned FD are outlined in Chapter 25, FAB Review Process.

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

A Remand Order is written in narrative format to the claimant(s), but does not contain the normal sections of a FD (Statement of Case, Findings of Fact, and Conclusions of Law).

However, where objections have been filed or a hearing has been held, the remand order should discuss and respond to the objections raised.

A Remand Order may instruct the DO to perform further development, address an error or other deficiency contained in a RD, address new evidence or a new claim received prior to the issuance of the FD, or address a change in the law, regulations, policies or procedures. A Remand Order can be warranted at any point during a review of the written record, before or after a hearing, or during the review of a RD.

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

Should the FAB find a technical, procedural, or some other error requiring a remand order, the FAB returns the case file to the DO with specific instructions in the remand order as to how to proceed further. Remand orders are largely issued in instances where further development is required at the DO level. FAB does not issue a remand order where FAB personnel can conduct minor development to resolve the issue at hand.

a. Change in Law, Regulations or Policies. If FAB determines that a RD outcome is erroneous in light of a recent change in the law, regulations, or policy, FAB may remand the case. When this occurs, the Remand Order is to include specific narrative content explaining the basis for returning the case to the DO. For example, newly designated SEC class, changes to the DOE facility or AWE facility coverage, date or facility changes to the list of residually contaminated sites, modified program information on toxic substance or occupational health effects data or other regulatory or policy changes that could affect the claim outcome.

b. Erroneous Application of Law, Regulations, Policies or Procedures. If FAB determines that the recommended determination in the RD resulted from a misapplication of the law, regulations, policies or procedures, FAB may remand the case. The Remand Order identifies the misapplication of law, regulations, policies or procedures and describes how it effects the adjudication of the case. To expedite a favorable decision, the FAB CE/HR can reverse the decision without issuing a Remand Order, following procedures set forth in subpart 2.d of this chapter.

c. Receipt of New Medical Evidence or a New Claim for a Previously Unclaimed Illness. If while the case is at FAB, new medical evidence or a new claim for a new illness is received that is material to the recommended denial, FAB may remand or reverse to accept the claim, as applicable.

For example, if the RD denies a claim for CBD on the basis of a lack of medical evidence and the claimant later submits medical evidence establishing CBD, the FAB may remand the claim or reverse the RD if all elements of the adjudicatory process are complete.

If a claim for a new illness is received, the case will be remanded for development of the newly claimed illness if it will affect the outcome of the issue before the FAB. If filing of the new claim will not affect the issue before the FAB, the FAB can issue a FD and return the new claim to the DO for further development. If the FAB is not immediately ready to issue the FD, then the FAB is to notify the DO that a new claim has been filed so that the assigned DO CE may create the new claim and begin development while the case is at FAB.

d. Receipt of Other New Evidence. If FAB receives new evidence that was not a part of the file when the RD was issued and that is material to the recommended determination (such as employment evidence, survivorship evidence, or evidence of a SWC/tort suit); FAB may remand the case or reverse the RD if it is advantageous to the claimant. The Remand Order will describe the new evidence and its possible effect on the adjudication of the case.

e. Evidence Already in File. If the RD fails to properly address material evidence in the file and the failure could have an effect on the adjudication of the claim, FAB may remand the case. The Remand Order will describe the evidence and its possible effect on the adjudication of the case. If advantageous to the claimant,

and all adjudicatory issues are complete, FAB may reverse the RD and accept the claim.

For example, if evidence in the file sufficiently supports a diagnosis of a claimed cancer but the cancer was not included in the dose reconstruction, FAB may remand the case for a re-work of the dose reconstruction.

f. Miscalculation of Tort Offset or SWC Coordination. If FAB determines that the RD contains a finding of fact or conclusion of law that is based on a material miscalculation of the offset arising from a tort lawsuit or SWC coordination, FAB may remand the case.

(1) If a case is remanded for this reason, FAB includes its calculation worksheet in the file and a supplemental explanation of what FAB considers the evidentiary basis for its calculation.

(2) If FAB determines that the miscalculation was relatively minor and was not favorable to the claimant, FAB may exercise its discretion and issue a FD which corrects the calculation in the claimant's favor, without a remand.

g. Where a case is at FAB for review of one claim element and a remand order is issued on another claim element; the designated DO CE addresses the remand order. If there are no outstanding issues before FAB, the remand order and case file is returned to the DO that issued the RD. FAB may also issue remand orders in part, returning one portion of the claim to the DO for further action and issuing a FD on other portions of the claim.

h. Format of Remand Order. A Remand Order follows a narrative format and is directed to the DO which issued the RD. It includes a brief discussion of the claim's adjudicatory history when pertinent to the matter at hand, the basis for the remand, any explanation and supplemental documentation required and an explanation of the actions to be undertaken by the DO. A sample Remand Order is shown in Exhibit 26-3.

i. Notification and Transfer of File. When a Remand Order is issued, FAB inserts into the case file a copy of the Remand Order, certificate of service, and any supporting calculations or supplementary documentation. FAB sends a copy of the Remand Order, certificate of service, and cover letter to the claimant and the AR, if any.

(1) The cover letter explains the Remand Order and the DOs responsibility for preparing a new RD after further development. Additionally, the cover letter advises the claimant to which office the case file is being forwarded, and provides the address and telephone number of that office. See Exhibit 26-3.

(2) A certificate of service, which certifies the Remand Order was mailed on a certain date, is also prepared for each individual recipient, attesting to the date the remand order is sent, and is also included in Exhibit 26-3.

(3) Upon issuance of a Remand Order, FAB transfers the case file to the DO that issued the RD.

j. Challenging a Remand Order. No procedure allows a claimant to directly challenge a Remand Order, but each DD has the authority to formally challenge a FAB Remand Order with the DEEOIC Director if sufficient cause exists to do so. In such instances, the DD prepares a memorandum to the Director of the DEEOIC outlining his or her concerns and the case file is transferred to the Office of the Director for review.

5. Administrative Closure. If FAB determines that an individual claim requires administrative closure, a Remand Order is not necessary. These situations include:

a. Claimant Withdraws Claim. If a claimant advises the DEEOIC that he or she wishes to withdraw the claim, the FAB administratively closes the claim and drafts a memo to the file explaining the reason for the closure. Additionally, the FAB is to send a letter to the claimant advising him/her of the administrative closure.

b. Claimant Dies. If the claimant dies after the issuance of a RD but prior to issuance of the FD, the decedent's claim is administratively closed by the FAB. In the case of a single claimant, the FAB returns the claim to the DO to pursue survivor claims. In situations involving multiple claimants, the case is remanded to the DO for the issuance of a new RD which reallocates benefits. However, if the RD is recommending denial of all claims, the FAB may issue a FD to the remaining survivors, denoting the administrative closure of the decedent's claim.

c. Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.

d. SWC/Tort/Fraud Statements (EN-16) Not Obtained. Where signed statements are required regarding tort lawsuits, SWC claims and any possible fraud committed in connection with an application for or receipt of any federal or SWC benefit, and the claimant has not submitted such statements within 30 days of the issuance of the RD, the FAB administratively closes the claim. A memo to the file is drafted explaining the reason for the closure, and a letter is sent to the claimant advising him/her of the administrative closure.

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

When a consequential injury is to be accepted, the CE must get a new signed EN-16 SWC/Tort/Fraud affidavit from the claimant for that consequential injury.

FAB's responsibilities in obtaining the appropriate EN-16 forms are described in further detail in Chapter 31 - Tort Action and Election of Remedies and Chapter 32 – Coordinating State Workers' Compensation Benefits.

6. Claimant Rights Following the Issuance of FAB FDs. A claimant may seek review of a FD by filing a request for reconsideration or by filing a request for reopening of the claim. This section discusses requests for reconsideration and provides guidance relating to the initial receipt of requests for reopening.

a. Receipt of a Request for Review.

(1) A request for reconsideration will be considered timely if it was filed within 30 calendar days of the date of issuance of the FD. Pursuant to 20 C.F.R. § 30.319(b), the request will be considered to be "filed" on the date the claimant mails it to the FAB, as determined by the postmark, or on the date the written request is actually received by the DO or FAB, whichever is the earliest determinable date. A request for reopening may be filed at any time after the FD is issued.

(2) Any correspondence from a claimant or AR which is received in the DO or FAB within 30 calendar days after the FD is issued, and which contains either an explicit request for reconsideration or language which could be reasonably interpreted as intent to disagree with the FD will be considered a timely request for reconsideration. If new evidence is received in the DO or FAB within 30 calendar days after the FD issuance, and the new evidence relates to an issue which was adjudicated and denied in the FD, this new evidence will be considered a timely request for reconsideration. If the DO receives the request for reconsideration, it must be sent to FAB-NO for handling.

(3) Upon receipt of correspondence or new evidence which constitutes a timely filed request for reconsideration, FAB will send a letter to the claimant acknowledging receipt of the correspondence or evidence and advising that such receipt is considered a timely filed request for reconsideration.

(4) If correspondence received within 30 calendar days of the FD specifically requests a reopening instead of reconsideration, it will be handled as a reopening request by the DO. If both reconsideration and reopening are

requested, FAB will process the reconsideration request first and then forward the claim to the DO to process the reopening request.

(5) A request for reopening may take several forms:

(a) Any correspondence or evidence containing or accompanied by a specific request for reopening, which is received at any time after the issuance of the FD, will be treated as a reopening request.

(b) If correspondence or evidence is received without a specific request for reopening after the deadline for a timely reconsideration request, and the FD denied the claim to which the correspondence or evidence relates, the evidence is reviewed for possible reopening.

If FAB determines that such correspondence or evidence meets the evidentiary requirements set forth in 20 C.F.R. § 30.320(b), the FAB-DO district manager or the FAB-NO Branch Chief will prepare a memorandum to the EEOICP Director outlining the relevant claim history and the nature of the evidence and forward the case file to the EEOICP Director for review for possible reopening.

Should the evidentiary requirements not be met, FAB will associate the correspondence or evidence with the case file. In either case the claimant will not be notified of the actions taken by the FAB, because the claimant has not requested a specific action.

(6) Upon receipt of a request for review:

(a) Any request for reconsideration, along with the case file, is forwarded to FAB and assigned to a FAB CE/HR for review. A reconsideration request will not be assigned to a FAB CE/HR who issued the FD for the specific claim element being addressed in the reconsideration request.

Additionally, should the claimant specifically request that the reconsideration be addressed by a different FAB office, every effort should be made to accommodate the claimant.

The FAB CE/HR will screen the case to determine if the correspondence constitutes a request for reconsideration and, if so, if the request was timely filed.

(b) All requests for reopening received in the DO are initially reviewed by the DD. If a reopening request is received in FAB, the FAB-DO district manager or FAB-NO Branch Chief will

transfer the request, any supporting evidence, and the case file to the DD for review.

(7) Upon receipt of a timely request for reconsideration, the FD in question will no longer be deemed "final" until a decision is reached on the reconsideration request. Receipt of a request for reopening does not have a similar effect and the subject FD remains "final" until such time as the EEOICP Director issues an order reopening the claim.

(8) A reconsideration request does not come with further reconsideration rights but only reopening rights or right to file suit in District Court. Therefore, if FAB denied a request for reconsideration and the claimant subsequently files another request for reconsideration of the same FD, FAB will not entertain the subsequent request. A letter explaining to the claimant that reconsideration rights attach only once to a FD is signed by the FAB chief.

b. Processing an Untimely Request for Reconsideration.

(1) Any initial reconsideration request which is filed after the above-noted deadline is an untimely filed request for reconsideration.

(a) No letter is sent to acknowledge receipt of an untimely request for reconsideration. FAB issues a Denial of Request for Reconsideration advising the claimant that the request for reconsideration was not filed within 30 days of the issuance of the FD and must be denied.

(b) If FAB concludes that any evidence received with an untimely request for reconsideration may warrant a reopening, FAB may forward the request to the DD of the DO with jurisdiction over the claim for review.

(2) If an untimely filed request for reconsideration is accompanied by a specific request for reopening, FAB issues a Denial of Request for Reconsideration based on the untimely filing. The FAB CE/HR then forwards the reopening request with the case file to the DD of the office with jurisdiction over the claim for review for possible reopening.

c. Adjudicating a Timely Request for Reconsideration. Requests for reconsideration typically come in a number of different forms. To determine the appropriate action to be taken in response to the request, the FAB CE/HR must review the request and, if appropriate, any accompanying argument or evidence.

(1) If the request for reconsideration simply states that the claimant disagrees with the FD and provides no new argument or evidence in support of their request, the CE/HR may simply deny the

request for reconsideration on the grounds that no argument or evidence was submitted that would alter the FD. See Exhibit 26-4.

(2) If the request for reconsideration raises new legal arguments with respect to the FD but includes no new evidence, the CE/HR reviews the FD and considers the arguments made by the claimant. The reviewer must examine the evidence of record and the FD challenged by the claimant. See Exhibit 26-5.

(a) If the arguments do not change the outcome of the FD under review, the request for reconsideration is denied with appropriate and specific response to the arguments made in the request. FAB does not make any factual findings.

(b) If the arguments made in the request for reconsideration support a conclusion that there was a misapplication of the law, regulations or procedures in the FD, the request for reconsideration may be granted, and the case remanded to the DO or a new FD issued by the FAB reversing to accept the claim.

(3) If the request for reconsideration includes evidence which is duplicative, or essentially duplicates that which is already in the file and was previously considered in the FD, the request is denied with an explanation of how the new evidence does not change the outcome of the claim.

(4) If the request for reconsideration includes new, probative evidence which would alter the outcome of the FD, the request for reconsideration is granted.

d. Effect of denial or grant of reconsideration on finality.

(1) If the FAB denies the request, the FAB decision which was the subject of the request will be considered "final" on the date the request is denied. No further requests for reconsideration of that particular FD of the FAB will be considered.

(2) If the FAB grants the request for reconsideration and issues a new FD, that decision will become final on the date of its issuance. Accordingly, the FAB will consider subsequent requests for reconsideration pertaining to that decision.

(3) If the FAB grants the request for reconsideration and remands the case to the DO for further development, the claimant(s) will receive a new RD with the full rights that go with a RD and a new FD.

7. Alternative Filing, Part E. If a claimant is denied as an ineligible survivor under Part E, he or she has the right to alternatively receive a non-decision determination regarding the employee's claimed illness (es). FAB advises the claimant of this right in the cover letter of the

FD (see Exhibit 26-6 for a sample cover letter). Additional information regarding Alternative Filing can be found in Chapter 20, Establishing Survivorship.

CHAPTER 27 – REOPENING PROCESS

1. Purpose and Scope. This chapter describes the process by which the Director of the DEEOIC reopens claims for benefits under the EEOICPA and vacates decisions of the FAB.

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

The Director will delegate reopening authority by issuance of policy directives or other formal guidance that explains the extent of reopening authority conferred. In certain circumstances, the Director may delegate authority to reopening claims to the Branch Chief of the Policy Branch, the Unit Chiefs for the PRPU, and the DDs. For delegated reopening authority granted to the DDs, the delegation applies to ADDs when agreed to by a DD. The DEEOIC Director can grant reopening authority to other individuals in the program as needed. The Director retains sole reopening authority in any instance where he or she has not delegated reopening authority.

3. Claimant's Explicit Request for Reopening. The regulations allow a claimant or a claimant's duly AR, at any time after the FAB has issued a FD, to file a written request seeking reopening of a FD under the EEOICPA, pursuant to 20 C.F.R. § 30.320(b). The Regulations allow that such a request may be filed:

Provided that the claimant also submits new evidence of either covered employment or exposure to a toxic substance, or identifies either a change in the PoC guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the SEC.

There is no limit to how many times a claimant may request a reopening. A written request for a reopening is to result in a written decision either accepting or denying the reopening.

a. Timeliness. A claimant may file a request for reopening at any time after the FAB issues a FD. The CMR is to associate incoming reopening documentation to the case record in the OWCP OIS. Upon review by the responsible staff person in the DO or FAB, the reopening is marked as reviewed and indexed clearly as a request for reopening.

b. Initial Review. The responsible staff person who screens the incoming reopening request in OIS is to direct the documentation to the DD responsible for the case file.

Requests for reopening received in the NO FAB (FAB-NO) are reviewed by the FAB-NO Branch Chief. The DD or FAB-NO Branch Chief is to conduct an

initial review of the correspondence to determine whether the request is accompanied by new evidence, or other information, which is of a sufficiently compelling nature to warrant a reopening.

c. Referral for Reopening Action. Once initial review of a reopening request is completed, the DD or FAB-NO Branch Chief is to determine the responsible party for issuing a reopening decision. In many instances, the DD will have authority to issue a reopening decision on his or her own authority, as delegated by the Director. The FAB-NO Branch Chief, however, does not have the capacity to reopen a FD. Accordingly, he or she is to decide the appropriate office to which the reopening request is referred for review. The options available to the FAB-NO Branch Chief are to refer the matter to a DD with jurisdiction over the case or refer it to the DEEOIC Director. Circumstances in which a DD can reopen a FD are as follows:

(1) Employment. Newly submitted employment evidence contradicts a FD that the employee did not have covered employment.

(2) Survivorship. A previously denied survivor submits new evidence to document his or her qualifying relationship to the employee. A DD may also reopen a FD when a new survivor subsequently files a claim in a multiple claimant case and is determined to be eligible.

(3) SEM. An update occurs to SEM or the claimant presents new factual evidence that a previously denied, closed, or unverified toxic substance exposure is newly shown to be linked to the claimed illness(es).

(4) PoC. Cases containing a FD based on a PoC of less than 50% are reopened by the DD when new evidence is received that warrants a referral to the NIOSH resulting in a revised PoC that makes the claim compensable. This most commonly occurs with claimant submission of an additional cancer claim. In those instances where a new cancer is evaluated by NIOSH and does not result in a PoC of 50% or greater, a reopening of the prior FD is not necessary. The DD directs his or her staff to proceed with any additional development that may be warranted (Part E analysis for non-radiogenic toxic substances) or proceed with a recommendation to deny the new cancer claim if Part E does not apply.

(5) New Medical Evidence. New medical records or documentation is submitted, which clearly establishes a diagnosis of a medical condition or the existence of a percentage of permanent partial impairment, previously denied in a FD due to insufficient medical evidence.

(6) Change in Law, Regulations or Policies. If the initial review reveals that the claimant has identified a change in the law, regulations, or policies governing the EEOICPA, the DD determines whether the nature and extent of such information satisfies the requirements of 20 C.F.R. § 30.320, and whether it is sufficient to warrant reopening.

d. Denial of Request for Reopening. If no evidence is submitted, or if the evidence submitted and/or the change in law, regulations, or policies identified by the claimant is insufficient to support a reopening, the DD issues a Denial of Request for Reopening.

e. Referral to DEEOIC Director. If the DD or FAB-NO Branch Chief cannot determine whether the evidence submitted, and/or the change in law, regulations, or policies identified by the claimant, is sufficient to warrant a reopening, or if the request presents an issue for which the Director has not delegated reopening authority, he or she is to refer the matter to the DEEOIC Director. A DD or the FAB-NO Branch Chief is to refer to the Director requests involving uniquely complex or potentially sensitive topics. In these instances, the person making the referral to the Director prepares a memorandum explaining his or her reasons for requesting the Director review the case for reopening. The memorandum is to outline the case history, the evidence of record and explain why the new evidence, or other information, is material to a potential reopening. It is important that the DD or FAB-NO Branch Chief merely identify the issue(s) requiring review. He or she is not to advocate for a particular reopening outcome, as that is the exclusive purview of the DEEOIC Director.

4. Claimant's Non-Specific Correspondence or Evidence. Once FAB issues a FD there may arise situations where a claimant submits non-specific correspondence or evidence. Under these circumstances, it is difficult to interpret the documentation to determine if the claimant is objecting to a particular Conclusion of Law referenced in the FD. To address this problem, it is necessary for the staff person responsible for the claim to contact the claimant by telephone to ascertain his or her intent to pursue an objection.

During contact with the claimant, the responsible CE or FAB representative is to notify the claimant of his or her options, which may include reconsideration within 30 days of the FD (if applicable) or evaluation under the authority granted to the Director to reopen a claim. If the claimant provides written or verbal clarification of his or her intention, the CE or FAB representative is to input a note in the ECS documenting clearly the information provided. Should the CE or FAB representative not reach the claimant by phone within a reasonable period (approximately 3 days), and clarification cannot be obtained by telephone, he or she will need to evaluate the evidence to determine the appropriate action to be undertaken.

a. Non-Specific Correspondence or Evidence Received Within 30 Days of a FD. If attempts to clarify the intent of the claimant are not successful, and the 30-day period granted to request reconsideration has not expired, a DO FAB Manager or FAB-NO Branch Chief is to determine if a sufficient basis exists to treat the documentation as a request for reconsideration. A DO FAB Manager or FAB-NO Branch Chief can delegate this responsibility to other FAB staff persons. If it is determined that the evidence warrants a reconsideration determination, a DO FAB Manager or FAB-NO Branch Chief ensures that the matter is referred to the proper FAB staff person to record the request as a reconsideration requiring action.

b. Non-Specific Correspondence or Evidence Received After 30 Days of a FD. Once the claimant's option of requesting reconsideration expires, the claimant only has the ability to pursue reopening should he or she disagree with a FD. With the receipt of non-specific correspondence after the period of reconsideration submission expires and efforts to have the claimant clarify his or her intent to request reopening are unsuccessful, the staff person in possession of the file is to coordinate with the DD with jurisdiction over the case file to determine the appropriate course of action. The DD (or his or her delegate) reviews the evidence to determine whether there is sufficient basis to warrant a reopening, and whether he or she has been delegated authority to reopen based on the case circumstance. If the DD or their delegate decides that the evidence supports taking reopening actions and possesses the authority to reopen the FD, he or she proceeds to review the case for a reopening decision. If the DD does not have the requisite authority to reopen the FD, or there is some other complication, he or she seeks guidance from the DEEOIC Director.

c. Non-specific Evidence That Does Not Warrant Reconsideration or Reopening. Under any circumstance where incoming correspondence does not support reconsideration or reopening, the assigned CE or FAB representative assigned to the case is responsible for uploading a memorandum to file in OIS documenting the actions taken to review the correspondence that supports taking no action.

5. Reopening and Vacating a FAB Decision. The DEEOIC Director or an individual acting under a delegated authority, reopens a FD or letter decision by issuing a Director's Order.

a. Director's Order Content. A Director's Order contains three components.

(1) Cover Letter. The cover letter is addressed to the claimant(s) receiving the Director's Order. It cites the authority by which a FD or Remand Order is being vacated, and provides a summary of the issue under review, a clear indication of all actions taken under the Order and the reopening conclusion.

(2) Director's Order. A Director's Order is the written notice which provides narrative explaining the basis for reopening and vacating a FAB decision. It is divided into three parts; including: a Background section, which discusses the history of the case record leading to the FD under contention; a Discussion section, which includes analysis of the evidence supporting the decided outcome; and a Conclusion (see Exhibit 27-1) The decision narrative is to provide descriptive explanation of the rationale supporting the reopening and the basis for vacating a FAB FD or Remand. There are many reasons for reopening a FD, including the receipt of new evidence, incorrect application of program policy, or content errors. In addition to including a written explanation of the reason(s) for reopening a FD or Remand, a Director's Order may provide corrective action instruction to a district or FAB office responsible for the case record.

(3) Certificate of Service. This confirms the mailing date of a Director's Order, and lists the name and address of the intended decision recipient. A Certificate of Service is completed individually for each claimant (or his or her AR) who is party to the Director's Order. It must be dated on the date of decision mailing.

b. Reopening Multiple Claimant Claims. Under certain situations, the CE or FAB representative is to proceed with a reopening referral when a circumstance involves a change to a benefit entitlement after the issuance of a FD involving multiple claimants. Each individual named in a multiple claimant FD is required to be a party to any decision that addresses a benefit entitlement, even if the outcome does not necessarily change each claim. The reason for this is to ensure each filed claimant receives notification of the distribution of benefits under the claim to which he or she is a claimant. It also permits each claimant to contest any outcome to which he or she disagrees. Common reasons for reopening a prior FD to multiple claimants includes the identification of a new qualifying survivor, new evidence documenting that a previously ineligible survivor now qualifies, or reallocation of lump-sum compensation that was held in abeyance until the status of a non-filing survivor was determined.

c. District or FAB Offices are Responsible for Complying With Any Guidance or Instruction Provided in a Director's Order. The issuance of a Director's Order is at the discretion of the Director or a delegate. As the decision represents the intent of the Director to address a defect in a FD, district or FAB offices are required to comply with any guidance or instruction included in a Director's Order.

6. Reopening and Vacating a FAB Decision Following an Employee's or Survivor's Death. In cases where an employee or survivor dies following the issuance of a FD and a new survivor files a subsequent claim, the CE takes action to administratively close the deceased individual's claim. He or she then initiates action to adjudicate the claims for any additional new survivor(s). In some instances, during the adjudication of the claim for a new survivor, the CE may determine that a factual finding and/or Conclusion of Law in a previously issued FD (i.e., covered employment, survivorship, medical diagnosis, etc.) is not accurate and affects the adjudication of the new survivor's claim. Once FAB incorporates a factual finding and/or Conclusion of Law into a FD, a CE cannot undo the decision by administratively closing it. A factual finding and/or Conclusion of Law cited in a FD is legally operable until vacated by a Director's Order issued by the Director or someone with delegated authority to do so. For example, the employee received a FD that specified covered dates of employment at facility A; however, with the employee's death, a survivor decision is now needed. Upon review, the CE finds that the employee's employment actually occurred at facility B. Under this circumstance, the CE must obtain a reopening of the decision that was issued to the employee to allow for a correct reference to covered employment at facility B. The CE is only required to address factual findings and/or Conclusions of Law that contradict directly with the evidence necessary to proceed with a new decision. It is not necessary for the CE to obtain a Director's Order when FAB concluded that it did not have the necessary evidence needed to arrive at a decision regarding a particular factual finding and/or Conclusion of Law.

In cases where the CE identifies a material factual finding and/or Conclusion of Law in a prior FD that is now contradicted based on a new examination of case evidence, he or she is to obtain a Director's Order vacating the FD containing the erroneous factual finding and/or Conclusion of Law.

a. When issuing a Director's Order to correct a factual finding and/or Conclusion of Law from a previously issued FD, the Director or DD with authority to reopen the claim issues the decision to all the parties named in the vacated FD. In the circumstance where all the parties who received the decision are deceased, the Director or the DD is to issue the Director's Order as would normally be the case, but annotate that he or she is issuing it to the case file as an administrative function.

7. Denying a Specific Request for Reopening. A Denial of Reopening Request is a written decision issued by either the DEEOIC Director or a designated representative. The content of a denial is similar to that of a Director's Order in that it contains a cover letter, decision notice, and Certificate of Service. Much like a Director's Order the decision notice provides a background of the case history leading up to the decision under contention, and a discussion of the evidence or argument presented in support of a reopening. However, the decision is to provide a detailed explanation as to why the evidence presented is insufficient to warrant reopening of a FD or Remand Order (Exhibit 27-2). The Director or designated representative responds comprehensively to each objection presented by a claimant.

a. Issuance of a Denial of Reopening Request is to be Limited to the Individual(s) Requesting Review of a FD.

b. Requests to Vacate a FAB Remand Order. The DEEOIC Director is the only authority that is permitted to vacate a FAB Remand Order. A reopening review of a Remand Order will normally originate from a DD or ADD due to the identification of misapplied program policy or a challenge to FAB's rationale for returning a case to the DO. In these scenarios, the DD or ADD is to send his or her request for a review of the Remand to the Director. The referral is to include a memorandum identifying the specific Remand Order under contention and state merely that the DD or ADD wants the Director to review the Remand for accuracy. The DD or ADD is not to advocate for any particular outcome, merely that there is a potential deficiency contained in the Remand that the Director needs to review. Upon receipt, if the Director agrees with the Remand Order, he or she will deny the request to vacate by issuing a memorandum to the requesting party. Otherwise, the Director issues a Director's Order to vacate the Remand and return the case file to the proper office for handling.

8. ECS Implications. All reopening requests, requests to vacate FAB decisions, and decisions granting or denying such requests are to be properly documented in ECS pursuant to DEEOIC procedures.

CHAPTER 28 – MEDICAL BILL PROCESS

1. Purpose and Scope. This chapter describes the roles of the CE, Medical Benefit Examiner (MBE), FO, and MS), in the medical bill process. It also outlines the procedures for evaluating and approving requests for employees who are in need of medical services, supplies, or reimbursement of expenses related to medical care.

2. Roles and Responsibilities. Upon issuance of a FD approving a specific medical condition, the CE, MBE, the BPA, the FO, and the MS must ensure that the medical needs of the claimant, as they relate to his or her accepted medical condition, are reasonably provided for.

a. Medical BPA. The use of a contractor for processing medical bills allows the DEEOIC to provide a high level of service to eligible claimants and their providers. Once a claimant has been accepted for a covered condition under the EEOICPA, an eligibility file is automatically generated in ECS and sent to the BPA electronically.

(1) When the BPA receives the eligibility file, the BPA sends a medical bill identification card (MBIC) and general information about the medical bill process to the claimant.

(2) Providers, Claimants and DO Staff send all medical bills, bill attachments, treatment notes, and requests for claimant reimbursement to the contractor for scanning and keying into their system.

(3) The BPA maintains a customer call center, medical staff, and bill resolution units.

b. Medical Benefit or Claims Examiner – MBE staff are responsible for reviewing, developing, and deciding whether to authorize the payment of services, appliances, supplies, modifications or travel expenses necessary to cure, give relief, or reduce the degree or period of illness.

(1) The MBE considers the level of care prescribed by the treating physician as it relates to the accepted medical condition and the facts of the case. The MBE must then make an informed judgment based on the level of care prescribed by the doctor.

(2) This decision must take into account the overall desires and needs of the patient, as well as those of the family. The DEEOIC will not dictate what option an employee must accept, nor will decisions be made based solely upon cost. The MBE must also consider what level of care or services satisfy the patient's needs.

(3) The MBE is responsible for communicating all decisions (approval/denial) to the requestor.

(a) If a request for services or payment originates from the BPA, the

FO notifies the MBE via email. These requests may come to the MBE as a prior authorization request, or may come after submission of a charge to the BPA.

The MBE emails his or her determination to the FO, inputs it into ECS under the correspondence tab and communicates the decision via thread to the BPA.

(b) If the request originates from a claimant or provider, the MBE immediately sends a copy via facsimile to the FO, and concurrently begins development for approval or denial of the request. The MBE communicates all approvals or denials to the requestor as outlined above.

c. FO. The FO acts as liaison between the MBE and the BPA, serves as coordinator for medical bill issues between the DO and the NO, and maintains a DO record of persons authorized to access the BPA website. The FO does not determine eligibility or authorize payments.

d. District MS. The MS coordinates all requests for both CMC and Non-Contracted Impairment reviews.

e. CMC. The CMC reviews and evaluates the medical evidence of record and provides medical opinions about various aspects of cases; including interpretation of medical evidence, causation between an illness and occupational toxic substance exposure, and percentage of impairment.

3. Parameters for Payment. OWCP procedures employ four levels of review in the medical bill process, only two of which DEEOIC currently uses. The BPA processes charges for Level 1 services without MBE approval. Any higher level of service (i.e. two, three or four) is treated as a Level 4 service in our program and requires that the MBE review the proposed procedures or service(s), the proposed charges if applicable, and the supporting medical documentation, prior to approving or denying the request.

4. Mailbox for Medical Bill Inquiries. An electronic mailbox (email) is available to resolve medical billing questions. DEEOIC staff may submit billing inquiries, through designated supervisory staff, to the mailbox about medical bills, travel reimbursement, treatment suites, provider outreach, or policy questions regarding medical bill processing. Use of this mailbox provides for expedited resolution of medical bill issues as they arise, and provides a uniform process for responding to questions and issues, program wide. DEEOIC CEs are to submit inquiries to the assigned FO. DEEOIC MBEs are to submit inquiries to their assigned Team Lead/Supervisor. Once reviewed, the FO or MBE Team Lead/Supervisor will work to address the inquiry locally or decide to forward the inquiry to the mailbox for review and response.

a. To maintain consistency and to provide clarity in the communication process, email submissions by the FO or MBE Team Lead/Supervisor to the medical bill mailbox must provide sufficient information, clearly defining the nature of the question, so that it can be routed properly for response. Inquiries to the mailbox

must be categorized using the subject headings below, and the subject line of the email must contain one of the following four subject headings:

(1) Medical Bill Processing Policy Questions. This subject involves policy interpretation of existing program guidance related to medical authorizations, bill processing, travel reimbursement and other ancillary services.

(2) Treatment Suites. This subject involves automatic payment of treatment or services based on accepted conditions.

(3) Provider Outreach. This subject involves inquiries from medical providers regarding assistance with enrollment, submission of bill(s), or understanding DEEOIC's medical billing process.

(4) Bill Payment Processing. This subject involves inquiries regarding reimbursement of medical bills that do not require policy interpretation of existing program guidance. The body of the email itself must contain the following information (as applicable):

- Location;
- CE/MBE Name;
- Employee's Name;
- DOL File Number(not to be used in the subject line);
- Accepted Condition(s) with ICD-9/10 code(s);
- Billed Amount(s);
- Date(s) of Service(s)or Travel day(s);
- Medical Provider Name(s);
- Type of Service(s) (i.e., Pharmacy, In-Home Health);
- Question(s) or issue(s) to be resolved.

b. Upon receipt of a mailbox inquiry, designated staff within BMB will evaluate the submission and determine the proper course of action to generate a response. If follow-up is necessary, the staff person will contact the CE or MBE for clarifying information about the nature of the inquiry. BMB staff will work with appropriate subject matter experts within DEEOIC to draft a response. Managerial staff within BMB will then review drafted responses to clear for publication to the submitting FO or MBE Team Lead/Supervisor. The FO and MBE Team Lead/Supervisor will then refer the response to the originating CE or MBE.

5. Medical Records Procurement. DEEOIC pays costs associated with obtaining medical records regardless of whether a claim has been approved for benefits. This reimbursement is payable only to a hospital, physician's office, or other medical facility that charges a fee to produce records. The maximum allowable reimbursement is $100 per request.

a. Form of Request. The provider provides the MBE with the written fee request on official letterhead or billing statement. The request includes the tax identification

number of the facility, total amount charged for the record request, and the provider enrollment number. If the provider is not enrolled, the MBE forwards an enrollment package to the provider with a letter requesting that the provider enroll, and after completion of the enrollment process, the provider informs the MBE of their new provider number.

b. Approval of Payment. Upon receipt of the required information, the MBE approves the payment of the bill by completing a Form OWCP-1500, sending an approval letter to the requestor, and completing ECS coding as required in DEEOIC procedures. The MBE then forwards the completed Form OWCP-1500, approval letter, and invoice to the FO for payment processing.

6. Treatment Suites. At the core of the medical bill reimbursement process is the use of treatment suites. The treatment suites used by the DEEOIC are contained in a database maintained by medical professionals within the OWCP. They compare an accepted (ICD-9/10 coded) diagnosis for which a provider has billed, with acceptable, allowable treatments for that condition. The use of treatment suites allows automatic payment of bills, for authorized services, when the amount billed is reasonable and customary for an accepted condition.

7. Eligibility Files. In order for a claimant's bills to be paid, an eligibility file is generated automatically in ECS and sent to the BPA once a condition has been accepted. This eligibility file contains the accepted condition for which a claimant is entitled to medical treatment. When the accepted condition(s) are coded and billed with the correct ICD-9/10 Code, the volume of suspended and denied bills is significantly reduced. Consequently, accurate code selection expedites provider reimbursement for all approved medical services rendered to the claimant.

8. ICD-CM Codes. The International Classification of Diseases, 9th and 10th Revision, and Clinical Modification, (referred to simply as ICD-9/10 codes), is a statistical classification and coding system used to assign appropriate codes for signs, symptoms, injuries, diseases, and other medical conditions.

These codes are assigned, based on the claimants' medical documentation (records), including, but not limited to physician notes, diagnostic tests, and surgical reports. ICD-9/10 codes are divided into an alphabetic index, which is an alphabetic list of terms and their corresponding codes. ICD-9/10 codes are composed of numbers with 3, 4, 5, 6, or 7 digits. Three-digit category codes are generally subdivided by adding a fourth, fifth and/or sixth digit to further specify and clarify the nature of the disease or medical condition. The CE entering an ICD-9/10 code must identify and enter the code that references the disease, illness or medical condition that was reported, and should identify the organ(s) or portion of the body affected by the condition.

In general, three-digit codes identify a category of illness, while codes with fourth digits are called subcategory codes, and those with fifth digits are referred to as sub-classifications.

When a specific condition, illness, etc., contains a 5th or 6th digit, the MBE uses all available digits to identify the condition. In addition to providing further specificity of the anatomical site, the 4th and 5th digits also provide additional pertinent clinical information related to the injury or medical condition. Therefore, when selecting ICD codes, the MBE should always use the

code that most specifically describes the medical condition reported.

a. Examples of valid 3-character ICD-10-CM codes:

(1) I10 Primary Hypertension

(2) N19 Renal Failure.

b. Examples of 4, 5, and 6 character ICD-10-CM codes:

(1) J44.9 chronic obstructive pulmonary disease unspecified (requires a 4th digit).

(2) C34.11 Malignant neoplasm of upper lobe, right bronchus or lung (requires 5th digit).

(3) C50.012 Malignant neoplasm of lower-outer quadrant of left female breast (requires a 6th digit).

For all medical conditions with a medical eligibility begin date on or after October 1, 2015, the MBE will use ICD-10-CM coding in ECS, development, and decisions. If the condition is input into ECS after October 1, 2015, ECS will default to entry of an ICD-10 code. However, the system will allow entry of an ICD-9 if appropriate. If the condition is determined to be a consequential condition and the underlying condition has a filing/eligibility begin date prior to October 1, 2015, the ECS system will force the user to enter an ICD-9 code, even though the condition itself was filed after October 1, 2015. Ultimately, the medical eligibility begin date is the driving factor on whether an ICD-9 or ICD-10 code must be used on a medical condition. If the medical eligibility begin date is on or after October 1, 2015, the ICD-10 code is what will be reflected throughout the system wherever ICDs are reflected. MBEs will also reference ICD-10 in decisions and development letters if the filing/eligibility begin date is on or after October 1, 2015. For example, if the medical records list a primary diagnosis of renal failure and the status effective date is October 1, 2015, the MBE enters (N19) as the ICD-10-CM code in the medical condition field and uses this code in the rest of the correspondence throughout the case.

9. Coding Software. MBEs are to utilize Optum, an online tool that helps to identify the appropriate ICD-9/10-CM code. These guidelines are to be used as a supplement to the ICD-9/10-CM Coding books.

10. Prompt Pay. The Prompt Payment Act requires federal agencies to pay vendors in a timely manner. The Act requires assessment of late interest penalties against agencies that pay vendors after a payment due date. The DEEOIC has identified three classes of bills that fall under the Prompt Pay Act: Reviews by a CMC, Second Opinion/Referee Medical Examinations, and Impairment Rating Examinations. These bills must be processed within seven calendar days from date of receipt in the DO. (Refer to Chapter 16 – Developing and Weighing Medical Evidence for the specific actions to be taken by the CE and the MS in the processing of CMC bills.)

11. Time Limits for Submission of Medical Bills. DEEOIC pays providers and reimburses employees promptly for all bills that are properly submitted on an approved form and which are submitted in a timely manner. No such bill is paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was provided; or, more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later.

12. Fee Schedule. For professional medical services, OWCP maintains a schedule of maximum allowable fees for procedures performed in a given locality. The schedule consists of:

a. An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class.

b. An index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs.

c. A monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

Generally, bills submitted using HCPCS/CPT codes cannot exceed the fee schedule. If the time, effort and skill required to perform a particular procedure varies widely from one occasion to the next, DEEOIC may choose not to assign a fee schedule limitation. In these cases, the allowable charge is set individually based on consideration of a detailed medical report and other evidence. At its discretion, DEEOIC may set fees without regard to schedule limits for specially authorized consultant examinations, and for other specially authorized services.

13. Fee Schedule Review Process. As part of the medical bill review process, program regulations provide for the reconsideration of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service). A provider whose charge OWCP partially pays under the fee schedule has 30 days to request reconsideration of the fee determination.

a. Fee reconsideration circumstances. A medical provider may contest a payment under the OWCP fee schedule under the following circumstances:

(1) The service or procedure was incorrectly identified by the original code; or,

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or,

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

b. A provider is to submit a fee schedule reconsideration involving a DEEOIC claim to the BPA at the medical bill processing mailing address. The fee

reconsideration request is to communicate clearly that the provider is contesting a payment under the fee schedule relating to a DEEOIC case file and the applicable fee reconsideration circumstance the provider is pursuing. The provider is to attach any remittance voucher or other accompanying material the provider is using to support the fee reconsideration request.

c. Once received, the BPA will register the fee reconsideration request and forward it to the MBPU. MBPU will coordinate with the DO with jurisdiction over the claim to assess the reconsideration request. Within 30 days of receiving a fee reconsideration, the responsible DD is to issue a written determination on the reconsideration request. The DD's written determination is to state whether or not an additional amount will be allowable as reasonable considering the information submitted in the reconsideration request. If the DD decides to deny the reconsideration request, the DD is to include the following notice within the written decision:

> *If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. Direct any request for additional review to the National Administrator for Field Operations (NAFO). You may submit with the application any additional information you wish the NAFO to consider. Mail your application for additional review to the DEEOIC BPA at the following address:*
>
> <Insert BPA Mailing Address>

d. If a provider seeks further review of a denied reconsideration request, the DEEOIC BPA will coordinate with the MBPU to direct the request to the NAFO. The NAFO performs the same functions as, and serves as the equivalent of, a Regional Director, which the regulations reference as having to conduct this review. DEEOIC reorganized its regional offices into National Field Operations, so the position of Regional Director no longer exists. The NAFO will seek any information to allow for a comprehensive review of the application, including review of any information supplied by the provider or maintained by DEEOIC regarding the case file. Once the NAFO completes a review of the application and relevant documentation, the NAFO will prepare a written response to the provider within 60 days of the receipt of the request for further review. The decision will communicate whether or not an additional amount is allowable. If the NAFO denies an additional amount, the NAFO's decision to communicate to the provider that the decision is final and is not subject to further administrative review.

14. Issuing Medical Payments To A Survivor After The Employee's Death. Upon receipt of documentation establishing the employee's date of death, the PCA changes the Employee Mail Name on the Claimant Information screen in ECS to read "Estate of [plus Employee Name]."

This change is necessary so that any subsequent checks for medical reimbursement will be made payable to the employee's estate, not to the employee name.

a. If a survivor returns a medical reimbursement check and requests that it be reissued to a payee name other than the employee, the check is bronzed into OIS along with accompanying documentation, and the original check is forwarded to the NO MBPU. That unit reviews the request to determine the appropriate response.

(1) If the payment was issued after the employee date of death but before the DO was notified, the MBPU responds and advises that the DEEOIC requires a copy of the employee death certificate in order to reprocess payment. Upon receipt of the death certificate, the original check and death certificate are forwarded to the MBPU for cancellation, and reissuance of payment to the estate.

(2) If a check is being requested to a payee other than the employee's estate, the MBPU reviews the request to determine the appropriate action:

(a) If the person requesting payment is the surviving spouse who resides in a community property state, the DO requests that the spouse provide proof of the couple's legal marriage and the employee's death certificate. These documents are bronzed into OIS and forwarded through the MBPU to the SOL for review and guidance.

(b) If the request is for any reason other than a "community property" issue, the DO obtains any documents the requesting party wishes to produce in support of his or her claim, and forwards them to the MBPU.

(c) The MBPU forwards the request and supporting documents to the SOL for review and comment.

(d) If necessary, the MBPU requests that the DO provide additional documentation or explanation from the requesting party, in accordance with guidance from the SOL.

(3) Upon approval from the SOL, the MBPU will:

(a) Cancel the returned check in the Treasury PACER system.

(b) Request that the DO change the Employee Mail Name in ECS.

(c) Reissue the check payable to the payee name approved by the SOL.

CHAPTER 29 – ANCILLARY MEDICAL SERVICES AND RELATED EXPENSES

1. Purpose and Scope. This chapter includes the procedures that DEEOIC claims staff use in evaluating and approving requests for ancillary medical services, DME and supplies, and related expenses.

2. Requests for Ancillary Medical Services and Related Expenses. This chapter provides further guidance relating to the review process for requests pertaining to a wide variety of ancillary services and related expenses. A claimant, AR, treating physician, or a provider may request the services and related expenses described in this chapter. Requestors are to make their claims by sending them to the DEEOIC BPA via fax, mail, or electronic submission. The assigned MBE, or FAB staff person, who receive requests through OIS, forwards them to the BPA.

a. The BPA creates an electronic record of the request and initiates a thread to the FO at the DO where the claimant's case file resides. The thread from the BPA advises the FO of a pending request for authorization of services. For DME or supplies requests, the thread details will include a statement indicating if any requested DME or supplies are subject to the OWCP Medical Fee Schedule.

b. The requestor must submit a Letter of Medical Necessity (LMN), (or an updated LMN in the event that reauthorization for an additional period of time is being requested). A LMN is the written explanation from the treating physician describing the medical need to assist the claimant in the treatment, care, or relief of their accepted work-related illness(s). To ensure that the physician's opinion derives from a recent physical assessment of the claimant's medical status, the physician is to document that a face-to-face visit/evaluation occurred between the claimant and the prescribing physician, within six months prior to the date that the physician orders the service. The LMN must clearly identify the type of ancillary medical service sought, explain why it is medically necessary for the accepted condition, and specify the duration of use. The requestor is to submit any supporting documentation substantiating the medical need for the requested service (i.e.; medical reports, prescriptions, therapy reports, diagnostic reports).

c. Requests submitted for authorization are to include the following:

(1) Claimant information such as name, case file number, date of birth, and telephone number.

(2) Provider, supplier, or requestor information including name, provider address, provider number, Tax ID number, National Provider Number (NPI), telephone number, and fax number.

(3) Prescribing/treating physician contact information including name, address, telephone number, and fax number.

(4) The billing code(s) such as HCPCS and/or Current Procedural Terminology (CPT), code modifier(s), total cost, begin date, and end date.

(5) Diagnosis code(s) for the condition(s) for which the item(s) is being prescribed.

(6) In addition, requests submitted for authorization for DME or oxygen therapy DME and oxygen medical supplies are to include the following:

(a) Supporting documentation that provides the need for DME and/or Medical Supplies (i.e.; prescription, narrative LMN, supporting medical documentation).

(b) Equipment billing code(s) (HCPCS/CPT), modifier(s), quantity, purchase price and rental price, total cost, begin date, end date, duration of use and frequency.

(c) The provider will need to bill with the appropriate billing modifier to receive reimbursement. If the billing modifier is missing or invalid, the BPA will deny the bill.

(d) Prior to payment being made for purchased equipment, the provider is to submit, along with the bill, proof of a transferred title to the claimant, bill of sale, and/or signed invoice by the claimant indicating receipt of the purchased equipment.

d. Upon receipt of an authorization request, not accompanied by appropriate medical evidence, the MBE begins development.

(1) The CE sends a development letter to the claimant advising that he or she has received a request, but without the required supporting documentation. The CE's development letter to the claimant must include a clear description of the medical documentation needed to support the request, and grant the claimant 15 calendar days to provide the evidence. If the requested evidence is not received within the 15 day period provided, the CE sends a second development letter, providing an additional 15 days to receive the requested evidence. The CE also notifies the claimant that a lack of response or submission of insufficient evidence will result in a denial of the request. (Exhibit 29-1 provides a sample development letter for ancillary medical services. Exhibit 29-2 is a sample development letter for DME / Oxygen therapy and related medical supplies.) The CE updates the correspondence section of ECS to record the issuance of the development letter, once mailed.

(2) A MBE may utilize the services of DEEOIC Nurse Consultants in assessing the rationale of the prescribing physician in justifying the medical necessity of prescribed ancillary services or DME. In any instance where a DEEOIC Nurse Consultant identifies a concern with the LMN from a claimant's physician, the MBE must permit the claimant's physician the opportunity to provide clarification. In those situations where the claimant's physician does not provide clarifying rationale to address a deficiency in the evidence within 15 days, the MBE may refer the matter to a CMC for review.

e. Communicating the decision to the requestor. Upon completion of all appropriate development steps for the requested services, and upon review of all evidence submitted, the MBE communicates a decision to approve or deny such services to the requestor. The MBE sends an e-mail to the FO, who prepares and sends a thread to the BPA, authorizing or denying the claimed medical services or related expenses. The MBE also creates a correspondence entry in the Correspondence screen of ECS, documenting the decision.

f. Communicating the decision to the claimant. When the MBE receives a request for authorization, accompanied by appropriate medical evidence, the MBE prepares an authorization letter to the claimant, approving the requested services. The MBE sends a copy of the letter to the supplier/vendor designated by the claimant. The approval letter is to include the following information:

(1) Covered medical condition(s) for which the DME is approved, massage therapy is prescribed, or the condition to be treated with acupuncture.

(2) Authorized billing code(s) relevant to the approval.

(3) Time period (To and From dates) during which the DME rental/purchase is authorized and/or number of frequency and visits approved for massage therapy and acupuncture therapy (i.e.; two visits per week for eight weeks).

(4) Statement advising that fees are subject to the OWCP Medical Fee Schedule.

(5) Statement advising that if the rental is converted to a purchase, rental expenses incurred and paid will be deducted from the purchase price and only the difference will be reimbursed.

3. DME. A physician must prescribe all DME, supplies, and custom devices. DME serve a medical purpose and can withstand repeated use (e.g.; hospital beds, walkers, and wheel chairs, etc.).

a. A MBE must review all requests for the rental and/or purchase of DME to determine their medical necessity. Requests for DME rental or purchase require pre-authorization.

b. In instances where DME, supplies, and custom devices have a total purchase price greater than $500 and the OWCP Medical Fee Schedule does not apply, the MBE is to undertake development with the claimant.

(1) The claimant must submit two estimates from two different DME suppliers to include the supplier name and supplier contact information. These estimates must be for exactly the same type of DME, and/or supplies.

(2) Each potential supplier must submit a signed statement describing the DME, supplies, or unadorned item meeting the treating physician's specifications, and a breakdown of all costs including delivery and installation, and the current Healthcare Common Procedure Code System (HCPCS) code for each DME, supply and/or item needed.

c. Where the purchase of DME, supplies or custom devices are less than $500 or when the OWCP medical fee schedule applies, the MBE may approve the purchase request, after appropriate medical evidence is received, without obtaining cost estimates.

d. The MBE reviewing a DME request may consider authorization for rental rather than purchase. In most situations, DME rental is the preferred choice. The MBE may authorize the rental of DME for up to six months.

(1) The MBE should review the LMN and the provider-submitted rental proposal to ensure that the DME will satisfy the needs of the claimant as outlined by his or her physician. If the MBE determines that the rental meets the medical requirements of the physician, he or she is to grant authorization for DME rental for six months (or less depending on the need of the claimant). The MBE mails a letter of authorization to the claimant, along with a copy to the chosen DME provider. Additional details on the DME authorization are provided later in this section.

(2) For each DME rental authorization that may extend beyond the initial authorization period, the MBE is to enter a reminder in ECS that reauthorization occurs at a six-month interval. The MBE must set the reminder to occur 60 days prior to the expiration date of authorized DME rental.

f. In certain situations, the MBE may authorize the purchase of DME or supplies. When considering the purchase of DME, the MBE is to use

discretion to ensure that any authorization granted for the purchase of any DME satisfies the medical needs of the claimant. The MBE should not authorize a request for DME based on convenience, comfort, or other non-medical reasons.

DME purchases can only be approved if the MBE is able to obtain such an option from an enrolled provider.

(1) Items that should not be rented but considered for purchase include medical/surgical supplies (i.e.; ostomy, incontinence, dialysis, wound care), canes, crutches, and commodes.

(2) The MBE may evaluate a DME purchase, when the purchase price of such equipment or item is more cost effective than the rental price. For example, if the price of renting a standard wheelchair is more than the cost to purchase it, the MBE should approve the purchase of the wheelchair rather than renting it.

(3) When reauthorizing rentals, the MBE must consider whether the cost to purchase the equipment, minus the rental amount paid, is less than the total cost to authorize another six months of rental. If agreeable with the claimant and the DME provider, the MBE may authorize the purchase of such equipment. Otherwise, the MBE is to continue to review the claim as a DME rental.

(a) Situations may arise when the MBE previously authorized the rental of a DME, then subsequently receives a request for authorization to purchase that same item. Under these circumstances, it may become necessary to convert the rental to a purchase. If the MBE receives a request for a purchase, the rental charges were paid for the same DME with no break in service between the rental period and the approved purchase period and the provider who billed for the rental is the same as the provider now requesting the purchase, the MBE must request that the provider deduct the rental charges previously paid from the cost of the item being purchased. DEEOIC reimburses all post-purchase requests (from a rental) in accordance with the applicable OWCP Medical Fee Schedule amount.

g. Repair/Maintenance Cost. The MBE must authorize the cost for modifications and maintenance to DME equipment when evidence is received validating the need for changes/repair/maintenance of previously approved DME.

h. Replacement. A new request must be submitted if a claimant requires a replacement of previously purchased equipment approved by DEEOIC for

purchase. The MBE must approve DME for replacement if the equipment is three years or older, inoperable and beyond repair, or the request demonstrates repair costs that exceed the cost to replace the equipment, and that the equipment is no longer covered by warranty, or if the equipment is lost or stolen. In the event the equipment is stolen, the claimant must furnish a police report documenting the incident. The MBE can consult with the NO MBPU for situations involving unique or unusual circumstance.

i. DME add-ons or Upgrades. DEEIOC will consider approval for DME add-ons or upgrades where the evidence substantiates the medical need for the enhancement. Add-ons and/or upgrades are not approved for the claimant's convenience or where such enhancements do not significantly improved DME functionality.

j. Emergency situations. The MBE may authorize the rental of DME for a preliminary 30-day period while additional development is undertaken.

(1) If medical documentation from the treating physician supports the need for immediate DME authorization, the MBE provides approval for 30 days pending additional development.

(2) The MBE sends a letter to the treating physician (with a copy to the claimant) requesting necessary evidence to substantiate that the DME is medically necessary. This should occur within the preliminary 30-day authorization period. The MBE may grant extensions in increments of 30 days, not to exceed a total of six months, while awaiting necessary medical evidence.

k. When the MBE receives a request for authorization of DME and appropriate medical evidence does not accompany the request, the MBE begins development. Refer to Section 2(d) for further guidelines to begin development.

l. When the MBE receives a request for authorization of DME, accompanied by appropriate medical evidence, the MBE prepares a decision letter to the claimant authorizing the DME. Refer to Section 2(e-f) for further guidelines in communicating a decision.

4. Oxygen Therapy DME and Oxygen Medical Supplies. This section provides procedural guidelines the MBE follows when reviewing and authorizing requests for the rental or purchase of Oxygen Therapy DME or Oxygen Medical Supplies.

a. Physicians prescribe Oxygen Therapy DME and Oxygen Medical Supplies to treat patients diagnosed with different forms of pulmonary disease. Some examples of Oxygen Therapy DME and Oxygen Medical Supplies include stationary and portable oxygen concentrators, gaseous and liquid oxygen delivery

systems, cannulas, tubing, regulators, etc. (Exhibit 29-3 provides definitions and describes the functions of some of the more commonly prescribed oxygen DME.) The MBE reviews requests for the rental and/or purchase of Oxygen Therapy DME and Oxygen Medical Supplies to validate their medical necessity. Refer to Section 2(c) to see what is required for authorization.

b. Upon receipt of the request for rental or purchase of Oxygen Therapy DME and/or Oxygen Medical Supplies, the MBE evaluates the medical evidence to determine if there is sufficient justification to authorize the request as medically necessary for the treatment or care of an accepted condition.

(1) As noted earlier in this chapter, the MBE must obtain a LMN from a claimant's physician that provides a written explanation regarding the justification for any prescribed ancillary services or equipment. For Oxygen Therapy DME or Oxygen Medical Supplies, the prescribing physician must describe the diagnostic or clinical evidence that supports the medical necessity for the prescribed care in treating the accepted pulmonary condition.

c. Additional Information. If the MBE determines the evidence is deficient, for example, the physician has not provided a clear description of the needed Oxygen Therapy DME and/or Oxygen Medical Supplies, or has not provided information on the duration or use of the prescribed equipment, the MBE initiates development. Refer to Section 2(b) for guidance on development.

d. Upon receipt of appropriate evidence establishing the medical necessity for Oxygen Therapy DME and/or Oxygen Medical Supplies, the MBE proceeds to assess whether it is appropriate to authorize a short-term rental, continuous rental, or a purchase of the requested DME.

(1) For authorization of equipment rentals, the DEEOIC will reimburse monthly charges for the approved equipment. A rental period for oxygen equipment is one month (30 or 31 days) and is equivalent to one unit of service. When oxygen equipment is purchased, the DEEOIC will reimburse for a one-time charge, not to exceed the total allowable amount as set forth in the OWCP Medical Fee Schedule.

(2) If the request for oxygen equipment is for a period of 90 days or less, oxygen equipment shall be reimbursed on a monthly rental basis according to the OWCP Medical Fee Schedule. The rental reimbursement amount includes delivery, set-up, education, and training for the claimant, and is not separately reimbursable.

(3) If the request for oxygen equipment is for a period of less than 30 days (partial month), reimbursement occurs on a daily basis. The

MBE is to authorize units by the number of days that is being requested (e.g.; the request is for dates of service 4/1/2016 – 4/20/2016. The maximum number of units authorized is 20).

(4) If the request for oxygen equipment is for a period of more than 90 days, the MBE is to approve continuous rental, up to one year, or purchase of prescribed oxygen equipment if requested by the DME supplier.

(5) In emergency or urgent situations (such as the claimant being discharged from the hospital to home with urgent oxygen needs), the MBE can authorize up to a 30-day rental period for oxygen equipment, while additional development is undertaken. The MBE may grant additional extensions of 30-day increments during development, not to exceed a six month period.

e. Authorization Limitations. The MBE is to adhere to the following restrictions when evaluating claims for Oxygen Therapy DME and/or Oxygen Medical Supplies.

(1) Approval for a portable oxygen system (liquid or concentrator) will only be made in combination with a request for a stationary system, or after verification by the MBE that the claimant already has a stationary system in the home.

(2) Approval should not be given for more than one delivery system within a claimant's home. A claimant is entitled to one stationary and one portable oxygen system during an authorization period unless there are extenuating circumstances justified by medical rationale (LMN).

(3) Approval for a mechanical ventilator will be coordinated by the DEEOIC Medical Director. The DO will obtain the properly completed LMN, a copy of the hospital admission history and physical, hospital discharge summary, and a detailed report from the claimant's treating physician containing diagnosis, prognosis, proposed treatment regime, and the qualified professional(s) who will monitor the claimant and the ventilator. Once the completed information package is obtained, the MBE forwards it to the DEEOIC Medical Director for review and consideration. The MBE addresses any such requests to the DEEOIC Medical Director, through the DEEOIC Bill Pay Mailbox. Further information regarding this mailbox is discussed in Chapter 10 – Resource Centers.

f. Upon the approval of either rental or purchase of the prescribed Oxygen Therapy DME and/or Oxygen Medical Supplies, the MBE prepares a decision letter to the claimant and the requestor as outlined above in

Section 2, e-f, authorizing the equipment and/or supplies. Renewal of an existing authorization requires the claimant to obtain a LMN demonstrating a continuing need for the oxygen therapy DME or oxygen medical supplies.

g. DEEOIC will reimburse for repair, maintenance, non-routine service, modifications necessary to make the equipment operable, and replacement of medically necessary oxygen equipment that a claimant owns. DEEOIC will not provide separate reimbursement for maintenance and service for DME covered under a manufacturer or supplier warranty agreement unless the charges are excluded from the warranty. Reimbursement for repair, maintenance, non-routine service, or replacement of rented oxygen equipment is included in the monthly payment allowance and is not separately reimbursable.

h. All repair, maintenance, and non-routine service requests for authorization must include the following:

(1) Supporting documentation itemizing each repair/maintenance/non-routine service.

(2) The request for authorization is to indicate that the equipment is claimant-owned (non-rented) and out of warranty.

(3) DEEOIC will not authorize separate travel time or equipment pick-up and/or delivery time. Services are reimbursed according to the OWCP Medical Fee Schedule.

(4) DEEOIC allows up to two hours of service within a 120-day period. If a MBE receives a repair request for more than two hours of service within a 120-day period, the MBE forwards the request and supporting documentation to the NO for review through the DEEOIC bill pay mailbox. The MBE is to list details of the documented thread, including the document control number retrieved from the medical bill processing system and/or attached supporting documentation.

(5) The request for authorization is to indicate whether a temporary replacement or “loaner” will be required. If a temporary replacement or loaner is required, DEEOIC will authorize the temporary equipment on a rental basis for up to a one-month period, not to exceed the estimated repair time.

(a) The temporary replacement request is to include a description of the equipment being dispensed, and is to be the same type of equipment that the claimant uses to treat their illness.

(b) A new LMN is not required for the repair or temporary equipment as long as the type of equipment and/or the medical necessity is unchanged. DEEOIC will cover the cost for repair up to the OWCP Medical Fee Schedule maximum allowable amount, not to exceed the cost of a replacement.

(6) A new request must be submitted if a claimant requires a replacement of previously purchased equipment approved by DEEOIC for purchase. The MBE must approve DME for replacement if the equipment is three years or older, or it is inoperable and beyond repair, or the request demonstrates repair costs that exceed the cost to replace the equipment, and that the equipment is no longer covered by warranty, or if the equipment is lost or stolen. In the event the equipment is stolen, the claimant must furnish a police report documenting the incident. The MBE can consult with the MBPU for situations involving unique or unusual circumstance.

i. DME suppliers may not automatically deliver additional oxygen accessories or medical supplies to claimants without a request from the claimant, an order from the treating physician, or a pre-determined schedule that is medically necessary. Accessories and supplies are comprised of, but not limited to, regulators, wheeled carts, stands, battery packs and chargers, cannulas, tubing, oxygen contents, etc. When authorizing contents and content refills:

(1) For the Rental of a Stationary Gaseous System/Liquid: The content refills are included in the rental price. Therefore, contents are not separately reimbursable.

(2) For the Rental of a Portable Gaseous System/Liquid. The MBE can approve contents for the duration of the rental of a portable gaseous system or portable liquid system. One unit of contents is equal to one month's supply. Therefore, when authorizing contents for the rental period of a portable gaseous system, the MBE should only authorize one unit per month.

(3) For the Purchase of a Gaseous System/Liquid. Purchased systems do not include contents, thus, when authorizing the purchase of a gaseous system or liquid system the MBE authorizes contents for a period of one year. Contents are authorized based on one unit per month (i.e.; 12 units = one year). The claimant must provide an updated LMN that supports the need for continued authorization of additional contents.

5. Massage Therapy/Acupuncture Treatments. This section provides procedural guidance with regard to the review and development process leading up to an authorization or denial of a request for Massage Therapy and/or Acupuncture Treatments.

a. The treating physician must prescribe massage therapy and/or acupuncture treatment only for the treatment or care of the claimant's covered medical condition(s). Along with the signed prescription from the treating physician, the requestor must submit a LMN to reflect that an initial face-to-face visit was held with the claimant. Face-to-face visits are only required for the initial pre-authorization request. The narrative of the LMN should describe the unique physical and therapeutic benefits that the claimant will derive from massage therapy or acupuncture treatment, and specify the frequency and duration of care to be provided in allotments of time (e.g.; twice a week for eight weeks).

b. When the CE receives a massage therapy and/or acupuncture treatment request unaccompanied by an LMN, the MBE begins development. Refer to Section 2(d) for further guidelines to begin development.

c. If the MBE receives the appropriate medical evidence within the 30-day development period, the MBE prepares a letter to the claimant authorizing massage therapy and/or acupuncture treatment. Refer to Section 2(e-f) for further guidelines in communicating the approval.

d. The initial authorization period may be fewer than, but should not exceed eight weeks, and the MBE may approve up to two visits per week, for 16 visits during the initial authorization period. Each visit is equal to a maximum of 1.5 hours. Reauthorization, including obtaining updated medical evidence is required for any request for additional massage therapy or acupuncture treatment after the initial eight-week period. The MBE may not authorize more than 60 massage therapy and/or acupuncture treatment visits per calendar year.

e. If, at the end of the initial eight-week authorization period, the MBE receives a new request for additional massage therapy and/or acupuncture treatment, the MBE must conduct a new evaluation of the medical necessity for continuation of care. If the request is appropriate (updated medical documentation adequately explains the medical necessity for continuing massage therapy and/or acupuncture treatment), the MBE grants authorization for the extension of care within the authorization parameters of no more than two visits per week and a maximum of 60 visits per year.

f. Massage therapists and/or acupuncture providers, must hold a valid massage therapist's license or certification in the state where services are rendered.

g. Massage therapy and/or acupuncture treatment services must be conducted in an appropriate setting (i.e.; medical clinic, medical office) and should be billed daily (i.e.; one date of service per OWCP-1500 line).

(1) The service provider must submit medical notes to the DEEOIC's BPA, along with their bill, describing the particular therapeutic care provided during each visit with the claimant. The notes should describe the effect of the massage therapy, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. The BPA then forwards the medical notes to the DO for review.

(2) The OWCP Medical Fee Schedule does not provide a separate allowance for massage therapy and/or acupuncture supplies (i.e.; tables, equipment). The cost of supplies is factored into the fee schedule amount.

h. If the MBE receives a request for in-home massage therapy and/or acupuncture treatment, the claimant must be homebound in order to receive authorization for such services. Medical evidence from the treating physician must demonstrate that the claimant is medically unable to travel to obtain massage therapy and/or acupuncture treatment. Once the MBE receives convincing evidence that the claimant is not able to travel for care, and sufficient documentation exists regarding the medical necessity for care, the MBE may authorize in-home massage therapy and/or acupuncture treatment.

i. Massage therapy and/or acupuncture treatment is not restricted by medical diagnosis or condition, but is not appropriate when prescribed solely for prevention of future injury, recreation (spa therapy), and/or stress reduction.

6. Chiropractic Services. The MBE may authorize chiropractic services limited to treatment for correction of spinal subluxation, along with the tests performed or required by a chiropractor to diagnose such subluxation. A physician or chiropractor must document a diagnosis of spinal subluxation in his or her LMN as demonstrated by an x-ray before a MBE can authorize services, and the spinal subluxation must be related to an accepted condition.

7. Pulmonary Rehabilitation. The MBE is required to authorize pulmonary rehabilitation services when prescribed by the treating physician. The treating physician must submit a LMN describing the need for pulmonary rehabilitation and its association to an accepted work-related illness. The LMN must specify the type, amount, frequency, and duration of pulmonary rehabilitation. The LMN must also include measurable and expected outcomes and estimated timetables to achieve these outcomes. Pulmonary rehabilitation must be conducted in an outpatient hospital setting or doctor's office. A MBE may authorize pulmonary rehabilitation for a period of up to six months. Recertification is required for any period beyond six months.

Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

8. Hearing Aids. A claimant requesting hearing aid(s) must submit a LMN from his or her treating physician. The LMN must contain an explanation for obtaining hearing assistance due to an accepted work-related hearing loss. Services associated with the assessment, provision or fitting of hearing aids must be rendered by a licensed otolaryngologist, otologist, audiologist, or hearing aid specialist. Hearing aids are limited to one per ear every three years. The MBE must authorize needed repairs within the three-year period, if the manufacturer's warranty has expired.

When submitting a bill for a hearing device dispensing fee, providers are to indicate the current Healthcare Common Procedure Coding System (HCPCS) procedure code that most appropriately reflects the quantity of hearing devices dispensed. For example, if a provider dispenses one hearing device to a claimant, the provider is required to indicate the HCPCS dispensing fee for a monaural hearing device. Hearing aid dispensing fees will be reimbursed per the OWCP fee schedule. The MBE only approves hearing aid dispensing fees when hearing aids have been authorized by DEEOIC.

9. Organ Transplants (including Stem Cell). Organ transplants are a complicated and medically challenging treatment option. As a result, a special level of review is required. Once the FO alerts the MBE to a request for organ transplant, the MBE immediately obtains all relevant documentation from the treating physician relating to medical necessity of an organ transplant. In particular, the MBE seeks a LMN describing the justification for the transplant, laboratory and diagnostic test results, CT or MRI scan results, and a transplant protocol. Once the MBE has obtained this information, the MBE forwards the information to the MBPU, via the DEEOIC Bill Pay Mailbox, requesting review for organ transplant authorization. The MBPU will then forward all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the transplant. The MBPU will then forward the signed memorandum to the jurisdictional office responsible for the claim.

a. With notification of approval, the MBE updates ECS Notes with a confirmation of organ transplant authorization. The MBE then prepares a letter of authorization to the claimant with a copy to his or her physician. The letter is to provide notification on the organ transplant authorization including:

(1) Covered medical condition(s).

(2) Authorized billing code(s) relevant to the approval.

(3) Statement advising that organ transplants must be performed at a Center for Medicare and Medicaid Services (CMS) approved facility.

(4) Statement advising that fees are subject to the OWCP fee schedule.

(5) Statement advising that an organ donor is not considered an "employee" or "claimant" within the meaning of DEEOIC and is

not entitled to compensation for wage-loss or permanent impairment, nor is a donor entitled to benefits for any post-operative complications resulting from the transplant. Only those medical and related expenses of the donor, which are necessary to secure treatment for the employee, are allowable.

b. In-Patient or Outpatient Setting. Depending upon the transplant center, the condition of the patient, and geographic limitations, transplant procedures may occur on an in-patient or outpatient basis.

(1) Autologous transplants may be performed in either an in-patient or outpatient setting, depending upon the transplant center. This type of transplant requires stem cells that have been gathered and stored, coming directly from the patient.

(2) Allogenic transplants may also be performed in either an in-patient or out-patient setting. Allogenic transplants require that donor-blood stem cells be drawn, stored, and then transplanted into the patient.

c. Choice of Donors.

(1) The first choice of a donor is generally a family member or relative. If the transplant facility approves a related donor, transportation expenses and the cost of required medical procedures for obtaining the organ(s) or blood stem cells are reimbursable. The transplant facility submits bills to the BPA, referencing the employee's (recipient) SSN, and including the medical documentation/ information pertaining to the donor. Donor travel is reimbursed following the same guidelines established for companion medical travel, and is paid directly to the employee.

(2) If no suitable match is available through a relative, an unrelated donor search must be authorized. The transplant center coordinates with the National Donor Program for the testing of each potential donor. The transplant center submits bills to the BPA for all such tests and procedures. Unrelated donors are not paid for their donation; the only coverage is for the medical expenses related to the organ donor procedure. These procedures are billed by the transplant facility, the same as with related donors, referencing the covered employee's SSN on all bills.

d. Long-Term Living Expenses. Transplants involve prolonged outpatient procedures requiring the patient to remain within a short distance of the transplant center. If the MBE authorizes a transplant procedure and if the claimant requires extended residency near the facility, the MBE must

authorize lodging, per diem, companion, and other travel-related expenses on a long-term basis.

10. Mental or Psychiatric Illness Treatment. A MBE may accept a mental or psychiatric illness under a Part B or Part E claim as a consequential illness to another accepted illness. In these situations, the MBE must obtain a narrative medical report from a licensed clinical psychologist, psychiatrist, or licensed clinical social worker which includes:

a. Diagnosis (with correct ICD10 code) and the initial date of diagnosis.

b. Medical rationale in support of how the mental or psychiatric illness is related to a condition accepted by the DEEOIC under Part B or Part E of the EEOICPA.

11. Experimental Treatment. The MBE may consider authorizing experimental treatment if the accepted condition is life threatening, conventional therapy has been tried to no avail and a significant body of data supports the view that the experimental procedure is indeed beneficial.

To request experimental treatment, the treating physician must send the treatment protocol, medical rationale, and peer-reviewed documents supporting the treatment to the CE. The MBE forwards the information to the MBPU via the DEEOIC Bill Pay Mailbox. The MBPU will forward all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the experimental treatment. The MBPU will then forward the signed memorandum to the requesting DO.

Upon receipt of the approval from the DEEOIC Medical Director, the MBE sends an email to the FO, who prepares and sends a thread to the BPA, authorizing the experimental treatment approved by the DEEOIC Medical Director. The MBE also documents the approval in the Notes section of ECS. The CE sends a copy of the approval letter to the provider designated by the claimant to provide the service. The approval letter must contain the following information:

a. Covered medical condition(s).

b. Authorized billing code(s) relevant to the approval.

c. Statement advising that fees are subject to the OWCP fee schedule.

12. Sun Protective Clothing. This section describes the procedures a MBE follows when authorizing a claimant's request for reimbursement of sun protective clothing. DEEOIC has established a maximum $400 limit for sun protective clothing per calendar year. Sun protective clothing used for general health or personal reasons is not covered.

a. Sun protective clothing is clothing specifically designed for sun protection and is produced from a fabric rated for its level of ultraviolet protection. Sun protective clothing is clothing that offers at least 30 or more Ultraviolet-A (UVA) and Ultraviolet-B (UVB) sun protection for

claimants with accepted conditions of melanoma, other skin cancer or other significant dermatologic condition.

(1) For authorization, the MBE obtains the following information:

(a) A LMN from the treating physician describing a medical need for sun protective clothing.

(b) The claimant must submit a receipt documenting that the clothing was purchased from a sun protective clothing company (i.e.; Solumbra or Coolibar).

(2) Once appropriate documentation is received, the MBE approves the reimbursement for the sun protective clothing using the OWCP procedure code Clothing Modifications - CLMOD.

13. Vehicle Modifications. DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their vehicle to accommodate the effect(s) of an accepted, work-related medical condition, as they relate to the use of that vehicle for purposes of medical transportation. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of those vehicle modification costs that are determined to be medically necessary and reasonable in cost. For the purposes of claim processing under the DEEOIC, a medically necessary vehicle modification means a mechanical alteration or addition to a vehicle, owned and operated by the claimant, necessary for purposes of medical transportation.

a. Vehicle Modification Claim Submissions. For the MBE to assess a claim for vehicle modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.

(1) Letter of Medical Necessity (LMN). The claimant must provide a LMN from a qualified physician who has conducted a face-to-face examination with the patient, prescribing vehicle modifications to address the effect of a work-related illness or injury, and providing a medical rationale for how those modifications relate to an accepted medical condition. The face-to-face examination must occur within 60 days of the date of the LMN. Specifically, the LMN must provide an explanation as to how the prescribed modification to the claimant's vehicle will accommodate the claimant's need for medical transportation.

(2) Evidentiary Requirements. Evidence supporting the need for specific vehicle modifications must include a description of the required equipment and/or labor operations necessary to modify the claimant's current vehicle, along with product information such as pamphlets, or technical diagrams, depicting the materials/equipment being proposed as part of the modification process. (For example: the claimant might provide a product brochure with photographs and technical information

describing the installation of a lift device, designed for the purpose of transporting the claimant's DEEOIC prescribed mobility device.) The product information may be included with the submission of written estimates, or submitted separately to DEEOIC. Any unique or exceptional circumstances, regarding the nature of the requested modification and estimates for the cost of installation or modifications, are to be explained by the claimant, in a written statement, with supporting documentation, if applicable.

(3) Competitive Estimates. The claimant must obtain and submit three, independent, written estimates from appropriately licensed businesses or DEEOIC enrolled providers, detailing the proposed modifications that align with the medical rationale supplied by the claimant's physician. The scope of the estimates must identify the same equipment and/or alterations specified in the LMN. Labor charges for modification of the existing vehicle and/or installation of DME are to be identified separately on the estimate. (This is important, as claims for DME purchase, and labor charges for installation, must be itemized separately when submitting claim forms for reimbursement.)

(a) Estimates for equipment added to a vehicle (e.g., scooter lift platform, motorized wheelchair lift platform, etc.) must specifically identify the description of the DME being purchased. Information must include manufacturer or brand name, model number, and any other identifying information unique to the item described in the estimate.

(b) Estimates for installation costs (labor and materials), for the permanent attachment of DME to the claimant's vehicle (e.g., receiver or other permanent mounting devices attached to the vehicle for mounting purposes) must be provided in separate estimates.

b. MBE Assessment of Medical Evidence. Upon receipt of medical evidence supporting a claim for vehicle modification, the MBE conducts a review to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's vehicle to facilitate the use of that vehicle for the purpose of medical transportation.

(1) Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant's treating physician and the employee, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested vehicle modification is linked to a DEEOIC accepted medical condition(s). If, upon review, either of these conditions are not satisfied, the MBE undertakes development with the claimant and the treating physician seeking the necessary evidence.

(2) The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested vehicle modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the physician's accurate and comprehensive knowledge of the claimant's medical history, diagnostic, and clinical status.

(a) In situations where the MBE determines additional information is needed to explain the medical necessity of a vehicle modification, the MBE initiates development with the claimant's treating physician. The treating physician is the principle point of contact for obtaining medical input. The MBE allows the claimant's physician the opportunity to respond to, or provide clarification with respect to, any development issue identified by the MBE. Additionally, the MBE may make referrals to DEEOIC nurse consultants, during the development process, for assistance in clarifying issues, obtaining information, or in seeking recommendations for additional development.

(b) In those instances, where development occurs with the treating physician, the MBE allots 30 days for the submission of necessary evidence to support a vehicle modification claim. For an initial request, the MBE allots 15 days to allow for a response. If the MBE does not receive the requested evidence within the 15-day period, the MBE sends a second development letter, providing an additional 15 days for submission of the requested evidence.

(c) When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed vehicle modification, the MBE refers the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested vehicle modification. Upon receipt of the SECOP results, the MBE reviews the SECOP report and conducts a full examination of the case evidence, including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a vehicle modification, as prescribed by the claimant's physician, the MBE proceeds with a review of the cost estimates for the modifications.

If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the

recommendation of the SECOP, and issues a RD or, the MBE can request that the claimant revise and resubmit any requested vehicle modification. If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a vehicle modification, the MBE proceeds with a referral for a referee examination. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving conflicting medical opinions.

(d) Depending on the outcome of medical development, the MBE proceeds with adjudication of the claim. Where the medical evidence establishes the necessity for a vehicle modification, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity for a vehicle modification, the MBE issues a RD denying the claim.

c. MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a vehicle modification, the MBE reviews the competitive estimates from the claimant. It is the responsibility of the claimant to produce valid, complete, and accurate competitive estimates that reflect only the work necessary to accommodate the claimant's need for medical transportation. Unless exceptional reasons exist, that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the estimates to determine if the scope of the requested modification(s) reasonably aligns with the modifications prescribed in the physician's LMN. The MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the written estimates reflect a medically necessary accommodation of the claimant's transportation needs. MBEs may also request input from nurse consultants regarding alternatives for accommodating the claimant's medical transportation needs.

(1) Comparing Competitive Estimates. The MBE examines the estimates to determine whether the scope of the proposed vehicle modification aligns with the physician's opinion of medical necessity. Each estimate must represent a proposal from a separate and distinct bidder desiring to perform the medically necessary vehicle modification. Estimates must be similar in their description of the equipment to be installed or work to be performed. For modifications to the existing vehicle, such as hand controls, modified driver seat, etc., the estimates must provide an itemization of the cost of materials, and the associated labor charge for each operation performed. As outlined above, DME, and the cost of modifying the vehicle to accommodate the DME, must be itemized in separate estimates. Unusual or exceptional circumstances, associated with the requested modification, must be clearly described in the estimate. The

MBE is to undertake a careful, comparative analysis to determine if each estimate represents a viable proposal for completing a cost-effective modification consistent with the physician's LMN. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular service provider, or any other factors that relate to the requested modification.

(2) Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work, detailed in the contractor bids, is inconsistent with either the LMN or the condition (i.e., year, make, model) of the claimant's owned vehicle, or, if a viable alternative modification, or alternative transportation option exists, the MBE prepares a letter to the claimant. The letter should outline the deficiency(ies) in what is being claimed, and specifically describe the evidence needed from the claimant to support further assessment of the claim. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to contact the claimant directly, to explain a problem and describe the necessary steps for submission of needed evidence. When a development letter is necessary, the MBE allots the claimant a total of 30 days for the submission of the requested evidence. For initial requests, the MBE allots 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the initial 15-day period, the MBE sends a second development letter, allotting an additional 15 days for a response.

(a) Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary vehicle modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.

(b) If a deficiency is found to exist, with a request for prior authorization of reimbursement for a vehicle modification, and the claimant is unable to produce evidence or information that addresses the deficiency, the MBE determines whether the deficiency prevents the MBE from proceeding with consideration of the reasonably comparable estimates. If the determination is that the MBE cannot proceed because of that deficiency, the MBE proceeds with the issuance of a RD denying the request for prior authorization of reimbursement. In the RD, the MBE must clearly explain the specific deficiency(ies) in the evidence resulting in an inability to grant prior authorization of the reimbursement request.

(3) Issuing Authorization Decisions. Upon reaching a decision to grant a request for prior authorization of reimbursement, the MBE writes a detailed letter-decision to the claimant advising of the approval. The letter should specifically describe the modification(s) being approved and should include a blank Form OWCP-915 with instructions to use that form when submitting reimbursement requests. For approvals involving the installation of DME on a vehicle, the approval letter should instruct the claimant to separately list the purchased DME from labor charges necessary to complete the installation.

d. Retroactive Requests for Reimbursement. In those instances, where a claimant did not request prior authorization from DEEOIC and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide an LMN that meets the same evidentiary requirements as a prior authorization request, i.e., it must be sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's vehicle. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.

(1) Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement for a vehicle modification, the MBE collects all available information from the claimant regarding the completed modification. With the exception of requiring three estimates, the evidentiary requirements for a retroactive review are no different than those previously outlined for prior authorization requests. The MBE reviews the available evidence to determine if the claimed expenses appear reasonably in line with similar modification requests. The MBE calculates and deducts any costs for materials and/or labor not related to, or not necessary to complete the requisite vehicle modification. Upon completion of a thorough review, the MBE prepares a memo to file outlining any calculations performed and provides an explanation as to how the MBE arrived at a final cost for approval of any reasonable and medically necessary vehicle modifications.

(2) Issuing a Decision. Having determined that reimbursement is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE's final calculations of documented and/or reasonable costs represent an amount less than the amount claimed, or if the MBE recommends a denial of the requested amount, the MBE issues a RD. In that decision, the MBE must fully explain the analysis of available evidence and how the MBE arrived at the recommended amount of reimbursement. This explanation must include any reference materials or other information, utilized by the MBE, to calculate the reimbursable amount.

14. Housing Modifications. DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their residence to accommodate the effect(s) of an accepted, work-related illness. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of those home modification costs that are determined to be medically necessary. For the purposes of claim processing under the DEEOIC, a medically necessary home modification means an alteration, addition to, or repair of an existing residential structure to overcome a deficiency limiting or preventing the claimant, with an accepted, work-related illness, from performing activities of daily living.

a. Home Modification Claims Submissions. For the MBE to assess a claim for home modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.

(1) Letter of Medical Necessity (LMN). A qualified physician who has conducted a face-to-face examination with the patient is to submit a LMN prescribing home modifications to address the effect of a work-related illness or injury, and how those modifications relate to an accepted condition. The face-to-face examination must occur within 60 days of the date of the LMN. The LMN must provide the physician's rationale justifying the medical need for a modification to the claimant's residential structure. Specifically, within the narrative of the LMN, the physician has to explain the reasons for a home modification and how the modification will serve to overcome an established inability of the claimant to perform an activity of daily living arising from an accepted medical condition.

(2) Evidentiary Requirements. The claimant must submit evidence substantiating the need for home modifications, including a description of the required modifications, digital photographs of the existing areas requiring modification, and any other plans, drawings, or documentation, supporting the required modifications. This information should clearly depict the area or areas requiring modification and should show evidence of the existing grade and quality of construction in the home. The claimant my include this information with the initial submission of written estimates, or submit it separately. Any unique or exceptional circumstances regarding the nature of the requested modification and the competitive estimates are to be explained by the claimant in a written statement with accompanying supportive documentation, if applicable. Any modification to property not owned by the claimant is subject to approval by the landlord or owner.

(3) Competitive Estimates. The claimant must obtain and submit three, independent written estimates, from appropriately licensed contractors or vendors, detailing the proposed modifications that align with the medical rationale supplied by the claimant's physician. The estimates must include the same alterations, additions, or repairs as specified in the LMN. These estimates are to include itemized unit costs, broken down into materials and labor, for each operation (e.g. number of square feet of

drywall or flooring, with the associated cost of materials and labor per square foot). Construction estimates are to include the grade of proposed construction materials and contain specifics describing the type and manufacturer of fixtures and appliances (such as sinks, cabinets, bathtubs, flooring materials, etc.). Building materials and construction quality, described in the construction estimates for a medically necessary home modification, must conform to the same construction quality as the existing structure. Any additional services, improvements, or upgrades, desired by the claimant, which are not within the scope of medically necessary modifications, are to be itemized distinctly and separately in the estimate. Such services, improvements, or upgrades are not reimbursable as a medically necessary home modification.

b. MBE Assessment of Medical Evidence. Upon receipt of the evidence supporting a claim for home modification, the MBE first conducts a review and assessment of the medical evidence. The function of this review is to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's residence to accommodate the effects of a work-related illness on the employee's ability to perform activities of daily living.

(1) Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant and the treating physician, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested home modification is linked to the DEEOIC accepted medical conditions. If, upon review, either of these conditions is not satisfied, the MBE undertakes development with the claimant and the treating physician, seeking the necessary evidence.

(2) The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested home modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the following: the physician's accurate and comprehensive knowledge of the claimant's medical history; diagnostic and clinical status; living circumstances; and functional capacities. The LMN should include the physician's consideration of such information and how the physician relates the need for, and the scope of any home modification, to an established deficiency in the claimant's capacity to perform activities of daily living arising from an accepted, work-related illness.

(a) In those situations, where the MBE determines that additional information is necessary to explain the medical necessity of a home modification, the MBE is to initiate development with the claimant's treating physician as the principle point of contact for obtaining medical input. Moreover, the MBE is to allow the claimant's physician the opportunity to respond to, or provide

clarification with respect to, the development issue identified by the MBE. At any time in this process, the MBE may make referrals to DEEOIC nurse consultants for assistance in clarifying issues, obtaining information, or recommending additional development.

(b) In those instances, where development occurs with the treating physician, the MBE should allot 30 days for the submission of necessary evidence to support a home modification claim. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period, the MBE sends a second development letter providing an additional 15 days to submit the requested documentation. No further time will be granted for a response from the treating physician, unless extenuating circumstances exist and are documented.

(c) When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed home modification during the allotted 30 days, the MBE is to refer the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested home modification.

Once the SECOP medical examination is complete, the MBE will need to review the SECOP report and conduct a full examination of the case evidence including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a home modification, as prescribed by the claimant's physician, the MBE is to proceed with a review of the cost estimates for the modifications.

If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the recommendation of the SECOP, and issues a RD. In the alternative, the MBE can request that the claimant revise and resubmit any planned home modification. If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a home modification, the MBE is to proceed with a referral for a referee examination. The MBE is to consider the opinion of a

referee medical physician as possessing special weight in resolving a conflict of medical opinion.

(d) Depending on the outcome of medical development, the MBE will proceed with adjudication of the claim. Once the medical necessity of a home modification is established by the weight of medical evidence, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity of a home modification, the MBE is to issue a RD denying the claim.

c. MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a home modification to accommodate the claimant's inability to perform an activity of daily living, the MBE reviews competitive estimates, submitted by the claimant, to accomplish the proposed home modification. The claimant is responsible for producing valid, complete, and accurate, competitive estimates that reflect the work to be done to accommodate a medically necessary modification. Unless exceptional reasons exist that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the three estimates to determine if the scope of the requested modification(s) reasonably aligns with the information supplied in the physician's LMN. If necessary, the MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the proposals reflect a medically necessary accommodation of the claimant's needs and whether those modifications align with the treating physician's LMN. MBEs may also request input from nurse consultants regarding medically feasible options or alternatives for accommodating a medical need. If a claimant chooses to also have improvements outside the scope of medical necessity performed at the same time, the bids should provide a distinction between the medically necessary portion of the work and the personal improvements requested by the claimant.

(1) Comparing Competitive Estimates. The MBE examines the contractor estimates to determine whether the scope of the proposed home modifications aligns with the physician's opinion of medical necessity. Each bid must represent a proposal from a separate and distinct contractor, desiring to perform the medically necessary home modifications as spelled out in the LMN, which will serve to accommodate the claimant's medical need. Estimates must be similar in their description of the operations to be performed. Further, estimates must contain an itemization of the cost of materials and the associated labor charge for each operation performed. All estimates must reflect the use of construction materials comparable to the existing quality or grade of the structure to be modified. Unusual or exceptional circumstances associated with the requested modification must be clearly described in the estimate. The MBE is to undertake a careful comparative analysis to determine if each estimate represents a

viable proposal for completing a cost-effective modification to the claimant's residence to accommodate an established medical need. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular contractor, or any other factors that relate to the requested modification.

(2) Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work detailed in the contractor bids is inconsistent with either the LMN or the existing grade and quality of the claimant's dwelling; or if viable alternative modification options exist, the MBE prepares a letter to the claimant. The letter should outline any deficiencies, and specifically describe the evidence needed from the claimant to support further assessment of the request. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to contact the claimant directly, to explain a problem, and describe the necessary steps for submission of needed evidence. In those instances in which the MBE issues a development letter to the claimant, the MBE allots 30 days for the submission of the necessary evidence. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period provided, the MBE sends a second development letter providing an additional 15 days to submit the requested documentation. No further time will be granted for the submission of this documentation, unless extenuating circumstances exist and are documented.

(a) Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary home modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.

(b) If a deficiency is found to exist, and the claimant is unable to overcome it, the MBE is to issue a RD denying the request for home modification reimbursement. In the RD, the MBE clearly explains the specific deficiencies in the evidence.

(c) Issuing Authorization Decisions. Upon reaching a decision to grant prior authorization of a reimbursement request, the MBE writes a detailed letter decision to the claimant advising of the approval. (Exhibit 29-4 provides a sample of the home modification approval letter.) In the letter, the MBE provides

guidance to the claimant regarding the payment options available (as detailed in the exhibit letter) and requests that the claimant respond in writing, indicating the preferred payment option.

d. Retroactive Requests for Reimbursement. In those instances where a claimant did not request prior authorization from DEEOIC, and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide a LMN that is sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's residence. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.

(1) Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement of a home modification, the MBE must collect all available information from the claimant about the home modification that occurred. With the exception of requiring three estimates, the evidentiary requirements are no different from those previously outlined for prior authorization requests, and the burden of proving reasonableness of cost remains with the claimant. Supportive evidence could include diagrams, blueprints or floor plans, pictures, written descriptions, manufacturer and model number of appliances or fixtures, invoices, estimates, paid receipts, or other descriptive information. To the extent possible, the claimant must also document the pre-modification condition of the residence including photographic evidence and a description of preexisting structural grade and quality. In assessing a reimbursable amount, the MBE is to evaluate all the available evidence to ascertain only those materials and labor expenses that reasonably align with the cost of completing a medically necessary modification. The MBE must exclude any costs associated with materials and/or labor not necessary to complete the requisite home modification. Moreover, the MBE may calculate and deduct adjusted costs for any building materials or labor charges determined to exceed the pre-modification construction grade or quality of the residence. Once the MBE has conducted a thorough consideration of the available evidence and calculated the reasonably necessary cost required to accomplish the medically necessary modification (s), the MBE is to complete a memo to file, outlining in detail the analysis performed and calculations used in arriving at the reimbursable amount.

(2) Issuing a decision. Once the MBE has determined that reimbursement to the claimant is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE is unable to obtain evidence supporting reimbursement at the claimed amount, or if the MBE's calculation of allowable costs represents a figure that is less than the amount claimed, the MBE will issue a RD. Within the content of the

recommendation, the MBE is to provide a detailed accounting of the MBE's analysis of available evidence and how the MBE determined the reimbursable amount. This includes any reference materials or other tools utilized to calculate those costs that are attributable to modifying the claimant's residence at a cost comparable to the existing grade and quality of construction.

15. Health Facility Membership and Spa Membership. This section describes procedures when a claimant requests authorization for reimbursement of fees to join a commercial health club or spa.

a. Authorization. Membership in a health club or exercise facility, or treatment at a spa, may be authorized when recommended by the treating physician as likely to treat the effects, cure or give relief from a covered illness. All requests for reimbursement of health facility and spa fees require prior authorization from the MBE. In all cases where such membership is requested, the MBE determines whether the membership is likely to be effective and cost-efficient.

b. Payment. Whenever a request for payment of health club/spa membership is received, the MBE obtains the following information:

(1) Information from Physician. The MBE obtains the following information from the treating physician:

(a) A description of the specific therapy and or exercise routine needed to address the effects of the covered illness, including the frequency with which the exercises should be performed.

(b) The anticipated duration of the recommended regimen (i.e.; weeks, months).

(c) An opinion as to the actual/anticipated effectiveness of the regimen, treatment, goals attained/sought, and frequency of examinations to assess the continuing need for the regimen.

(d) A description/list of the specific equipment and or facilities needed to safely perform the regimen.

(e) The nature and extent of supervision, if any, required for the safety of the claimant while performing the exercises.

(f) An opinion stating whether exercise can be performed at home, as part of a home exercise program, or a recommendation as to what kind of public or commercial facility could provide the prescribed exercise routine.

(2) Information from Claimant. In addition, the MBE obtains the following information from the claimant:

(a) The full name, address, and distance from the claimant's home or work location, of any public facilities (no membership required) and those commercial facilities (membership required) able to accommodate the prescribed regimen.

(b) If applicable, the specific reason(s) membership in a commercial health club/spa is required when public facilities are available, and or where the doctor indicates the regimen can be performed at home.

(c) A signed statement from the health club/spa manager stating that the club/spa can fully provide the exercise regimen prescribed by the treating physician, and a breakdown of the fees and charges for various membership options and terms. The statement should describe all facilities, services, and special charges not included in the membership fee.

c. Approval.

(1) The MBE must write a letter to the claimant advising of the approval. The letter must include the following:

(a) The date the DO received the request.

(b) The period of time which the approval will cover.

(c) The amount approved (i.e.; monthly or annual fee).

(d) The type of membership approved.

(e) Two copies of a blank OWCP-957.

d. Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant (with a copy to the treating physician) requesting additional documentation that is necessary to continue with the review process. In the letter, the MBE provides 15 days for receipt of the requested information.

e. Period of Service. The MBE may approve health facility membership for up to twelve months. Recertification is required for any period beyond twelve months.

16. Medical Alert Systems. This section describes procedures the MBE follows when a claimant requests authorization for medical alert system.

a. Definition. A medical alert system is an electronic device connected to a telephone line. In an emergency, the system can be activated by either pushing a small button on a pendant or pressing the help button on the console unit. When the device is activated, a person from the 24-hour central monitoring station answers the call, speaks to the claimant via the console unit, assesses the need for help, and takes appropriate action. A medical communication system qualifies as a medical alert system if it includes the following requirements:

(1) An in-home medical communications transceiver;

(2) A remote, portable activator (Personal Pendant);

(3) A central monitoring station staffed by trained attendants 24 hours a day, seven days a week (optional).

b. Authorization. All requests for medical alert systems require prior authorization from the MBE. A request for a medical alert system must be documented with a LMN from the treating physician, linked to the accepted condition, which includes a statement that the claimant has an acute or chronic condition which can require urgent or emergency care.

(1) Period of Service. The MBE may authorize the medical alert system for up to twelve months at a time. The need for such equipment should be recertified by the prescribing physician prior to the expiration of the authorization period.

(2) Billing. Systems that require a one-time connection fee and monthly monitoring fee may be approved, based on the claimant's needs and the medical justification. The equipment provided is leased and must be returned when no longer needed to avoid further charges. DEEOIC is not responsible for any additional charges incurred for failure to return equipment or failure to timely return the equipment in a timely manner.

c. Approval.

(1) The MBE writes a letter to the claimant advising of the approval. The letter includes the following:

(a) The date the DO received the request;

(b) The period of time which the approval will cover;

(c) The amount approved.

d. Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant (with a copy to the treating physician) requesting specific documentation that is necessary to continue with the approval process. In the letter, the MBE provides 15 days for receipt of the requested information.

17. Medical Expense Reimbursement for Extended Travel. This section describes procedures to be followed for authorizing medical travel requests over 200 miles round-trip, and the process for approving claims for reimbursement, regardless of whether the claimant obtained prior approval for the trip.

a. Authorization. DEEOIC requires pre-authorization for reimbursement of transportation, lodging, meals, and incidental expenses incurred when a claimant travels in excess of 200 miles round trip for medical care of an approved condition. DEEOIC's BPA processes reimbursement claims for claimant travel without pre-authorization when travel is 200 miles or less round trip.

b. Processing. DEEOIC's BPA processes reimbursement claims in accordance with Government Services Administration (GSA) travel guidelines. Per diem rates for overnight stay and mileage reimbursement rates are published on the GSA website, and air fare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

c. Prior Approval. Upon acceptance of a medical condition, the claimant receives a medical benefits package from the DEEOIC that includes instructions on how to submit a written request for prior approval of medical travel when such extended travel (over 200 miles round trip) is required. Despite these instructions, it is not uncommon for claimants to submit their request for reimbursement after a trip has been completed, and without having obtained prior approval.

(1) Travel Exceeding 200 Miles. Medical expense reimbursement for travel exceeding 200 miles round trip must be authorized by the MBE. Claims that are submitted to DEEOIC's BPA, for reimbursement of travel expenses arising from medical travel in excess of 200 miles roundtrip, will not be processed for payment unless authorization has been provided by the DO.

d. Requests. Upon receipt of a travel authorization request from the claimant, the MBE takes immediate action to ensure that the request meets one basic requirement: that the medical treatment or service is for the claimant's approved medical condition(s). The medical provider's enrollment in the DEEOIC program is not a prerequisite to approving medical travel if the claimant chooses to receive medical services from a non-enrolled provider.

(1) Companion. If the travel request involves authorization for a companion to accompany the claimant, the claimant must provide medical justification from a physician. The justification must be in written form, relating the treatment to the accepted condition and rationalizing the need for the companion. If the doctor confirms that a companion is medically necessary, and provides satisfactory rationale, then the MBE may approve companion travel. In the alternative, the MBE can authorize the claimant to stay overnight in a hospital or medical facility, and can approve payment for a nurse or home health aide if a companion is not available. The MBE must use discretion when authorizing such requests and may approve one of the above alternatives when there is a definite medical need, accompanied by written justification from the physician.

(2) Mode of Travel. The MBE may allow the claimant to specify his or her desired mode of travel. It is the MBE's role to authorize the desired mode of travel for the time period(s) requested. When a request is received from the claimant that does not identify the mode of transportation, the MBE contacts the claimant by telephone and assists in determining the desired mode of travel. (RC staff may assist in this process.)

e. Approval. Once the basic requirements for travel over 200 miles are met, as outlined above, the MBE prepares and sends the claimant a travel authorization letter following the guidelines below. The MBE may approve an individual trip, or any number of trips within a specified date range, all in one letter to the claimant. Once an initial authorization letter has been sent, future visits to the same doctor or facility may be approved by telephone, and confirmed by a follow-up letter.

f. Authorization Letter. The authorization letter delineates the specifics of the trip being authorized, based upon the mode of travel the claimant has selected. In the travel authorization letter, the MBE advises the claimant that travel costs are reimbursable only to the extent that the travel is related to obtaining medical treatment. In the letter, the MBE also invites the claimant to contact the nearest RC for assistance prior to or upon completing any trip to complete Form OWCP-957, Request for Reimbursement.

g. Adjudication. When adjudicating claims submitted after the trip has been completed, but for which prior approval was not obtained, the MBE follows the same steps as for pre-authorized trips, to the point of sending an authorization package. At that point the MBE sends only the authorization (or denial) letter to the claimant, not an entire authorization package.

h. Notifying the BPA. In conjunction with sending the claimant an approval or denial of a travel request, the MBE conveys his/her decision to DEEOIC's BPA via the office's FO, who is the POC with DEEOIC's BPA for such

issues. The CE prepares an e-mail to the FO, who in turn generates an electronic thread to the BPA. In the e-mail the MBE provides the information specified below. The MBE must also enter the following information into ECS:

(1) Approved dates for a single trip or in the alternative, a date range and number of trips authorized within that time frame.

(2) Approved mode of transportation.

(3) Starting point and destination, (e.g.; claimant address and provider address, city & state at a minimum).

(4) Authorization for rental car reimbursement, if appropriate.

(5) Companion travel if approved.

i. Approval Package. The approval package must include the following:

(1) Two copies of the detailed authorization letter.

(2) Two copies of a blank OWCP-957.

(3) A prepaid express mail envelope, addressed to DEEOIC's BPA, for the claimant's use.

18. Enteral Formula. Enteral formula is a nutritional replacement for patients who are unable to get enough nutrients in their diet. Patients prescribed enteral formula consume it by mouth or through a feeding tube. The DEEOIC requires prior authorization for enteral formula.

a. Requests for the authorization of enteral formula may originate from an employee, a designated AR or a medical provider. The DEEOIC medical bill processing contractor is tasked with registering all authorization requests for enteral formula in its electronic case tracking system. If the contractor receives the authorization request directly, they will record it and forward the request, as a thread, to the appropriate DO for processing. If the DO receives the authorization request via mail or fax, it is routed through the FO to the medical bill processing contractor for record creation and thread initiation.

b. Once the assigned MBE receives a thread for authorization of enteral formula, he or she must undertake a review of the evidence in the case file to make a determination as to whether or not the request is medically necessary in the care of the covered employee's accepted work-related medical condition(s).

(1) Requests for enteral formula must be substantiated by a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for enteral formula based on a face-to-face

examination of the patient occurring within 60 days of the date of the LMN. In addition, the physician must identify the accepted work-related medical condition (preferably with a specific diagnosis code) that is necessitating the need for enteral formula. The physician must provide a description of the type of formula he or she is prescribing, along with a discussion of the specific quantity, frequency and duration of use. The physician may also provide guidance on how the patient receives the formula (orally or via feeding tube). The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.

c. When the MBE receives a request for authorization of enteral formula accompanied by an appropriate LMN, the MBE prepares a decision letter to the claimant authorizing the enteral formula at the prescribed level. The MBE grants authorization of enteral formula in six-month increments.

d. Upon receipt of requests for enteral formula unaccompanied by a sufficient LMN, the MBE undertakes development by contacting the prescribing physician and the claimant to request evidence necessary to allow for authorization. A MBE can refer requests with unclear medical support to a DEEOIC nurse consultant for review and expert advice on the proper course of action. If, after development, the MBE determines that the medical evidence is insufficient, he or she issues a letter decision denying the authorization request. The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The MBE is to send a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:

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

e. Once the MBE determines to approve or deny the request, the MBE sends an email to the FO, who prepares and sends a thread to the medical bill processing contractor, authorizing or denying the enteral formula request. The MBE creates a correspondence entry in the Correspondence screen of ECS, documenting the decision, and bronzes the letter along with the supporting documentation into OIS.

f. An employee, a designated AR or a medical provider must request a renewal of an expiring authorization or modification of an existing authorization for enteral formula. In either of these situations, a LMN documenting the medical necessity of prescribed formula must accompany the request. A MBE may authorize enteral formula in ongoing six-month increments, so long as the requestor continues to submit sufficient evidence of medical necessity.

19. Corrective Eyewear. The MBE may evaluate a claim for reimbursement of corrective eyewear, including eyeglasses and contact lenses that serve to accommodate a medically necessary effect from an accepted illness. In assessing a claim for corrective eyewear, the MBE is to obtain a LMN that convincingly and reasonably establishes the medical need for corrective lenses to address the effect of an accepted illness. The MBE may authorize eyewear reimbursement for those costs limited to correcting a vision deficiency brought about by an accepted illness. The MBE is to exclude from any calculation of reimbursement those costs relating to enhancements or other added features unrelated to accommodating a medical need, including tinting, polarization, colorization etc. Once the MBE provides an initial authorization for the reimbursement of eyeglasses, the MBE may authorize replacement with appropriate documentation of a change in medical need or other established circumstance such as damage or loss. Reimbursement of authorized contact lenses may occur in increments of time communicated in the claimant's LMN or prescription.

20. Marijuana Reimbursement Policy. All products that contain any amount of tetrahydrocannabinol (THC), an active ingredient of marijuana, are considered schedule I controlled substances by the U.S. Drug Enforcement Administration and are therefore not eligible for payment/reimbursement. State laws authorizing the use of Schedule I drugs, such as marijuana, even when characterized as medicine, are contrary to Federal Law. The Controlled Substances Act (Title 21 United States Code 801 et al.) designates Schedule I drugs as having no currently accepted medical use and there are criminal penalties associated with production, distribution, and possession of these drugs.

21. Rehabilitative Therapy Services. The DEEOIC requires prior authorization for the therapy services outlined below.

a. Types of Therapy Requiring Prior Authorization.

(1) Physical Therapy is the treatment of injuries or disorders using physical methods, such as exercise and massage. The goal of physical therapy is to relieve pain and to help the patient attain his or her maximum functional motor potential.

(2) Occupational Therapy involves treatment that helps develop adaptive or physical skills that will help the claimant to return to the ordinary tasks of daily living. Occupational therapy focuses on the use of hands and fingers, coordination of movement, fine motor skills and self-help skills such as preparing meals and dressing.

(3) Speech Therapy is the treatment of defects and disorders of speech and swallowing.

(4) Other rehabilitative therapy services is defined as a therapeutic service for which a provider charges a fee to render care outside of the scope of routine and customary medical care generally provided by a qualified physician.

b. The recommended other therapeutic service must be considered safe and effective by the medical community and intended to improve the health of the patient. An appropriately licensed (in accordance with relevant state requirements) or credentialed specialist must perform the prescribed rehabilitative therapy.

c. Requests for the authorization of rehabilitative therapy, including physical therapy, occupational therapy, speech therapy or other rehabilitative therapy, may originate from an employee, a designated AR or a medical provider. The DEEOIC Bill Processing Agent (BPA) must register all authorization requests for rehabilitative therapy services in its electronic case tracking system. The BPA will record authorization requests it receives and then forward the request, as a thread, to the Claims Assistant (CA)/FO for processing. Authorization requests received at the DO via mail or facsimile must be routed through the CA/FO to the BPA for record creation and thread initiation.

d. Once the assigned MBE receives a thread for authorization of a rehabilitative therapy, he or she must undertake a review of the evidence in the case to make a determination as to whether or not the request is medically necessary in the care of the covered employee's accepted work-related medical condition(s).

e. The MBE must approve requests for a rehabilitative therapy initial assessment as long as the employee's treating physician prescribes it. The MBE approves the request and sends an email to the CA who then notifies the BPA to authorize an initial therapy assessment. The MBE sends a letter authorizing the initial assessment to the requestor with a copy to the employee. If the MBE receives a request for an initial rehabilitative therapy assessment without a physician's prescription, he or she sends a letter to the employee (with a copy to the therapy provider) requesting a signed prescription for the initial assessment. In the letter, the MBE advises that the employee has 15 days within which to submit a signed physician's prescription for an initial therapeutic evaluation.

   If medical documentation or a signed physician's prescription is not received within 15 days, the MBE must deny the request. The MBE sends an email to the CA who then notifies the BPA to deny the request. The MBE sends a letter to the requestor with a copy to the employee denying the request and providing instruction to resubmit the request once the treating physician submits a signed prescription.

f. Requests for rehabilitative therapy must be substantiated by the results of the initial evaluation by the applicable therapy specialist and a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for the requested rehabilitative therapy based on the results of the initial evaluation and the physician's face-to-face examination of the employee occurring within sixty days of the date of the LMN.

   The physician must provide a description of the type of rehabilitative therapy he or she is prescribing, along with a discussion of the specific quantity, frequency

and duration of the therapeutic service. DEEOIC considers rehabilitative therapy services medically appropriate only if a qualified physician describes, with appropriate medical rationale, how the prescribed rehabilitative therapy will lead to an expected measurable improvement in one or more activities of daily living within a reasonable period. The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.

g. When the MBE receives a request for authorization of rehabilitative therapy accompanied by an appropriate LMN, the MBE prepares a decision letter to the employee authorizing the requested therapy. The initial authorization period may be fewer than, but must not exceed 3 months (90 days). The assigned MBE may approve up to 3 visits per week by therapy discipline. Each visit is equal to a maximum of 1.5 hours (6 units). PT, OT, or ST services are limited to one hour (4 billable units) when the provider bills with combined codes. The MBE may not authorize therapy for any one discipline more than 60 visits per calendar year. The approval letter must contain the following information:

(1) Covered medical condition(s) for the rehabilitative therapy.

(2) Number and frequency of visits approved (e.g., 3 visits per week for 12 weeks).

(3) Authorized billing code(s) relevant to the approval.

(4) Dates for the authorized period.

(5) Statement to indicate that corresponding medical notes must be provided for each service date.

(6) Statement advising that fees are subject to the OWCP fee schedule.

h. Upon receipt of requests for rehabilitative therapy unaccompanied by a sufficient LMN, the MBE undertakes development by contacting the prescribing physician and the employee to request evidence necessary to allow for authorization.

(1) After 15 days has passed with no satisfactory response from the treating physician, or no response from the employee, the MBE prepares a second letter to the employee(accompanied by a copy of the initial letter), advising that following the previous letter, no additional information has been received from the treating physician. The MBE advises that an additional period of 15 days will be granted for the submission of necessary evidence, and if the information is not received in that time, the request for rehabilitative therapy may be denied by the DEEOIC.

(2) If the employee or the physician does not provide a response to the second request for information within the 30-day period allowed, the MBE issues a letter decision to the employee denying the claim for rehabilitative

therapy. The MBE further sends an email to the FO, who sends a thread to the BPA for system update.

A MBE can refer requests with unclear medical documentation to a DEEOIC nurse consultant or CMC for review to obtain expert advice on the recommended course of action. Once the MBE has undertaken development, including allowance for the treating physician to provide further support for an unsubstantiated request for rehabilitative therapy, he or she can issue a letter decision denying the authorization if sufficient medical justification has not been forthcoming.

The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The MBE is to send a letter to the employee along with a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:

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

i. Once the MBE decides to approve or deny the request, he/she sends an electronic mail message to the CA/FO, who prepares and sends a thread to the BPA, authorizing or denying the rehabilitative therapy request. The MBE creates a correspondence entry on the correspondence screen of ECS, documenting the decision and bronzes the letter along with the supporting documentation into OIS.

j. An employee, AR, treating physician, or rehabilitative therapy provider must request a renewal of an expiring authorization or modification of an existing authorization for rehabilitative therapy and should do so prior to the expiration date of the existing authorization, to allow care to continue uninterrupted. In either of these situations, the requestor must submit a LMN documenting the continuing medical necessity of the request. Requests for rehabilitative therapy outside of this guidance must be evaluated on a case-by-case basis, including possible consultation with the DEEOIC Medical Director. The employee, or his or her AR, has final responsibility regarding the amount or type of rehabilitative therapy sought.

k. Rehabilitative therapy providers must conduct services in an appropriate setting; (i.e., in a clinic, professional office, or other similar location). If the MBE receives a request for in-home professional therapy, the employee must be homebound to receive such authorization. Medical evidence from the treating physician must demonstrate that the employee is medically unable to travel to obtain the therapy outside the home. Once the MBE receives convincing medical evidence that the employee is not able to travel for therapy, and sufficient documentation exists regarding the medical necessity for care, the MBE may

authorize in-home rehabilitative therapy. Provider travel to and from an employee's residence is not a billable service.

l. Rehabilitative therapy providers must submit appropriate clinical notes to the BPA, along with their bill, describing in detail the particular therapeutic care provided during each visit, and the time spent providing that care. The therapy notes must document compliance with the LMN. The notes should describe the effect of the rehabilitative therapy specific to unique features of the employee, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. The MBE may refer claims to the Program Integrity Unit for investigation of those situations where an applicable therapy provider does not provide an employee specific description of the services provided, lists vague or non-descriptive services or conducts therapy services that do not comply with the prescribing physicians LMN.

22. Ancillary Services or Expense Authorization RD. When a MBE decides to deny authorization for a claimed ancillary service or expense discussed in this chapter, the MBE sends a letter decision to the claimant. The letter decision is to include a narrative explanation as to why the evidence is insufficient to warrant authorization. The MBE is to send a copy of the letter decision to the provider, if applicable.

a. The letter decision is to include the following language:

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

Upon issuance of the denial letter, the MBE creates correspondence in ECS documenting the issuance of the decision letter denying the ancillary medical service.

b. RD. Should the claimant request a RD regarding denial of an ancillary medical service or related expense, the MBE completes the RD process in accordance with existing DEEOIC procedure. In particular, the MBE ensures that the narrative content of the Explanation of Finding includes a well-written discussion of the justification for the denial of authorization. The FAB is responsible for independently evaluating the recommendation of the MBE, along with the file evidence, and deciding whether to finalize the RD.

CHAPTER 30 – HOME AND RESIDENTIAL HEALTH CARE

1. Purpose and Scope. This section explains the process for the evaluation and authorization of claims for Home and Residential Health Care (HRHC) services available to DEEOIC claimants. DEEOIC staff evaluate all HRHC requests to ensure that claimants receive authorization for reimbursement of costs for medically appropriate care, either in the home or in an authorized HRHC facility, and that such care is necessary for the treatment of DEEOIC accepted, work-related illnesses. DEEOIC MBEs, or other designated staff reviewing claims for HHC, must rely on medical evidence produced by a qualified physician to determine the appropriate type, level, frequency and duration of the requested care. This section provides an overview of terms and definitions applicable to the provision of HRHC; discusses the process claimants must follow for submitting a claim for HRHC services; describes the evidentiary requirement for documenting the medical need for HRHC; provides the developmental steps that DEEOIC may take to obtain clarifying evidence; explains how DEEOIC staff is to weigh medical evidence to substantiate the medical appropriateness of HRHC; and documents the claim adjudication and communication process for all HRHC requests. During the HRHC claims process, DEEOIC staff are responsible for properly scanning all documents created during the review process into OIS, and for recording necessary updates to ECS.

2. Definitions. This section provides definitions of the common terms, phrases and roles of the individuals involved with HRHC that a DEEOIC staff person may encounter during the HRHC claim adjudication process.

a. Accepted Condition. A diagnosed medical condition, accepted by DEEOIC, resulting from work-related toxic substance exposure.

b. Assisted Living Facilities (ALF). Although the types of services offered by ALFs vary, the term generally refers to a system of housing and limited care, designed for individuals who need some assistance with activities of daily living, but who do not require care in a residential nursing home.

c. Assistive Health Care Personnel. Non-skilled individuals (home health aides, personal care attendants, or certified nursing assistants) who are trained, and in many states licensed or certified, to provide personal care services to claimants, in their homes, as prescribed by a licensed physician. Personal care services include assisting claimants with activities of daily living, performance of which is required for personal self-care and independent living, including bathing, dressing, transferring, using the toilet, continence, and eating. Licensing and certification requirements vary from state to state.

d. Activities of Daily Living (ADL). ADLs refers to a set of common, everyday tasks, performance of which is required for personal self-care and independent living, including bathing, dressing, using the toilet, continence, and eating.

e. Conflict of Interest. DEEOIC expects a designated AR to act in a manner that promotes the best interests of his or her client. A conflict of interest arises when an AR could benefit financially from the acceptance of a client's claim, either directly as a provider of services or supplies, or indirectly as an employee or

contractor of such a provider, regardless of whether those services or supplies have already been provided or may be provided after the claim has been accepted. If this situation occurs, DEEOIC will not recognize that individual as an AR and will inform the claimant of the need to designate another person as his or her AR who does not have such a conflict, if the claimant still wishes to have a representative (For additional conflict of interest information, refer to Chapter 12.7).

f. Enrolled Provider. A licensed or credentialed provider of medical or HHC services (whether an individual or a business entity) that has completed the OWCP enrollment process and is approved to submit bills for reimbursement of authorized services performed. Providers enroll based upon the type of service for which they have the required licensure, including physician, hospital, diagnostic center, HHC, DME, etc.

g. Face to Face Examination. An in-person physical examination of the claimant by his or her treating physician.

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

i. Home and Residential Healthcare Services (HRHC). The umbrella title of this chapter which encompasses hospice care, HHC, care in a skilled nursing facility, and assisted living facilities.

j. Home Health Aid. (See Assistive Health Care Personnel)

k. Home Health Care (HHC). HHC includes the services of skilled nurses (RN/LPN) or the services of assistive health care personnel, provided in the home, for the medically necessary care required of DEEOIC accepted condition(s).

l. Home Therapeutic Services. Physical therapy, occupational therapy, speech therapy, respiratory therapy, or any other professional therapeutic service that a provider charges a fee to perform.

m. Hospice. Hospice refers to a public agency or private organization, or a subdivision of either, that is primarily engaged in providing care to terminally ill individuals whose medical prognosis indicates a life expectancy of 6 months or less. Hospice care emphasizes palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the claimant's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the claimant.

n. Letter of Authorization. A written notice, issued by DEEOIC, describing the type, level, frequency and duration of care for which DEEOIC authorizes a designated provider to provide approved services.

o. Letter of Medical Necessity (LMN). The LMN is a narrative statement, prepared by a qualified physician who has been actively treating the claimant for one or more DEEOIC accepted conditions. The LMN is the physician's independent opinion regarding the claimant's HRHC needs.

p. Licensed Practical Nurse (LPN). The licensed practical nurse is any person licensed to practice practical nursing. State statutes define practical nursing as the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist.

q. Nurse Consultant. DEEOIC Nurse Consultants are registered nurses who function as subject matter experts in assessing medical evidence to ensure it reasonably correlates to the prescribed type, level, frequency, or duration of HHC, as prescribed by a qualified physician. Nurse consultants apply their individual experience, education, and working knowledge of the practice of nursing to provide consultative advice to MBEs regarding the medical appropriateness of HRHC requests.

r. Nursing Home, Skilled Nursing Facility, and Rehabilitation Hospital. These three types of facilities provide the services of skilled nurses and therapy staff, such as registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists, who treat, manage, observe, and evaluate medical care.

s. Personal Care Attendant. (See Assistive Health Care Personnel)

t. Plan of Care. HHC agencies prepare a Plan of Care, which is a description of the services it recommends for an individual, following an in-home assessment of the claimant's needs. A Plan of Care serves as a resource, in addition to other factors, that the treating physician may consider when preparing a LMN prescribing HHC.

u. Registered Nurse: A Registered Nurse (RN) is a nurse who has graduated from a nursing program and met the requirements, outlined by a county, state, province or similar licensing body, to obtain a nursing license. An RN's scope of practice is determined by legislation and is regulated by a professional body or council, depending upon the jurisdiction in which the RN is licensed.

v. Targeted Case Management (TCM). TCM is a process for coordinating multi-disciplinary home health services that assist eligible DEEOIC claimants in gaining access to medically necessary medical, social, educational, and other services directly related to their accepted conditions. Individuals performing

TCM must possess appropriate licensure or certification from the recognized state authority for oversight of such services (e.g., a state department of labor and/or a licensing and regulation board).

w. Treating Physician. The physician, selected by the claimant to manage his or her HRHC needs, is considered the treating physician.

x. Weight of Medical Evidence. The evaluation of the relative value, or merit of medical evidence in support of a claim for compensation, including claims for HRHC. When presented with a conflict of opinion between different qualified physicians on the need for HRHC, DEEOIC applies a weighing methodology to assign a higher weight to the medical opinion of greater probative value.

3. Claimant's Role in the HRHC Authorization Process. The claimant, or a properly designated AR, has the final decision-making authority regarding filing a claim for HRHC and can choose to decline or reduce the prescribed level and/or frequency of HRHC by submitting a written request to DEEOIC. Any HRHC claim, submitted to DEEOIC, represents a request from a claimant for authorization of reimbursement for those medically necessary costs to provide HRHC services, in a home or other residential setting, for the treatment or care of an accepted condition. The claimant is responsible for working with his or her treating physician to identify and collect medical evidence supporting the need for HRHC services (e.g. HHC, assisted living, nursing home, or in-home hospice care) directly related to DEEOIC accepted medical conditions.

a. Claim Form EE-17A. Upon issuance of a FD awarding medical benefits for an accepted condition(s) DEEOIC mails a medical benefits letter, which explains details regarding HRHC and includes Claim Form EE-17A (Exhibit 30-1). The claimant, or a properly designated AR, must complete, sign, and return this form to initiate the first claim for HRHC services.

(1) The claimant must designate a physician responsible for medical management of HRHC services, as instructed on the claim form. Once DEEOIC receives the Form EE-17A containing the physician information, a claimant wishing to change that physician must notify DEEOIC, in writing, of the name, address and telephone number of the new physician selected to medically manage their HRHC needs.

(2) Form EE-17A designates three types of HRHC for which a claimant may request authorization: HHC, care in a nursing home, or residence in an assisted living facility.

(a) The claimant must schedule a face-to-face examination with their designated physician, and that physician is responsible for the preparation of a LMN addressing the claimant's HRHC needs.

(b) To initiate an authorization request for in-home hospice care, a DEEOIC enrolled provider of hospice services must submit a request (via fax, mail, or electronically) to DEEOIC's BPA. Form EE-17A is not required to initiate a request for in-home hospice

care. The authorization request must include a Hospice Certification specifying the individual's prognosis for life expectancy as 6 months or less. Clinical information supporting the medical prognosis must accompany the certification.

4. Receipt of Form EE-17A. Upon receipt of a properly executed (signed by claimant or recognized AR) Form EE-17A, CMR staff route the form to the MBE Unit for assignment to an MBE.

a. MBE Review. Upon assignment, the MBE calls the claimant if any information on the form is incomplete. The MBE may provide the claimant with information about searching for enrolled medical providers, using the DEEOIC online provider search; however, the MBE may not advocate for any particular provider. The MBE may also refer the claimant to the closest DEEOIC Resource Center for assistance. Additionally, the MBE advises the claimant to submit their choice of a HRHC provider in writing, providing DEEOIC with the provider's name and contact information. At the conclusion of any telephone call, the MBE completes an ECS phone call note documenting the information discussed during the call.

b. Responding to Telephone Requests. Upon receipt of any telephone request for HRHC services, the receiving DEEOIC staff person (including any DO, FAB or RC staff) advises the caller that claim requests must be submitted in writing, using Form EE-17A, to initiate the first authorization process. DEEOIC staff is responsible for recording telephone requests in ECS, after explaining the forms process to the caller.

c. MBE Mails Form EE-17B to the Physician. The MBE mails Form EE-17B (Exhibit 30-2) to the claimant's designated physician (as identified on Form EE-17A) along with the DEEOIC Physician Letter (Exhibit 30-3) that explains how the DEEOIC HHC process works. The Physician Letter offers the physician two courses of action:

(1) Complete and sign the Form EE-17B and return it with a LMN.

(2) Sign and return Form EE-17B after checking the box to indicate the physician wishes to have claimant's designated HHC provider perform an in-home assessment of needs.

d. Handling Requests for In-Home Assessments. If the physician requests an assessment, the MBE sends an authorization letter to the claimant's designated HRHC provider. Upon receipt of the provider assessment, the physician completes a LMN and forwards it to DEEOIC.

5. Evaluating a LMN. The underlying function of the MBE is to ensure that covered employees receive medical care necessary for their accepted condition(s) and that any such request for care reasonably corresponds with the medical evidence in the case file. Evaluation of the medical evidence, contained in the case record, begins upon receipt of a request for HRHC services and a physician's LMN. The LMN is the physician's opinion regarding the claimant's

HRHC needs. After reviewing the medical evidence, the MBE must carefully examine the LMN to ascertain whether the care requested by the physician is consistent with and supported by the medical evidence.

a. Elements of a Physician's LMN.

(1) Evidence of a face-to-face medical examination, conducted within 60 days of the date of the LMN, and performed by the claimant's designated (as identified on the EE-17A) treating physician.

(2) A list of the accepted medical condition(s) and the care prescribed with respect to each condition.

(3) Physician notes during the face-to-face examination describing the claimant's general health, prognosis, and changes since the last exam.

(4) Physical findings such as measurements, observations, and test results, which support the need for HHC. Examples include:

(a) Significant measured reductions in oxygen saturations after activity;

(b) PFT that indicates obstructive/restrictive lung function;

(c) Demonstrated cognitive deficits that indicate inability to manage self-care routines such as medication administration, managing medical appointments, etc.;

(d) Invasive medical procedures or conditions that require the skill of medically trained personnel, such as intravenous medications, management of inserted urinary catheters, management of feeding/gastrostomy tubes, bed-bound patients, etc.;

(e) Significant gait disturbances secondary to neurological conditions;

(f) Management of wound infections, that require routine dressing changes;

(5) The physician's review of nursing notes (for reauthorization requests) supporting the need for continuation of the care previously authorized.

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

(7) Type of Care Required. The physician is to provide an explanation as to why any specific service for the claimant is required, either in the home, or at a facility, which provides a higher level of care, such as a nursing home or ALF. With respect to in-home services, the LMN must explain why any needed services cannot be performed outside the home, such as the claimant's inability to travel from home to a clinic or physician's office, or the need for medical services required on an hourly, daily, or unpredictable basis.

(8) Level of care required. The doctor's LMN must specify the appropriate level of care required for the claimant regardless of whether the claimant is residing in the home or in some other living arrangement (such as an ALF) where the prescribed care is not available.

(a) Skilled Nursing (RN/LPN). The physician's LMN must identify the specific medical needs of the claimant, for an accepted condition(s), and explain what services are required of a skilled nurse to meet those medical needs (e.g. administration of prescription medication, wound dressing changes, administration of intravenous medications, and assessment of claimant's medical condition.)

(b) Assistive Health Care Personnel (Home Health Aide/Personal Care Attendant). Separate from any prescribed skilled nursing services, the physician must describe the physical condition of the claimant and identify specific limitations related to the claimant's accepted condition(s) that necessitate ADL assistance. The LMN should identify clearly those activities for which the claimant requires assistance and explain how those activities are linked to the DEEOIC accepted medical conditions. Such services often include activities such as mobility within the household, dressing and undressing, toileting, bathing, and meal preparation.

(9) Frequency of service. The number of times each level of HRHC service is to be performed, (e.g. daily, weekly, monthly, or intermittently as needed, etc.).

(10) Duration of Care. The number of minutes or hours required to perform the HRHC service at the frequency prescribed. For example, a home health aide is required 8 hours each day, during the claimant's waking hours, to assist with activities of daily living or, a nurse is required 2 hours a day to clean, dress and evaluate the claimant's wounds.

(11) Period of Required Care. The length of time for which the HRCH care is required to address the effect of an accepted condition(s). For example, an assistive health care individual is prescribed to provide care for a period of 6 months. For assisted living or nursing home requests, the physician

must describe the relative permanency of the claimant's medical need for such care.

b. MBE's Review of LMN for HRHC Reimbursement. In judging the appropriateness of a LMN for authorization of service reimbursement, the MBE compares the information presented by the physician against other case information to determine whether the LMN reasonably aligns with information known about the status of the employee. This includes the MBE's analysis of the level and frequency of prescribed services and whether the physician properly explained how those prescribed services align with a claimant's need for specific skilled nursing services and/or the services of assistive health care personnel. Upon review, the MBE may make the determination that a LMN reasonably supports a request for HRHC, and may do so when the evidence sufficiently supports the request for HRHC. The MBE may consider several factors when making this judgement.

(1) The physician has provided relevant information regarding the claimant's medical history, findings during the face-to-face examination, a clear explanation of the specific level and frequency of HHC services required of the claimant, and an explanation (medical rationale) as to why the claimant requires that specific care for their accepted condition(s). Further, a properly written LMN will provide detail as to the specific functions a nurse or assistive health care aide is to perform in the home, for any or all accepted conditions, and the frequency with which these services are to be performed.

(2) Medical evidence contained in the case file reasonably aligns with the description of the claimant's status with regard to the effect of an accepted condition(s) and the claimant's ability to perform of ADLs. For assisted living or nursing home referrals, the physician must provide a descriptive assessment of the claimant's current living circumstances and medical rationale explaining the reason(s) why the claimant's current environment no longer safely supports the claimant's medical needs.

(3) The physician has provided sufficient justification to support the amount of time needed to fulfill the specific HHC needs of the claimant, as they relate to an accepted condition(s). Where assisted living or nursing home care is prescribed, the physician should provide an explanation of the duration or relative permanency of the need for such care.

Whenever the MBE has sufficient medical documentation to authorize reimbursement for a prescribed level of HRHC, at the frequency and duration recommended by the physician, the MBE should proceed with an authorization for reimbursement. In situations where more than one level of service is prescribed (i.e. the services of both a skilled nurse and an assistive health care aide) and the evidence is sufficient for the MBE to approve one level (at the prescribed frequency and duration), but not the other, the MBE may do so. However, under this circumstance, the MBE must proceed with development for the service level the MBE cannot

authorize. Additional guidance regarding authorization for assisted living or nursing home referrals is referenced later in this chapter.

6. Development Resources. If, after a review of the medical evidence and the physician's LMN, the MBE determines the treating physician's LMN does not provide sufficient information to permit authorization, the MBE must undertake additional development. The MBE must decide, from the available development options, which will be the most likely to produce a response that addresses the identified deficiency in evidence supporting the request. Development must concurrently address any remaining deficiencies so the MBE can ultimately issue a uniform decision for the balance of all claimed components of the HRHC.

a. Communication with the Treating Physician. The MBE should consider the claimant's treating physician (identified on Form EE-17A) as the primary source of medical information supporting the need for HRHC. As such, the MBE should permit the treating physician the opportunity to address any questions or other deficiencies the MBE identifies during an examination of the medical evidence. The simplest course of action might be for the MBE to contact the physician's office by telephone. If a telephone call results in a clarifying response, and appropriate information is forthcoming, no further action may be necessary. However, if a telephone call is not productive, a letter to the physician is necessary. Any such letter, to the physician who signed the LMN, should be clear and concise. The MBE should identify the specific issue requiring clarification and should describe the evidence or information the MBE needs to proceed with adjudication of the claimant's HRHC claim.

b. Nurse Consultant Referrals. DEEOIC Nurse Consultants assess medical evidence to ensure it reasonably support the type, level, and frequency of the care prescribed by the treating physician. Upon receipt of a referral from a MBE, a Nurse Consultant does not offer their own recommendations regarding the appropriate HRHC a claimant should receive, but serve to assist in providing advice allowing the MBE to make an informed decision whether to authorize the care prescribed, or to undertake further development. With regard to the assessment of HRHC prescriptions (or LMNs,) the Nurse Consultant can perform one or more of the following functions.

(1) Assessing objective evidence. The Nurse Consultant can evaluate a LMN, or a hospital discharge order for HRHC, to ascertain whether the prescribed care correlates reasonably with the objective evidence present in the case file.

(2) Assessing the appropriate skill-level of service. Nurse consultants can apply their knowledge and understanding of the field of nursing to assess whether the prescribed level of HHC relates properly to the skill level required to perform such service.

(a) For assisted living or nursing home assessments, nurse consultants can assess the medical evidence to determine if a move to assisted living or a nursing home has sufficient medical support and that

such care will properly align with the ADL assistance needed by the claimant.

(3) Frequency and Duration of Care. The Nurse Consultant can advise if the time allotted represents a reasonable period within which to accomplish specific tasks. Example: a nurse is required, 2 hours each day, to clean, dress, and evaluate the claimant's wounds.

(4) Period of Required Care. The LMN must state the length of time (days, weeks, or months) for which care is being prescribed. Emergency authorizations may be limited to a number of days, or weeks, but cannot exceed 60 days. Nurse consultants can advise as to whether the period of care, recommended by the physician, represents a reasonable period of time.

(5) Compliance with Plan of Care. Nurse Consultants can evaluate ongoing home health services to ascertain whether the authorized provider is complying with the physician's plan of care.

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

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

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

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

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

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

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

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

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

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

(2) SECOP Examination. In those instances where development with the prescribing physician has not produced evidence necessary to establish the medical appropriateness of the prescribed HRHC, the MBE is to refer the claimant to a SECOP Examination. The function of the SECOP Examination is to obtain an independent assessment of the medical need for HRHC. The MBE must make every effort to expedite a SECOP Examination referral to resolve an outstanding HRHC request.

(a) Once the SECOP Examination is complete and the report received, the MBE will then need to conduct a full examination of the case evidence, including any medical evidence submitted by the treating physician. If the SECOP Examination results in a validation of the care prescribed by the claimant's physician, the MBE is to authorize reimbursement of the prescribed care. If the SECOP Examination results in an opinion that recommends a reduction or termination of the requested HRHC, the MBE weighs the opinions

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

If for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the claimant's needed HRHC, the MBE is to proceed with a referee examination referral. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving a conflict of medical opinion.

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

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

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

8. Authorizing Reimbursement for Medically Appropriate Care. Upon completion of development and after a thorough review of the case evidence, a decision is necessary regarding authorization for reimbursement of medically appropriate HRHC. The MBE must issue authorization upon receipt of sufficient medical evidence that substantiates the medical appropriateness of a prescribed level of HRHC.

a. Letter of Authorization. In those instances where sufficient medical evidence supports the authorization of reimbursement for HRHC, the MBE prepares an authorization that describes the type, level, frequency, and duration of care approved for billing by an enrolled provider of HRHC services. The MBE addresses the authorization letter to the claimant (and AR if appropriate), with a copy to the HRHC provider identified by the claimant, and a copy to the prescribing physician.

(1) Authorization for levels of HHC may be authorized for up to 6 months duration, or a shorter duration as established by the medical evidence.

(2) Authorizations for residence in an assisted living facility, or for nursing home care, may be authorized for up to 12 months, or a shorter duration as established by the medical evidence.

(3) For the purposes of authorizing the reimbursement of TCM, the MBE is to authorize a maximum of 15 minutes (1 unit) of TCM services per week. TCM services may not exceed 26 units for 6-month period. The MBE authorizes TCM for reimbursement when an employee, with an accepted condition(s), is receiving HHC for multiple disciplines of care supplied by a single provider, or multiple service providers. Multiple disciplines of care are categorizations, by service level, including skilled nursing, assistive health care personnel, rehabilitative therapists, or other licensed/certified health care service providers. Authorization for TCM should align with the period of authorization for concurrent multiple disciplines of HHC (e.g. all HRHC authorizations must run concurrently).

(4) For claims involving a requested change to an existing authorization, the MBE may authorize a change, once any necessary development is complete and sufficient medical evidence exists to support the request. In this situation, the MBE must terminate the existing authorization and create a new one. The MBE sends a letter to all involved parties, terminating the existing authorization, and informing the parties of the new authorization terms.

(5) The MBE may authorize retroactive periods of HRHC, as long as the necessary medical evidence exists to support the level, frequency and duration of the previously provided services.

(6) Upon receipt of a claim for multiple levels of HRHC, the MBE conducts development, concurrently, to address each component of the claim. Upon receipt of sufficient evidence to authorize any component of a multiple level claim for HRHC, the MBE is to issue a written authorization. The MBE communicates in the authorization that the MBE has to defer any pending component of the HRHC claim until development completes.

(a) Once development completes for any deferred component, if the MBE cannot authorize any claimed HRHC at the level, frequency or duration requested, the MBE is to issue a letter decision. The MBE is to describe the components of the claim authorized for reimbursement. For any balance of care, that the MBE cannot authorize, the MBE explains the basis for the partial authorization. Included with any such partial authorization, the MBE must include the following language:

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in

writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

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

a. Denial of a claim for initial HRHC in its entirety. Where the medical evidence for an initial claim does not support an authorization for any of the claimed HRHC, the MBE issues a RD to deny authorization.

b. A reduction of previously authorized HRHC. For either an ongoing, or renewing authorization for HRHC, should the evidence support an authorization at a level, frequency, or duration of care that is less than previously authorized by the MBE, a RD is necessary. Under this circumstance, the MBE issues a recommendation explaining the evidence that warrants a reduction in the level, frequency, or duration of HRHC previously authorized. Within the recommendation, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the FAB determines whether to finalize the RD.

10. Notification of Discontinuance of Authorization. If a period of HRHC expires, without the claimant taking action to request renewal or submit a qualifying LMN for consideration, the MBE sends a letter notifying the claimant, the AR where appropriate, and the HRHC provider, of the expiration of authorized benefits, and that the HRHC claim is administratively closed.

11. Processing Requests for Emergency Authorizations. In certain circumstances, claimants may require HRHC on an emergency basis, for a limited time period, while a claimant's condition stabilizes. Emergency requests can arise from a number of situations, including hospital discharge, where the claimant needs immediate care in the home; or, a sudden change in the claimant's condition necessitating an urgent change in the level and/or frequency of currently authorized services. To obtain approval for an emergency authorization, the requesting party (hospital discharge staff, the claimant's AR, or a treating physician), must contact a DEEOIC enrolled provider of HRHC services. Alternatively, a currently authorized provider of HRHC services can initiate a request for an emergency increase in an existing authorization. In either circumstance, the designated or current HRHC provider contacts DEEOIC's BPA and provides (by fax or letter) an emergency care order from either the claimant's treating physician, or a hospital discharge order signed by a physician.

a. BPA Review and Reporting To DEEOIC. The hospital discharge order or LMN must describe a medical need for emergency HRHC. The BPA does not make a decision regarding the request, but receives the pertinent documentation and forwards it to the MBE unit.

(1) The MBE must evaluate an emergency request to ensure the medical evidence links the claimant's need for HRHC services to a DEEOIC accepted medical condition and that a reasonable medical basis exists for emergency care. If these two conditions are met, the MBE proceeds with

an authorization for 30 days of the prescribed emergency HRHC. If any reason exists to obtain additional information to substantiate an emergency authorization, the MBE must take expedited action to call an appropriate point of contact for clarification or initiate a prioritized Nurse Consultant referral seeking assistance.

(2) Upon approval of the emergency authorization, the MBE initiates development with the claimant's treating physician. The purpose of the MBE's development is to seek evidence regarding the duration of HRHC at the emergency level and the transition to the appropriate level of non-emergency HRHC. The MBE may grant additional, written authorizations for the emergency HRHC, in increments of 30 days during development. The MBE's authorized extensions should not exceed a total of 90 days.

12. Billing and Documentation of Services. DEEOIC requires that all provider billing, for services rendered, include evidence supporting those services. The supporting documentation must be dated and signed by the medical professional performing the billed services, and the dates of service on the supporting documentation must match the dates of service and charges listed on the billing form. Also, the name of the individual performing the service must be legible, and there must be a signature of that individual with their appropriate credential (i.e. MD, RN, PCA, HHA, PT, OT, etc.). For authorized billing codes relevant to the level and duration of care, reference Exhibit 30-4. The following supporting documentation must be included with the bills:

a. HHC documentation includes, but is not limited to, RN/LPN progress notes, HHA/PCA/CNA notes, Targeted Case Management notes, and initial assessments.

b. Home Hospice documentation includes, but is not limited to, admission summaries, progress notes, and initial assessments.

c. Assisted Living Facility documentation includes, but is not limited to, admission and/or discharge summaries, monthly/daily itemizations of bills.

d. Nursing Home documentation includes, but is not limited to, admission and/or discharge summaries, monthly/daily itemization of bills.

13. Medical Travel Occurring During Authorized Periods of HRHC. DEEOIC permits HRHC providers to travel with a claimant to and from medical appointments when medically necessary for the treatment or care of an accepted work-related illness. DEEOIC considers this type of travel assistance as included within the scope of authorized HRHC service hours and not a separate or additional transportation service. DEEOIC will reimburse travel mileage to either the HRHC provider or the claimant, depending on whose vehicle is used for the travel. Aside from mileage and HRHC service hours spent assisting with travel, no other ancillary costs associated with conducting travel covered under this section are reimbursable. As with any other billable medical service, HRHC providers are to document properly any service time spent assisting with medically necessary travel. Travel under this guidance will not require pre-approval by a MBE for travel under 200 miles round-trip or less than three qualifying trips per

week. DEEOIC provides guidance relating to extended travel authorization in Chapter 29 – Ancillary Medical Services and Related Expenses. For HRHC travel with the claimant for more than three trips in a week period, a pre-authorization request must be submitted to DEEOIC along with medical justification for such travel.

CHAPTER 31 – TORT ACTION AND ELECTION OF REMEDIES

1. Purpose and Scope. This chapter describes procedures to determine if a claimant is eligible to receive Part B benefits because of a lawsuit filed against a beryllium vendor or AWE due to the "election of remedies" provision of the EEOICPA. It also describes procedures for offsetting (reducing) EEOICPA benefits if the claimant is eligible to receive EEOICPA benefits but received settlement from a lawsuit for injuries resulting from exposure to the same toxic substance for which EEOICPA benefits are payable.

2. Authority. 42 U.S.C. § 7385 requires the offset for certain EEOICPA payments. 42 U.S.C. § 7385d requires the election of remedies for Part B beryllium vendor and AWE employees.

3. Signed Response Regarding Lawsuit, SWC Claim and Fraud. Before a claim can be accepted under the Act, the claimant must provide a signed response (affidavit) reporting whether a lawsuit had been filed for exposure to the same toxic substance for which EEOICPA benefits are payable, or whether a SWC claim had been filed for the same medical condition(s), or whether the claimant has ever pled guilty to or been convicted of fraud in connection with an application for or receipt of any federal or SWC. This signed response must be obtained regardless of the information contained on the forms EE-1 or EE-2 related to these three questions.

a. The CE may call the claimant to get an initial verbal response to the three questions. If the claimant confirms verbally or submits a signed response that he/she has not filed a lawsuit, SWC claim, or pled guilty to or been convicted of fraud, the CE may proceed with issuance of the RD.

   Since a signed response from the claimant must be included in the case file before issuance of the FD, the CE follows up with a development letter requesting the signed response from each claimant before transferring the case to the FAB. The development letter must be claim specific and clearly note that by signing the written response, the claimant agrees to report any changes to the information provided in the response, immediately, to DEEOIC. The CE also advises the claimant that failure to submit a signed response will result in administrative closure of the claim.

b. If the CE is unable to obtain a verbal response from the claimant or the claimant responds affirmatively to any one of the questions, or evidence in the case file indicates that a lawsuit, SWC claim or fraud was filed or committed, the CE cannot issue a RD without further development and clarification. The CE may consider administrative closure of the claim if the claimant is not responsive to the development request for clarification but only as a last resort, and after at least two development letters.

c. It is the responsibility of the FAB to obtain this signed response if a RD is issued without receipt of the signed response (i.e. the CE only received verbal confirmation). The FAB makes every effort to obtain this signed response

including calling the claimant and sending a follow up development letter. However, if the FAB is unable to obtain the signed response after 30 days from the FAB's follow up development letter, the FAB administratively closes the case and returns it to the DO. The FAB sends a letter advising the claimant of this course of action.

d. If the case is with the FAB, and there is evidence in the case file of a lawsuit, a SWC claim, or fraud in connection with an application for or receipt of workers' compensation that may impact the claimant's EEOICPA benefits, further development must be undertaken. If the matter could be clarified by a telephone call, the FAB takes this action. If the matter requires extensive development, the case is to be remanded to the DO for further development.

e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the lawsuit/SWC/fraud statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant had submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new written response regarding the bone cancer is required before this consequential condition may be accepted under the Act.

4. Developing for Lawsuit. If the claimant reports, or the evidence indicates, that a lawsuit was filed (regardless of what type, what happened, when it was filed or who filed it), the CE develops for verification of the lawsuit and lawsuit payments received.

a. Contact with Claimant. The CE confirms with the claimant as to whether a lawsuit was filed and requests documents related to the lawsuit if one was filed. The CE requests copies of any complaint, settlement document, award from a judge/jury, and settlement sheet from the legal proceeding. If the claimant states that he or she is not legally permitted to disclose the information, it may be possible to persuade him or her to do so based on the Privacy Act protections in place for claims filed under the EEOICPA.

b. Contact with Attorney/Law Firm. The CE advises the claimant to contact the attorney who filed the lawsuit to obtain copies of required documents if the claimant does not have them. If the claimant is elderly or he or she is confused as to the type of documents that are required, the CE may need to directly contact the attorney. If the attorney considers the release on the bottom of Form EE-1 or Form EE-2 to be legally insufficient to authorize the release of the required document, the CE requests a separate written release from the claimant.

If the attorney is no longer with the law firm, the CE attempts to find out who in the law firm inherited the attorney's clients, or where the records are stored.

c. Information from Other Sources. If information is not available from the claimant or the law firm, the CE attempts to obtain it from other sources. Some

information can be obtained from the court where the matter was litigated, such as the complaint, judge or jury award (if any), and pertinent court orders.

d. Initial Development Letter. The CE follows up with a development letter to the claimant explaining the need for the lawsuit documents and requesting a response within 30 days. The CE requests documents as noted in paragraph 4a. The letter indicates that failure to comply with the request may result in an administrative closure of the claim.

e. No Response. If there is no response to the initial development letter after 30 days, the CE sends a second development letter. The second development letter informs the claimant that the requested information must be submitted before the claim can be fully adjudicated, and the claim will be administratively closed if no response is received.

f. Administrative Closure. The CE may administratively close the file after two development letters are sent, if no response is received from the claimant and the CE is unable to obtain the lawsuit documents from other sources.

5. Evaluating Lawsuit Documents. Once the CE has obtained the necessary documents regarding the lawsuit, he or she must review them to see what impact, if any, the lawsuit will have on the claim.

a. Complaint. A complaint is a legal document in which the plaintiff alleges that certain events took place involving exposures to toxic substances and that those events were the fault of the defendant(s). The complaint asks for certain remedies (payment for the resulting medical condition). From the complaint, the CE can discern the reason why the plaintiff filed the lawsuit, the identity of the plaintiff, the identity of the defendant and the date the lawsuit was filed.

(1) The CE determines if the alleged exposures raised by the plaintiff were the same as the exposures for which EEOICPA benefits are claimed. There may be some exposures alleged by the plaintiff in the complaint that are not exposures for which EEOICPA benefits can be paid (non-employment exposures).

(2) The CE must thoroughly understand the basis for the lawsuit (e.g., whether the plaintiff alleged that he or she was exposed as a worker rather than just as an individual who lived in a particular locale).

(3) The CE also determines the identities of the parties to the lawsuit. To do so, the CE may need to inquire whether any later amended complaints were also filed.

b. Settlement Sheet. A settlement sheet is basically a billing document. It lists the amounts received from a defendant and attorney fees and other costs that are being charged against those amounts. However, there may not be a document

entitled "Settlement Sheet." Instead, a CE may receive a document that simply lists the name of each defendant and the amount that the defendant paid to settle the suit. The CE needs to be able to determine how much the plaintiff/claimant actually received.

When a settlement sheet lists the amount of the "costs" of bringing the lawsuit (not the attorney fees that are being charged), the CE must insist on an itemized list of costs, if they are not already itemized on the settlement sheet. If the legal costs are not itemized, the CE may not deduct the legal costs in calculating the amount of offset.

c. Court Orders. If the lawsuit was not settled, the CE may be provided with an order of a judge, or a jury award, that states the amount that the defendant must pay to the plaintiff and the reason for payment of that amount.

d. Asbestos Bankruptcy Trust. A claimant's settlement with an asbestos bankruptcy trust is treated like any other tort settlement for the purposes of offset determination. The CE obtains copies of all administrative claim forms that have been submitted to an asbestos bankruptcy trust to compare the pertinent exposure and injuries claimed under the asbestosis bankruptcy trust with payable EEOICPA benefits for possible tort offset.

6. Election of Remedies, Part B. Depending on the circumstances of the lawsuit and the Part B claim, the claimant may no longer be eligible for EEOICPA Part B benefits based on the "election of remedies" provision under the Act. The election of remedies provision does not apply to Part E benefits. Different scenarios are discussed below:

a. Lawsuit against AWE or Beryllium Vendor. The "election of remedies" provision applies only to Part B claimants who have filed a lawsuit against either an AWE or a beryllium vendor. To determine if this provision applies to a Part B claim involving a lawsuit, the CE must determine if the otherwise eligible claimant was the same person who filed the lawsuit, if the lawsuit was against an AWE or a beryllium vendor, and if the lawsuit was for employment-related exposure to either radiation or beryllium. If the answer to all three of these questions is yes, further development is required, based on the date that the lawsuit was filed.

b. Lawsuits Filed Before October 30, 2000, Terminated Prior to December 28, 2001. For lawsuits in this category, "terminated" means that the lawsuit was concluded in any way: the parties settled, after which the suit was dismissed by the judge; the claimant won the case; or even that the claimant lost the case (judgment was granted for the defendants). This meaning of "terminated" applies to this time period only.

The CE must look for proof that the matter has been resolved, regardless of the outcome. If the CE finds that the matter was terminated before December 28, 2001, the claimant is not disqualified from receiving any Part B benefits. The CE

must include a finding in the RD that the lawsuit did not cause the claimant to be disqualified.

c. Lawsuits Filed Before October 30, 2000, Still Pending as of December 28, 2001. For lawsuits in this category, the CE will need to determine if the claimant dismissed all claims in the suit that arose out of the same employment-related exposure to either beryllium or radiation that is the basis for the Part B claim by December 31, 2003.

Unlike the situation discussed on paragraph 6b, the suit must be dismissed, rather than merely terminated. That means that there must not be a final judgment in the suit for either the claimant or the defendant. If the suit was not dismissed by December 31, 2003 or if there is a final judgment in the suit, the claimant is not entitled to any Part B benefits.

d. Lawsuits Filed Between October 30, 2000 and December 28, 2001. For lawsuits in this category, the claimant will not be eligible to receive Part B benefits, if the claimant does not dismiss all claims in the suit that arose out of the same employment-related exposure to either beryllium or radiation that is the basis for the Part B claim by the later of May 30, 2003, or the date that is 30 months after the date the claimant either received a radiation dose reconstruction from NIOSH or a diagnosis of either beryllium sensitivity or CBD, depending on the occupational illness being claimed.

e. Lawsuits Filed after December 28, 2001. For lawsuits in this category, the claimant will not be eligible for Part B benefits if a judgment is entered against the claimant (that is, the claimant loses the lawsuit). If the judgment is entered for the claimant (the claimant wins the lawsuit), the claimant is eligible for Part B benefits.

If judgment has not been entered against the claimant, the claimant will not be eligible to receive Part B benefits, if the claimant does not dismiss all claims in the suit that arose out of the same employment-related exposure to either beryllium or radiation that is the basis for the Part B claim by the later of May 30, 2003, or the date that is 30 months after the date the claimant either received a radiation dose reconstruction from NIOSH or a diagnosis of either beryllium sensitivity or CBD, depending on the occupational illness being claimed.

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

a. Exceptions: There are several exceptions to the offset requirement.

(1) If the lawsuit alleges exposure that is clearly outside the time frame and/or location of exposure awarded under EEOICPA or if the lawsuit and EEOICPA claim are based on exposure to two different toxic substances, offset is not required. For example, if the EEOICPA claim is based on radiation exposure from 1952 to 1962 but the lawsuit is based on radiation exposure beginning in 1965, offset is not required.

(2) If the lawsuit alleges non employment exposures, offset is not required (nor is there an election of remedies requirement). For example, if a claimant alleges in a lawsuit that he was exposed to radiation because he lived in proximity to a facility that produced radiation, not because he was exposed to radiation while working in a covered facility, offset is not required.

(3) If an employee and his or her spouse were both plaintiffs with causes of action in a lawsuit they brought together and they both signed releases to settle their case, but only the spouse received tort payment and the employee was alive at that time, no offset is required.

8. Pending Tort Settlement Payment. The requirement to offset EEOICPA benefits does not apply if the claimant has not received any payments from a lawsuit at the time of the EEOICPA payment. The CE does not defer issuing the RD or the FD. The RD or the FD is issued without offset since the claimant has not yet received tort payment.

However, if the claimant receives tort payment that requires EEOICPA benefits to be offset, at any time after issuing the RD or FD, but before the issuance of EEOICPA payment, the EEOICPA payment cannot be issued until the following actions are taken.

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

b. Tort Payment Pending at the FAB. If the tort payment is pending at the time of the FD, the FAB HR issues the FD without an offset. However, the HR states in the FD's cover letter that if the claimant receives tort payment after the issuance of the FD, but before issuance of the EEOICPA payment, the FD authorizing the payment will be vacated.

c. Tort Payment Pending at the time of EEOICPA Payment. Before issuing EEOICPA payment, the CE calls the claimant to verify that tort payment is still pending. If the claimant receives tort payment after issuance of the FD, but before issuance of the EEOICPA payment, the DO forwards the claim to the NO for a reopening.

9. Required Tort Offset. After receipt of all relevant documents, the CE determines whether an offset is needed. If so, the CE completes the "EEOICPA Part B/E Benefits Offset Worksheet" (Exhibit 31-1). The Worksheet includes detailed instructions for computing the amounts that the CE uses to calculate the amount of any offset.

a. Complaint. While the complaint must be obtained if the claimant disputes the necessity of the offset, the CE may proceed with the offset without the complaint if the claimant does not dispute that offset is necessary, and the CE has sufficient evidence to fill out the EEOICPA Part B/E Benefits Offset Worksheet. This step occurs after confirming that the election of remedies does not apply.

b. EEOICPA Benefits Greater than Offset. If the amount of EEOICPA benefits to which the claimant is currently entitled is more than the offset, the balance due the claimant will be the amount appearing on Line 7b of the Worksheet. This is the amount of EEOICPA benefits that must be referenced in the RD, along with an explanation of how this amount was calculated.

c. EEOICPA Benefits Less than Offset. If the amount of EEOICPA benefits currently payable is less than the offset, the amount of the "surplus" payment still to be offset will appear on Line 7c of the Worksheet. All future EEOICPA benefit payments for the same exposure(s) that formed the basis for the lawsuit are subject to the offset to absorb a surplus. Since additional EEOICPA benefits must first become payable before a surplus payment can be absorbed, no further action to offset the surplus payment is required for a survivor's Part B claim.

(1) If a surplus payment is to be absorbed in an employee's Part B claim, this must be noted in the RD, along with an explanation that DEEOIC will not pay medical benefits until the surplus is absorbed.

(2) If a surplus is to be absorbed in an employee's Part E claim, this same explanation must appear in the RD, plus an explanation that DEEOIC will also not pay any benefits for wage-loss and/or impairment that may be due in the future until the surplus is absorbed.

(3) If a surplus is to be absorbed in a survivor's Part E claim and further monetary benefits may be payable based on the deceased employee's calendar years of qualifying wage-loss, this must be noted in the RD, along with an explanation that DEEOIC will absorb the remaining surplus out of those benefits if and when they become payable.

d. FAB Award Letter. In situations involving a surplus, the FAB issues an award letter which accompanies the FD and advises the claimant of the exact amount of the surplus. In the award letter, the FAB representative explains that the surplus will be absorbed out of medical benefits payable under EEOICPA (and lump-sum payments due in the future under Part E). The FAB representative instructs the claimant to submit proof of payment of medical bills to the until

notice is received that the surplus has been absorbed, and to advise medical providers to submit proof of payment of medical bills to the DO during this time.

10. Actions to Absorb Surplus. Each DD appoints a qualified individual to serve as the POC to monitor surplus situations for both tort settlements and SWC benefits. Tort settlement and SWC benefit surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. The POC tabulates the amounts of proofs of payment, using the DEEOIC Offset Tracking Database, until they equal or exceed the surplus amount.

a. While the surplus is being absorbed, the POC temporarily places the affected case file in a red jacket denoting that a surplus exists. All case file contents are maintained in the red jacket throughout the process of surplus depletion.

b. No further payments related to the same toxic exposure(s) that formed the basis for the lawsuit are made on any case file contained in a red jacket until such time the offset has been absorbed. Should an unpaid bill be submitted to the POC during the surplus period, it must be forwarded to the BPA so an explanation of benefits can be generated.

c. During the time in which the surplus is being monitored for depletion, the POC continually tracks the offset using the DEEOIC Offset Tracking Database, which is accessible through the shared drive. Upon payment of impairment benefits, wage-loss compensation, or proof of payment of medical bills, the POC enters the dollar amount being applied toward the offset into the appropriate field in the DEEOIC Offset Tracking Database, until such time the surplus has been absorbed.

d. While medical benefits are not being paid because of a surplus that is being absorbed, the CE may find it necessary to obtain a second opinion examination, a referee examination, or a medical file review. If so, DEEOIC pays the costs for these directed examinations or reviews and reimburses any reasonable expenses incurred by the employee, including medical travel expenses, without adding to the surplus.

In a case with a surplus, BPA creates a thread for all medical travel refund requests to the POC requesting authority to deny or proceed with payment. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to offset.

e. Once the DEEOIC has recorded the absorption of any calculated surplus, normal payment of benefits must commence. However, cases are not to be deleted from the DEEOIC Offset Tracking Database once the offset has been absorbed.

f. The POC sends a letter to the claimant that the surplus is absorbed. The letter provides the claimant with the address of the BPA and instructs him or her to submit all future unpaid medical bills to that address for processing.

CHAPTER 32 – COORDINATING STATE WORKERS' COMPENSATION BENEFITS

1. Purpose and Scope. This chapter describes procedures for coordinating Part E benefits with SWC benefits. "Coordination of benefits" occurs when the compensation payable under Part E of the Act is reduced to reflect certain benefits previously received by the claimant under a SWC program for the same covered illness.

2. Authority. 42 U.S.C. § 7385s-11 requires the OWCP to coordinate the Part E award(s) with the amount of certain benefits received from a SWC program for the same covered illness, after deducting the reasonable costs incurred by the claimant in obtaining those benefits.

3. SWC Benefits. SWC programs are no fault systems designed to provide injured workers or survivor benefits for work-related injuries or illnesses without having to sue their employers. SWC benefits may include payments for medical services, vocational services, cash payments to the injured worker for wage-loss or reduction in earning capacity, as well as death and funeral benefits to the worker's survivor(s).

The laws creating these systems differ by state, but the cash benefits (whether for temporary total disability, temporary partial disability, permanent total disability, permanent partial disability, or death of a worker) are typically a calculated percentage of the injured worker's weekly earnings for a set number of weeks. SWC benefits can be administered directly by a state commission (as in Ohio). Another method is to have a state board supervise or adjudicate disputed claims and enforce the required payments made by private parties such as employers or insurance companies. Payments can be issued in a lump-sum award or settlement, on an ongoing basis (weekly or monthly), or a combination of both.

4. When Coordination is Required. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary receives benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, and then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.
Similarly, where there is an election to receive the employee's benefits by the survivor (refer to Chapter 20.12b for specific requirements for a survivor who elects to receive the employee's benefits rather than survivor benefits), coordination is required if the employee received SWC benefits for the same covered illness. Coordination is required because the survivor is taking the place of the employee in this situation. For example, if the employee received a SWC payment for asbestosis and the survivor elects to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the benefits payable to the survivor.

In cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits awarded to the survivor through the date of the employee's death are subject to coordination if the employee had received SWC benefits for the same covered illness.

Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.

5. Exceptions. The following are exceptions to the coordination requirement. Review Exhibit 32-1 for additional scenarios and determination as to whether coordination is required.

a. Multiple illnesses. If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.

For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.

b. Covered illness. Because a "covered illness" is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a non-DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).

c. Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under $200.

If a waiver is to be granted, the CE prepares a memo to the file, approved by the DD, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.

d. Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.

e. Survivor Claim. In a survivor claim (except as noted in Section 4), the CE does not coordinate even if the employee or the deceased employee's estate received SWC benefits based on the same covered illness as the survivor's Part E claim (unless that survivor also received some form of SWC benefits, such as death benefits). For example, if the employee received a SWC payment based on asbestosis and the survivor Part E claim was also based on asbestosis, the CE will not consider this claim for coordination because the survivor did not receive the SWC benefits.

6. Signed Response Regarding SWC Claim, Lawsuit and Fraud. Before a Part E claim can be accepted under the Act, the claimant must provide a signed response (affidavit) reporting whether a SWC claim had been filed for the same covered medical condition(s), or whether a lawsuit had been filed for the same toxic exposure, or if the claimant has ever pled guilty to or been convicted of fraud in connection with an application for or receipt of any federal or SWC. This signed response must be obtained regardless of the information on the forms EE-1 or EE-2 as related to these three questions.

a. The CE may call the claimant to get an initial verbal response to the three questions. If the claimant confirms verbally or submits a written response that he/she has not filed a SWC claim, lawsuit, or pled guilty to or been convicted of fraud, the CE may proceed with issuance of the RD.

Since a signed response from the claimant must be included in the case file before issuance of the FD, the CE must follow up with a development letter requesting the signed written response from each claimant before transferring the case to the FAB. The development letter must be claim specific and clearly note that by signing the written response, the claimant agrees to report any changes to the information provided in the response, immediately, to DEEOIC. The CE must also advise the claimant that failure to submit a signed response will result in administrative closure of the claim.

b. If the CE is unable to obtain a verbal response from the claimant or the claimant responds affirmatively to any one of the questions, the CE cannot issue a RD without further development and clarification. The CE may consider administrative closure of the claim if the claimant is not responsive to the development request for clarification. This action is taken only as a last resort, and after at least two development letters.

c. It is the responsibility of the FAB to obtain this signed response if a RD is issued without receipt of the signed response (i.e. the CE only received verbal confirmation). Every effort should be taken by the FAB to obtain this signed response including calling the claimant and sending a follow up development letter. However, if the FAB is unable to obtain the signed response after 30 days from the FAB's follow up development letter, the FAB administratively closes the case and returns it to the DO. The FAB sends a letter advising the claimant of this course of action.

d. If the case is with the FAB, and there is evidence in the case file of a SWC claim, lawsuit, or fraud in connection with an application for or receipt of workers' compensation that may impact the claimant's EEOICPA benefits, further development must be undertaken. If the matter could be clarified by a telephone call, the FAB should take this action. If the matter requires extensive development, the case is to be remanded to the DO for further development.

e. By signing the written response, the claimant agrees to notify DEEOIC of any changes in the information provided in regards to the SWC/lawsuit/fraud

statement. It is not necessary to request this information again unless there is a new exposure or illness (including consequential) being accepted under EEOICPA. For instance, if the claimant has submitted a written response for lung cancer and is now filing a claim for a consequential condition of bone cancer, a new signed response regarding the bone cancer is required before this consequential condition is accepted under the Act.

7. Verifying SWC Claims. If the claimant reports, or the evidence indicates a SWC was filed, the CE verifies the illness and SWC benefits received, but only after the CE determines Part E eligibility.

Once the CE determines that there is qualifying employment, covered illness, and a SWC claim for the same illness, the CE sends the claimant a development letter. The development letter states that a decision under the EEOICPA cannot be rendered until the claimant provides evidence from the state commission, board, payment-issuing agency, or from an attorney who settled his or her SWC claim verifying the total amount and type of SWC benefits paid to date.

a. Benefit Categories. The evidence from the state commission, board, payment-issuing agency or attorney must specify the total amount in benefits the claimant received as of the date of the reply, and an itemized account of the total benefits paid for each benefit category, such as: medical benefits; disability benefits; death benefits; burial/funeral benefits; settlement amount; attorney fees; vocational rehabilitation; and the amount of any disability payment issued during vocational rehabilitation training.

b. No Response or Insufficient Response. If the claimant does not respond to the request or the material submitted is not sufficient to coordinate benefits, the claim is administratively closed and the claimant is advised that no additional action will be taken until the required documentation is provided.

In some limited cases, the claimant, the SWC board, commission, payment-issuing agency or attorney may no longer have the SWC records. If the CE independently confirms with the SWC board, commission, payment-issuing agency or attorney that the SWC record is no longer available, the CE may accept a signed affidavit from the claimant attesting to the amount of the SWC benefit. As a last resort, this affidavit can be used to determine the amount of coordination.

8. Pending SWC Payment. Coordination of benefits is tied to the dollar value of the SWC benefits the claimant received for the same covered illness. Therefore, the requirement to coordinate benefits does not apply if the claimant has not received SWC benefits as of the time of the Part E payment.

If payment of SWC benefits for the same covered illness is pending at the time of the Part E payment, the CE does not defer issuing the RD or the FD. The RD or the FD is issued without coordination since the claimant has not actually received SWC benefits yet.

However, if the claimant receives payment on the pending SWC claim at any time after issuing the RD or FD, but before the issuance of the Part E payment, the Part E payment cannot be issued until the following actions are taken.

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

b. SWC Payment Pending While the Case is at the FAB. If the SWC payment is pending while the case is in posture for the FD, the FAB HR issues the FD without coordination. However, the HR states in the FD's cover letter that if the claimant receives SWC payment after the issuance of the FD, but before issuance of the Part E payment, the FD authorizing the payment will be vacated.

c. SWC Payment Pending at the Time of EEOICPA Payment. Before issuing the Part E payment, the CE calls the claimant to verify that payment of the SWC benefits is still pending. If the claimant receives SWC payment after issuance of the FD, but before issuance of the Part E payment, the DO forwards the claim to the NO for a reopening.

9. Calculate Amount to Coordinate. Once the CE receives the documentation which verifies the amount of SWC benefits the claimant received for the same covered illness, the CE completes the "EEOICPA/SWC Coordination of Benefits Worksheet" (Exhibit 32-2). This Worksheet (and its detailed instructions) is to be used by the CE to make the calculations necessary to determine how much to coordinate a claimant's EEOICPA Part E benefits to reflect benefits received from a SWC program for a covered illness compensable under Part E.

a. Maximum Aggregate Compensation. The amount of monetary compensation provided under Part E (impairment and wage-loss compensation), excluding medical benefits, cannot exceed $250,000. In determining the aggregate compensation, reduction of compensation based on SWC coordination or tort offset is not taken into consideration. For example, if the employee is awarded benefits for impairment in the amount of $100,000 but his compensation is reduced because of coordination of SWC benefits to $60,000, the amount of compensation used to determine the maximum aggregate compensation is $100,000.

b. Periodic SWC Benefits. Some claimants receive ongoing periodic SWC benefits, such as a worker's or widow's annuity that can make calculation of the proper amount of coordination difficult. For cases with such SWC payments, the FAB is to use the same cut-off date for determining the amount of SWC received that was used by the CE at the DO.

c. Part E Benefits Greater than SWC Benefits. If the amount of EEOICPA Part E benefits (which may consist of lump-sum payments and/or post-filing and ongoing medical benefits) to which the claimant is currently entitled is MORE than the amount of the SWC requiring coordination, the balance due the claimant (i.e., a positive amount) will be listed on Line 7 of the Worksheet. This is the amount of Part E benefits that must be referenced in the RD, together with an explanation of how this amount was calculated.

d. Part E Benefits Less than SWC Benefits: If the amount of Part E benefits is LESS than the amount of the SWC requiring coordination, the amount of the "surplus" (i.e., a negative amount) is listed on Line 7 of the Worksheet. Because a surplus can only be absorbed from EEOICPA Part E benefits due an employee currently or in the future, no further action is required for a survivor claim.

If there is a surplus to be absorbed in an employee's Part E claim, this must be noted in the RD, along with an explanation that OWCP will not pay medical benefits and will apply the amount it would otherwise pay (directly to a medical provider, or to reimburse an employee for ongoing medical treatment) to the remaining surplus until it is absorbed. In addition, the CE explains in the RD that OWCP will not pay any further lump-sum payments for wage-loss and/or impairment due in the future until the surplus is absorbed.

e. FAB Award Letter. In situations involving a surplus, the FAB issues an award letter to the claimant containing special language. The FAB award letter accompanies the FD and advises the claimant of the exact amount of the surplus.

(1) The FAB explains in the award letter that the surplus will be absorbed out of medical benefits payable and further lump-sum payments due in the future (i.e. wage-loss and impairment) under Part E of the EEOICPA.

(2) The award letter further instructs the claimant to submit proof of payment of medical bills to the DO until notice is received from the DO that the surplus has been absorbed.

(3) In addition, the award letter instructs the claimant to advise medical providers to submit proof of payment of medical bills to the DO during this time.

10. Actions to Absorb Surplus. Each DD appoints a qualified individual to serve as the POC to monitor surplus situations for both tort settlements and SWC benefits. Tort settlement and SWC benefit surpluses are absorbed until the surplus is exhausted and EEOICPA benefit disbursement can commence. The POC tabulates the amounts of proofs of payment and further lump-sum awards for wage-loss and impairment benefits using the DEEOIC Offset Tracking Database, which is accessible through the NO Shared Drive, until they equal or exceed the surplus amount.

a. While the surplus is being absorbed, the POC temporarily places the affected case file in a red file jacket denoting that a surplus exists. All case file contents are maintained in the red file jacket throughout the process of surplus depletion.

b. No further payments are made on any case contained in a red file jacket. Should an unpaid bill be submitted to the POC during the surplus period, it must be forwarded to the medical BPA so an explanation of benefits can be generated.

c. During the time in which the surplus is being monitored for depletion, the POC continually tracks the offset using the DEEOIC Offset Tracking Database until the surplus has been depleted. Proofs of payment amount and further lump-sum awards for wage-loss and impairment benefits will be entered into the appropriate fields in the DEEOIC Offset Tracking Database, until they equal or exceed the surplus amount.

d. Once the surplus is completely absorbed and EEOICPA benefits may commence, the POC removes the temporary red file jacket and returns the case contents to the original file jacket. Removal of the red file jacket signifies that future benefits may be provided on the case. Cases are not to be deleted from the DEEOIC Offset Tracking Database.

e. The POC sends a letter advising the claimant that the surplus is absorbed. The letter provides the claimant with the address of the BPA and instructs him or her to submit all future medical bills to that address to review for payment.

f. While medical benefits are not being paid because of a surplus that is being absorbed, the CE may find it necessary to obtain a medical examination, second opinion examination, a referee examination, or a medical file review. If so, DEEOIC will pay the costs for these directed examinations or reviews and will reimburse any reasonable expenses incurred by the employee, including medical travel expenses, without adding to the surplus.

In a case with a surplus, BPA creates a thread for all medical travel refund requests to the POC requesting authority to deny or proceed with payment. Medical travel expenses related to a directed medical examination must be approved for payment and are not subject to coordination.

11. Contact with SWC Office. Due to privacy and disclosure regulations, the CE cannot disclose any information regarding a claim filed by a claimant to a SWC office unless:

a. CE Requires Information from the SWC Office. If the CE requires information from a SWC office to process an EEOICPA claim, the CE can disclose to that SWC office that the claimant filed for benefits under the EEOICPA.

b. The SWC Office Requests Evidence. If a SWC office requests evidence to establish that the EEOICPA claimant should not receive benefits from a SWC

claim, the request should be submitted to the NO for review. The NO will provide instructions for responding to the request after reviewing all information.

CHAPTER 33 – COMPENSATION PAYMENTS

1. Purpose and Scope. This chapter describes the policy and procedure for the DEEOIC claim staff to process compensation payments, and defines the roles of the various personnel in DO and the FAB, with respect to the compensation payment process. At the discretion of the DD, the order and manner in which payment documents are routed in OIS, from one individual to another, may vary; however, the ECS process cannot.

2. Responsibilities. When lump-sum compensation is awarded by FD, the FAB CE or HR, the DO CE, SrCE or SCE, FO, and DD all ensure that the payment is processed in an accurate and timely manner. The payment process begins at the FAB office, and continues at the DO, upon return of the completed Form EN-20. Persons in the roles listed above serve to validate the accuracy of payment data and enforce security of the payment creation process by conducting individual assessments of each lump-sum payment prepared for issuance.

Throughout this document, the term "routing," as it is used to describe the movement of the EN-20 from one individual to the next, entails assignment of the document in OIS, by means of OIS Notification, to the next appropriate role designation.

3. Processing the EN-20. Upon issuance of a FD awarding compensation, the FAB enters the AOP amount in ECS. ECS generates the EN-20 (Acceptance of Payment Form) and the EE-20 (award letter), which FAB mails to the claimant, along with the FD. ECS will automatically assign an AOP sent date to correspond with the issuance date of the FD. As part of the electronic document retention process, the appropriate staff person will electronically image (a/k/a bronze) the cover letter, FD, and a copy of the EN/EE-20 for viewing in OIS. If the claimant requests another EN-20, it is permissible to send a photocopy or facsimile to the claimant, for signature, however, it must be returned by mail, bearing an original payee signature, with no changes or alterations to the information contained on the original EN-20.

If a claimant or AR inadvertently returns an EN-20 to a RC, or to the CMR in London, KY, staff in these facilities will upload the document through the EDP, then mail the original document to the appropriate DO via regular mail.

a. DO Mailroom Handling. The FD cover letter instructs the claimant to return the completed EN-20 to the DO that issued the RD. Upon receipt of the completed EN-20, mailroom staff date stamps the form (AOP Received Date), in the upper right corner, using an ink date stamp.

b. Retention of Form EN-20.

c. ECS Routing. Once the completed EN-20 is bronzed into the OIS case record, the document automatically appears in the OIS Unreviewed Document Tab of the ECS-assigned DO or FAB CE, for initial review.

(1) Accuracy of Payment Data. The CE reviews the signed EN-20, in OIS, (or the original document if so desired,) to determine if the form contains correct payment data, and that the form has been correctly completed by the payee, examining each of the following items:

(a) Case ID

(b) Payee name. The Payee Name, as it appears at the top of the Form EN-20, must be listed as one of the account holder names provided in the Account Information section. In the event the payee name is not listed as an account holder, the CE contacts the payee for an explanation. If it is determined that the payee wants his/her payment to be deposited in a third-party account, a Payment Memorandum is prepared, and bronzed into OIS, explaining the name variance. The only exception to this requirement is when the EN-20 is signed by an approved POA and the payment is being deposited in the POA's bank account.

(c) Payee SSN.

(d) Verification of Account Information: "type account" block is checked ("C" for checking, "S" for savings) and the routing and account numbers are listed correctly, with no trace-overs, or corrections.

(e) EN-20 is signed and dated. (If the form is signed by an individual with POA, refer to the POA process below).

If the CE, SrCE, FO, or DD wishes to examine the original EN-20, because the OIS document is not clear, that individual obtains the original document from the DO folder, then returns the original document to the DO folder, when finished.

d. Deficient EN-20. Minor deficiencies in claimant-provided information, other than items (a) through (e), above, can often be explained by a memorandum to the case file without having to return an EN-20 to the claimant. However, if the CE determines that a significant deficiency exists in one of the above-described items, the CE/FO prepares a letter to the claimant explaining the EN-20 deficiency and the corrective action required for the payment to proceed. In either case, the CE bronzes the memorandum, or the claimant letter, to OIS. The CE also annotates the OIS description field identifying the EN-20 as defective. When returning a defective EN-20 to a payee, a new copy of the EN-20 is to be provided for the claimant's use. If a modification of the original EN-20 is required, due to incorrect information provided by the FAB, the DO POC contacts the FAB and requests that a corrected EN-20 be mailed to the payee. In this instance, the FAB office is responsible for sending a new EN-20 to the claimant and imaging a copy of the corrected EN-20 into OIS.

(1) Signature by POA. If the EN-20 contains a signature by a POA, either the FO, or the CE (at the DD's discretion) conducts a document review to ascertain whether the individual who signed the EN-20 has the legal authority to sign on behalf of the payee. To accomplish this, the CE identifies and reviews the legal document authorizing an individual as

POA. If such a document does not exist in the case file, the FO/CE undertakes development to obtain this information. Upon receipt of a document identifying the designated POA, the FO/CE prepares a cover memorandum and sends the memorandum, the EN-20, and the POA documents,(via facsimile), to the NO Policy Branch, for referral to the SOL. The DO memorandum requests a review of the POA documents to determine their legal sufficiency as they pertain to the signing of an EN-20. The person preparing the memorandum ensures that it is bronzed into OIS. At the time of referral to the Policy Branch, the FO/CE enters a 7-day "reminder" in ECS.

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

(a) If the SOL determines that the POA documentation is deficient for any reason, the CE sends a letter to the claimant (with a copy to the POA), advising that the SOL has determined the POA documents to be unacceptable, and stating the reason why. The CE does not send a copy of the Solicitor's opinion to the claimant. Upon notification to the claimant, of a deficient POA, the CE deletes the "AOP received date" from ECS.

(b) All documents pertaining to the acceptance or rejection of a POA are imaged and stored in OIS, separate from the payment documents, and are specifically identified as POA documents.

e. Check Requests. In accordance with Department of Treasury Regulations, individuals requesting payment by check can only be approved for such under limited circumstances, and upon written request from the payee.

An exception was granted by Treasury for check requests by law firms that receive multiple payments (refer to 3d (6) below), and for payments made to foreign addresses (refer to 4e, below).

(1) In the event that a claimant contacts the DO, by letter or telephone call, requesting payment by check, the request is routed to the responsible CE. The CE is to inform the payee that compensation payments are delivered via EFT, unless the claimant meets one of two exceptions:

(a) Payment by electronic funds would impose a hardship because of the individual's inability to manage an account at a financial institution due to a mental impairment; or,

(b) Payment by electronic funds imposes a hardship because the individual lives in a remote geographic location lacking the infrastructure to support electronic financial transactions.

(2) If the claimant states that one of these two exceptions is applicable, the CE instructs the claimant to return the signed and completed EN-20 (leaving the EFT section blank), to the DO accompanied by a signed letter which:

(a) Requests payment by check;

(b) States which of the above two exceptions applies;

(c) States the mailing address for the check.

(3) Upon receipt of a satisfactory letter, which meets the above criteria, and which accompanies a properly executed EN-20 (minus the EFT information) the letter and EN-20 are bronzed into OIS, and the EN-20 is sent to the FO for review. If approved, the FO notifies the CE, via OIS, that the request for payment by check is approved.

(4) Unsolicited letters from claimants, requesting payment by check, that do not meet the above exceptions [(items d (1)(a) and (b)], require a telephone call to the claimant explaining the limited exceptions to the EFT rule. If the claimant states that he/she meets one of the exception criteria, the claimant submits a new signed letter, specifically requesting payment by check, citing the applicable exception.

(5) If, after the CE has explained the limited exceptions to a claimant and upon receipt of a letter deemed deficient or lacking in explanation, the CE refers the letter to the Policy Branch and requests that the NO contact the payee.

(6) It is the responsibility of the DD in each DO to prepare procedural guidance for the law firms within their jurisdiction that regularly submit check requests to DEEOIC. This includes advising the firms as to what specific information should be contained in cover letters to be used when requesting payment by check. (See 3d above)

f. EFT. If the FO finds that the EN-20 and associated payment documents are acceptable for payment processing, the FO sends a notification to the Pay Change Assistant (PCA) for continuation of the payment process. If the case is designated "Terminal" in ECS, the FO directs the CE to prepare an Expedited Processing Payment

Transaction Form (EPPTF) for use by the NO. If the DO is unable to process the payment through ECS, an EPPTF is prepared for use by the NO. The payment forms available for use in creating expedited and exception payments, (samples of which are found in the Appendix), are as follows:

(1) Expedited Payments – Expedited Processing PTF (Exhibit 33-1)

(2) Expedited Payments to third-party account names or alias names – Expedited Processing PTF, Third Party Accounts (Exhibit 33-2)

(3) Exception Payments (Non-ECS Payments) – Exception Processing PTF (Exhibit 33-3)

Further instructions pertaining to exception processing of payments, by the NO, appear in section 8, below.

4. Creating the EFT Payment.

a. PCA Data Entry: The PCA enters the following items in the ECS payment screen:

(1) AOP received date (i.e., date the EN-20 was date-stamped as received at the DO).

(2) Banking Information pertaining to the recipient's financial institution (bank or credit union).

(a) Bank or Credit Union Name.

(b) ACH (Federal Reserve Bank) Routing Number.

(c) Recipient's account number.

(d) Type of account: Checking or Savings. (Payments may also be made to money market accounts, as long as no third-party routing system is involved and the account type can be classified as checking or savings.)

(3) Names listed on EN-20 for all account-holders. [Note: For wire transfer (Fed Wire) payments, the Payee Name on the EN-20 must match one of the Account Holder names.]

b. PCA Verification. Upon PCA submission of the data in ECS, the CE automatically receives a "Payment Pending" item in their ECS work queue.

c. Verification of Federal Reserve Bank Routing Number. The FO (or designated alternate) verifies the authenticity of the bank routing number, listed on the EN-20, through the Federal Reserve Financial Services website: Search for ACH Participants. Once verification of the routing number is complete, the FO memorializes the verification in an ECS Note. The Federal Reserve website is found at: https://www.frbservices.org/EPaymentsDirectory/agreement.html.

d. Special Routing Instructions for Expedited Payments (Terminal Claimants). When processing EN-20 payment requests, for terminal claimants, it is permissible to substitute the bank ACH routing number for a Fed Wire routing number to that same bank. The staff person completing this task documents this

change with a printout of the Treasury Fed Wire webpage, and a memorandum of explanation signed by the DD/ADD. These documents become part of the payment record in OIS.

e. International Payments.

(1) Payments to claimants living outside the U.S. can only be made by check; however, a claimant living outside the U.S. can open a bank account at a U.S. bank and arrange for withdrawal or transfer of funds, once payment has been made to that account.

(2) When preparing a check request in ECS, for a mailing address outside the U.S., the addressee information (street name and number, building name, etc.) is entered on the three address lines provided on the payment screen; the City and any special City Code is entered on the "City" line; 5 zeroes are entered in the Zip Code field; and "Non-USA State Address" is selected from the "State" drop-down menu. The Country Name is typed in the "Country" field.

5. Creating the Check Payment. After review by the FO, check requests are routed directly to the CE, who reviews the claimant's address listed on the EN-20, and verifies this address against case file documents, the current address displayed in ECS, and any change of address requests in the case record. If the claimant provides a different mailing address on the EN-20, from the current address of record, and indicates this is a "Payment Only address," the CE contacts the claimant by telephone to determine if the change of address is permanent, or if it is a one-time payment-only address. An appropriate call note is added to the ECS record.

a. Permanent Change. If the payment address provided on the EN-20 represents a permanent change of address, the CE instructs the claimant to submit a separate signed document requesting a permanent change of address.

b. Temporary Change. If the payment address is a temporary address for that payment only, the CE advises the payee that any permanent change of address will be processed upon submission of a separate written and signed request.

6. Completing the ECS Payment. Once the PCA has verified the accuracy and completeness of the information provided on the EN-20, and entered the payment data in ECS, the CE receives a "Pending Payment" item in their work queue. The CE verifies the banking information (account number, routing number, and account type) by re-entering it in ECS. The CE Creates the payment in ECS and routes the payment to a Senior CE for Certification. After certification, the payment is routed to an FO for Verification, then to a DD (or an individual with DD privileges), for Authorization. As each individual (CE, SrCE, and FO) completes their function in ECS, the next designated user automatically receives a pending payment item in their ECS work queue. Each individual, who completes their respective payment step in ECS, is responsible for examining the payment documents and affirming that the payment amount and associated data, recorded on the EN-20, appears correctly on the ECS payment screen. Once the DD completes the authorization step, the payment is automatically added to the weekly batch payments for that DO and the payment is authorized for issuance by the Department of Treasury.

7. Entering and Identifying Payments in OIS. Payments completed at both the DO and the NO are to be bronzed in OIS and identified as follows:

a. DO Payments. At the time a payment is Authorized by the DD (or an approved person with the DD role), the EN-20, and any associated correspondence or memoranda associated with the final EN-20, are to be bronzed and saved as a "final payment" documents in OIS. When adding these documents to OIS, they are to be labeled with a unique identifier consisting of the letters "PMT" followed by the first 4 letters of the payee's last name, the last 4 numbers of the payee SSN, and the Authorization Date as it appears in ECS. For example, the EN-20 for a payment to someone named Jones, with a "last 4" of 9876, and an Authorization Date of 01/01/2014 would be stored in OIS as follows:

Category:	Forms & Claims
Subject:	EN-20
Description:	PMT JONE9876, 01-01-2014

The purpose of this unique identification is to allow for easy identification of the final EN-20 and associated documents used in the creation of the ECS payment.

8. Expedited and Exception Payments. The NO FO and NO staff with Certifying Officer status process expedited (terminal) payments, and other "exception" payments that cannot be processed through the normal ECS payment method. For expedited and exception processing of payments at the NO, the Expedited Processing, or EPPTF (Exhibit 33-1 & Exhibit 33-3) is completed by the DO. For payments where the account-holder name is different from the payee name, the CE verifies with the payee that payment is being made to a third-party account name and uses the Third-Party PTF (Exhibit 33-2). The third-party EPPTF is also used by the DO to account for minor variances between the account holder name and the payee name of record in ECS (a/k/a alias name). Any memorandum of explanation, or record of a telephone call to the payee, is printed and becomes a part of the payment record in OIS. Once the DO actions are complete, the payment documents are forwarded to the NO for processing, and bronzing, as follows:

a. Expedited Payments are payments involving cases coded "Terminal" in ECS, and which require immediate processing by the NO.

(1) Upon receipt of an ECS payment requiring expedited processing, and upon review and confirmation that all ECS payment data has been completed correctly, the FO selects "Expedited Payment" on the ECS screen and proceeds with Verification of the payment in ECS.

(2) The FO then compiles the payment documents (i.e., EPPTF, EN-20, payment memo, etc.) in a PDF document and forwards that document to the DD, via email, advising that the expedited payment awaits completion in ECS by the NO fiscal staff.

(3) The DD (or individual with DD role) reviews the payment in ECS, and upon verification that all payment data is correct, the DD forwards the

payment documents to the NO payment team, authorizing completion of the expedited payment in ECS.

(4) Upon completion of the expedited payment, the NO fiscal staff bronzes the final payment packet, including the final EPPTF, into OIS, and identifies the documents with the unique identifier described in 7a, following the same process as the DO.

b. Exception Payments are payments, such as 2nd Part B payments, and payments that exceed the programmatic limits. Because ECS is unable to process these payments, they must be forwarded to the NO for completion. The DO staff is to process and bronze exception payments as follows:

(1) Because exception payments are created outside ECS, the DO staff will create and circulate an EPPTF, collecting the names and signatures of the appropriate ECS user roles required to create a payment (i.e., CE, SrCE, FO and DD). Upon completion of the EPPTF, the FO forwards the documents (EPPTF, EN-20, and other related documents) to the DO mailroom for bronzing into OIS. Upon completion of OIS bronzing, the FO sends a notification to the NO Certifying Officers, advising that exception payment documents are pending action.

(2) Upon completion of an exception payment at the NO, the NO fiscal staff bronzes the payment packet into OIS, using the unique identifier described in 7a, and following the same process as the DO. Once the final payment documents are bronzed into OIS, a notification is sent to the verifying FO in the DO.

c. Retention of Documents. Upon completion of any payment, both DO and NO staff will retain the original payment documents (excepting the EN-20) in accordance with the document retention schedule for OIS documents. (EN-20 forms will be retained by the FO, for a period of 3 years, as previously specified in 3a.)

9. Deleting Payments and Cancelling Transactions. During the payment process, if a staff person discovers a critical issue relating to the sufficiency of the EN-20, or an error in the accuracy of ECS payment data, or (in limited circumstances) the EPPTF, that individual stops the payment process and undertakes corrective action to rectify the error.

a. Error in EN-20. If the cancellation is due to a deficient EN-20, the CE is notified, via OIS, that corrective action is required. (Return to Item 3c above.)

b. Data Entry Error from EN-20. If the CE, or any individual above the CE level, identifies a data entry error after the payment information has been entered in ECS, the payment is returned (via OIS Notification) to the CE, who "Deletes" the payment from ECS. "Deleting" the payment removes the AOP received date in ECS, and any information on the payment screen. (Note: If there is a pending Part B and Part E payment included in the same EN-20, deleting one payment will

cause both payments to be deleted. If one of the two payments is not in a state that can be deleted, then the System will abort and will not allow the deletion. Once a payment is created, it must be rejected by the reviewer [SrCE or SCE prior to certification, FO prior to verification, or DD prior to authorization] before the CE can delete it. Once the payment is deleted the payment process begins anew, with the PCA, upon receipt of a corrected EN-20.

10. Payment Reports. On Thursday of each week, at close-of-business (5:00 PM EST), ECS automatically creates an electronic file of all pending, "Authorized" payments created during that weekly cycle. The Branch of Automated Systems (BAS) forwards this electronic payment file to Treasury for payment the following Thursday. The BAS also stores a copy of this weekly report (Benefit Transaction History Report or BTHR) on a shared-access drive, available to the DO fiscal staff on the Monday following the close of the payment cycle. Once the weekly payment cycle is closed, the FO closes the separate weekly spreadsheet report of all DO payments for that pay cycle, and reconciles the DO spreadsheet against the BTHR. After reconciliation, each DO FO prepares an email summary report containing the total of all weekly payments, broken down by Part (B or E) and by payment type (EFT or check), authorized during that week's payment cycle. Each FO forwards their DO summary report to the NO FO, via email. Upon completion of the reconciliation of these three documents (BTHR, DO spreadsheet, and email summary), the FO scans and stores the reports in a secure, limited-access payment folder on the DO share-drive, labeling them as the DO weekly payment report.

11. Substitutions Among Staff. If the creator, certifier, verifier, or authorizer is not available to perform a particular payment function, alternate persons in these same roles can substitute for them. Any CE, SrCE, or SCE can create the payment. Any SrCE or SCE can certify the payment as long as that person did not create it.

In the absence of a FO, either the DD or ADD can verify a payment. However, the same individual who verifies a payment cannot authorize that same payment, as no one person can perform the function of two different roles for any particular payment.

If both the DD and ADD will be unavailable to authorize payments on any given date, advance notice is sent by one of those individuals, via email, to the Unit Chiefs for Policy, Regulations and Procedures, the Policy Branch Chief and the Deputy Director at the NO. The DD/ADD advises the name of the person to be designated as Acting DD, and the applicable dates. In response, the Policy Branch Chief, a Unit Chief, or the Deputy Director sends an email request to Energy Technical Support (ETS), requesting that they assign a temporary DD role to the designated individual, thus allowing that individual to authorize ECS payments on the requested date(s). ETS notifies the Policy Branch, via email, once the role-change request is processed.

12. Temporary Role Changes for Expedited Payments. For Expedited Payments requiring authorization by an individual assigned a temporary DD role in ECS, the FO includes a copy of the approval email (Step 11) confirming the temporary role-change approval associated with that individual for that date, when forwarding the payment documents to the NO.

The FO will not accept any expedited payment without the necessary role-change email attached, and returns the payment documents to the appropriate party, requesting that a temporary role-change request be approved by the NO.

13. Stolen Check Claims. Upon notification that a payee's compensation check has not been received, the CE requests that the payee (or appropriate representative) provide the DO with immediate written notification of non-receipt of payment. Upon receipt of such notification, the FO forwards that notice to the NO FO, who takes the following actions:

a. Review payment status in the Treasury Check Information System (TCIS).

b. If Payment Status in TCIS shows as: "Negotiated" (check cashed), the NO FO creates a claim in the Treasury system for that payment and selects Option #2 – Entitlement After Status.

c. After 24 hours, the NO FO reviews the payment and confirms that the updated status of the payment appears properly in the Treasury TCIS system. Once confirmed, the NO FO contacts the claimant and provides the toll-free telephone number for the Treasury Stolen Check Department. Upon reporting the claim to Treasury, the investigation and disposition of the stolen check claim is entirely between Treasury and the payee.

d. Treasury will notify the payee of its determination once the investigation is complete. If Treasury determines that the stolen check claim is bonafide, Treasury will reissue payment to the payee.

14. Processing Payment Cancellations. A "cancelled" payment is a payment, either electronic or check, that has been issued by, and then returned to, the Department of Treasury. When this occurs, Treasury notifies the DEEOIC via Cancellation Report that a payment has been returned to Treasury and credited to the DEEOIC account. In order to maintain an accurate and comprehensive accounting of all funds disbursed by the DEEOIC, it is then necessary to cancel any returned payment in ECS, as well.

The ECS payment cancellation process is completed before the compensation payment is reissued to the same payee, or before the funds can be awarded to other claimants in the same case. Multi-level reviews, concurrence by DEEOIC management and documentation of the actions taken by all parties (claimants, financial institutions, and DEEOIC claims staff) are essential to safeguarding the integrity and security of the DEEOIC's financial accounting processes.

a. Cancellation Initiated by Treasury. The Treasury Department transmits an electronic Cancellation Report to the DEEOIC when EFT payments are rejected or returned to Treasury by the payee's bank, or when a check is returned to Treasury for any reason. These reports are sent to the DEEOIC NO FO, who then notifies the appropriate DO fiscal staff (via OIS and email) of the returned payment. The NO FO also has the capability of viewing the status of any payment through Treasury's online TCIS system.

b. Cancellation Initiated by Claimant. Upon notification from a claimant of non-receipt of payment, the DO takes the following steps:

(1) The CE documents any telephone call or correspondence in ECS regarding contact from a claimant who has not received a payment. A printed record of all phone calls is bronzed into OIS.

(2) If notification of non-receipt is by telephone, the CE instructs the claimant to provide DEEOIC with a written, signed notice of the non-receipt of payment.

(3) Upon receipt of either a telephone call or letter advising of non-receipt, the CE transfers the case file to the FO.

(4) The FO notifies the NO FO, via email, of the non-receipt of funds.

(5) The NO FO initiates an inquiry in Treasury's TCIS system, determines the status of the payment, and advises the FO of one of the following:

(a) Check Outstanding (not yet negotiated)

(b) Check Cancelled (returned to Treasury)

(c) Check Reconciled in Treasury system. (This indicates the check has been negotiated [cashed] by someone, but not necessarily the payee.)

(d) EFT transaction completed

(e) EFT funds returned to Treasury (Cancelled)

(6) The NO FO provides the FO with a screenshot of the Treasury payment status, via email.

(7) The FO notifies the claimant of the payment status and explains the payment cancellation process, if appropriate.

(a) EFT Status. If Treasury shows delivery of the funds to the payee's bank, the FO notifies the payee of same. If Treasury shows that the EFT payment was returned by the payee's bank, the FO advises the payee that the DEEOIC will begin the payment cancellation process and, if appropriate, process a new payment.

(b) Check Status. For checks outstanding in the Treasury payment system, upon receipt of the signed notice of non-receipt of payment from the payee (or AR), the FO initiates an email to the NO FO and requests that a "Stop Pay" order be placed on the check. The NO FO initiates a stop pay request, in TCIS, and after 24 hours, verifies that the cancellation request has been processed. Upon confirmation that a stop pay order has been placed on the

check, the NO FO sends a screenshot confirmation, via email, to the FO.

15. ECS Payment Cancellation Process. Upon receipt of documentation (from the NO FO), through OIS, confirming return of a payment to Treasury, (check or EFT), or confirming a valid stop pay order on an outstanding check, the FO proceeds with an ECS Payment Cancellation request. The steps outlined below ensure that appropriate documentation exists to explain and validate the need for cancellation of a payment in ECS.

a. The DO FO conducts inquiries with the payee and the payee's bank to determine why the payment was returned to Treasury.

b. DO FO prepares a memorandum to the NO, with an explanation as to the reason for the returned payment and requests payment cancellation in ECS. The memorandum is imaged in OIS, and notification is sent to the NO FO. Additionally, the DO FO notifies the NO FO, and the two Policy Branch Unit Supervisors, via email, that a Payment Cancellation Request is pending in OIS.

c. It is not necessary to transfer the ECS case record to the NO when requesting initiation of a payment cancellation by the Director. [ECS allows appropriate NO staff to initiate the cancellation action without file transfer.]

d. Upon receipt of the DO memorandum requesting cancellation, the NO FO prepares a Payment Cancellation Memorandum and an ECS Payment Cancellation Form (Exhibit 33-4) for review and signature by a Policy Branch Unit Chief and the Director or Deputy Director of DEEOIC.

e. The Director or Deputy Director completes the relevant portion of the ECS Payment Cancellation Form, and initiates cancellation of the payment in ECS. Upon completion of these actions the payment cancellation documents are returned to the NO FO for bronzing of the partially completed cancellation form into OIS.

f. The NO FO notifies the DO FO and the DD that a partially completed ECS Payment Cancellation awaits final action by the DD, and that the relevant documents are available in OIS.

g. The DD reviews the payment cancellation documents and completes the payment cancellation in ECS. If the payment is not being reissued, the DD checks the box labeled "Claimant Repayment Not Authorized" when completing the cancellation action. Upon completion of the ECS cancellation, the DD signs the ECS Payment Cancellation Form and routes the completed form to the appropriate DO personnel for imaging in OIS.

16. Post Payment Cancellation Actions.

a. Reissuing Payment. If the compensation payment is to be reissued, the DD routes the case file to the CE, advises that the ECS payment cancellation process is complete, and instructs the CE to reissue the payment.

b. Voided Transactions. If the compensation payment is not being reissued, the FO confirms that the "Void Transaction" has been completed in ECS, and verifies that the "Claimant Repayment Not Authorized" option has been checked by the DD. The case is routed to the DO file room, and/or transferred to "FIL" in ECS, on the transfer screen, or, is routed to the CE for survivor development, if applicable.

17. Death during Payment Process. If the employee or survivor is alive when the FAB issues its FD, but that individual dies before the DO processes the payment, the assigned CE, FAB CE, or HR shall administratively close the deceased individual's claim in ECS.

In the event that payment is processed and DEEOIC receives notification that the payee died prior to receipt of payment, it is the responsibility of the DO FO, in conjunction with the assigned CE, to attempt recovery of the payment. The OWCP Regulations state that under these circumstances, the person who receives the payment shall return it to OWCP. Should the DO encounter difficulty in recovering the payment, the DO refers the case to the NO Policy Branch to initiate overpayment procedures.

In either instance, the assigned CE administratively closes the deceased individual's claim and undertakes necessary development to identify any individuals potentially eligible for redistribution of the payment.

CHAPTER 34 – POST-AWARD ADMINISTRATION

1. Purpose and Scope. This chapter outlines the actions the CE takes on Part E cases after a claim has been approved for benefits. The chapter also describes the procedures used by the NO to ensure that payment of medical benefits to covered Part E employees is fully coordinated with any SWC benefits received by those employees or their survivors.

2. Authority. Section 7385s-11(a) requires that compensation to an individual under Part E be coordinated with SWC benefits, other than medical benefits and benefits for vocational rehabilitation, that the individual has received for the same covered illness. The Director of the DEEOIC has been delegated the authority to request information from SWC authorities concerning SWC benefits that covered Part E employees receive.

3. CE Responsibilities. The CE sends a Form EE-12 letter, accompanied by Form EN-12 enclosure, to each covered Part E employee who receives medical benefits under Part E for a covered illness. These forms are sent on the one-year anniversary of the latest award of any type of Part E benefits, and every year thereafter in which the employee continues to receive medical benefits. The employee must complete and return the EN-12 questionnaire within 30 days.

If the employee does not return the completed form within 30 days, the CE attempts to verify the employee's contact information in the case file. The CE sends another Form EE/EN-12 and provides the employee with an additional 30 days in which to respond. If the employee does not respond within 30 days, the CE may consider suspending benefits.

Upon receipt of a completed Form EN-12 from an employee, the CE reviews the employee's responses and takes the appropriate action as noted below.

a. Change of Address. If the employee lists a new address or telephone number, the CE notes the new information in the case file. The CE also ensures that the new contact information is reflected in ECS.

b. Treatment Concerns. If the employee identifies concerns about the treatment that he or she is receiving for a covered illness, the CE acknowledges these concerns by letter and advises that they are being referred to the appropriate person for further action.

c. Additional Impairment or Wage-Loss. If the employee indicates that he or she wishes to claim additional Part E compensation due to increased permanent impairment as a result of an accepted covered illness, or additional compensation for another calendar year of qualifying wage-loss, the CE follows established procedures for facilitating these claims.

d. SWC. If the employee indicates that he or she has filed for or received SWC benefits after the receipt of an award of Part E benefits, the CE ensures that the employee provides all the requested information concerning the SWC benefits filed for or received.

e. Tort Awards or Settlements. If the employee indicates that since receiving an award of benefits under Part E, he or she has received a tort award or settlement (other than for a claim for SWC) in connection with a lawsuit alleging exposure to a toxic substance for which the Part E award was received, the CE ensures that the employee provides all the requested information concerning the tort award or settlement.

4. NO Responsibilities. At the beginning of each fiscal year, the NO FO sends a Form EN-13 information request to each state's workers' compensation authority advising of the requirement under the EEOICPA that any SWC benefits received by a covered Part E employee for an accepted covered illness must be coordinated with Part E benefits received for that same illness, and requesting information about workers' compensation benefits paid to employees who have been awarded Part E benefits.

Upon receipt from the states, the NO FO must coordinate with each DO FO to reassess any need to evaluate a particular claim for coordination with information of payment of SWC benefits.

a. Initial Requests. Form EE-13 lists employees who worked at DOE facilities in the state in question whose claims for compensation under Part E were accepted during the 12 months preceding issuance of the Form EE-13. For each employee, the list contains the following information:

(1) Name(s) of the claimant(s);

(2) Whether the claimant is the employee or the employee's survivor;

(3) SSN of the employee;

(4) Employee's accepted medical condition; and

(5) Date the claimant's eligibility for Part E benefits began.

For each employee listed, the state agency is asked to provide information about any SWC claim(s) that was filed on behalf of the same worker, including the name(s) of the claimant(s), whether the claim was accepted, and, if so, the medical condition accepted and the effective date of the award.

b. Subsequent Requests. Form EE-13 also contains a second list of employees for whom information has already been requested by a prior Form EE-13. For each employee on the second list, the state agency will be asked to indicate whether any information provided in response to the initial request has changed.

CHAPTER 35 – OVERPAYMENT PROCESS

1. Purpose and Scope. This chapter describes how the OWCP, through the DEEOIC, identifies, evaluates, provides notification of, waives, issues FDs regarding, and recovers overpayments under both Parts B and E of the EEOICPA.

2. Legislative Authority and Directives. The instructions in this part of the PM derive from the following regulations and authority:

a. The EEOICPA at 42 U.S.C. 7385j-2 authorizes the Secretary of Labor to recover because of an error of fact or law, except when an incorrect payment has been made to an individual who is without fault and the adjustment or recovery would defeat the purpose of the EEOICPA or would be against equity and good conscience. With respect to recovery, the EEOICPA authorizes DEEOIC (as designee of the Secretary of Labor) to recover the overpayment pursuant to regulations prescribed by the Secretary.

b. Public Law 89-508 [Federal Claims Collection Act of 1966 (80 Stat. 308), amended by Public Law 900-904 (2000)], assigns the Secretary responsibility for the collection of debts arising from the activities of the DOL. It also provides the authority to compromise, terminate, or suspend collection action on debts not in excess of $100,000 (exclusive of interest, penalties, and administrative costs and after partial payments have been deducted). In such cases, there must be no indication of fraud, and it must appear that:

(1) The debtor is unable to pay the full amount within a reasonable period of time, as verified through credit reports or other financial information;

(2) The Government is unable to collect the debt in full within a reasonable time by enforced collection proceedings;

(3) The cost of collecting the debt does not justify the enforced collection of the full amount; or

(4) There is significant doubt concerning the Government's ability to prove its case in court.

The Department of Labor Manual Series (DLMS) 6, Chapter 1100, Debt Management, provides that DOL Agency Heads are delegated the authority to compromise, suspend or terminate collection action on debts stemming from program activities not in excess of $100,000, and that Agency Heads may re-delegate this authority to officials in their agencies with approval of the Chief Financial Officer. DLMS6-1111b (1),c (2).

c. Public Law 97-365 (Debt Collection Act of 1982) amended several statutes, including the Federal Claims Collection Act of 1966. The Debt Collection Act authorizes Federal agencies to collect certain charges on outstanding debts, to use salary offset or administrative offset to collect claims and to use the services of

private collection agencies. (Note: The Federal Claims Collection Act of 1966 as amended by the Debt Collection Act of 1982 has been codified as 31 USC 900-904.)

d. Public Law 104-134 (Debt Collection Improvement Act of 1996) also amended several statutes, including the Debt Collection Act of 1982. The Debt Collection Improvement Act provides that any non-tax debt or claim owed to the United States that has been delinquent for a period of 180 days be turned over to the Secretary of the Treasury, who will determine whether to collect or terminate collection actions on the debt or claim.

e. 31 CFR Parts 900-904 (Federal Claims Collection Standards) describes standards for the collection and compromise of debts, termination of agency collection, and referral of civil claims to the DOJ. In particular, 31 CFR 902.1(b) and 903.1(b) provide that the DOJ has the exclusive authority to compromise, suspend or terminate claims in excess of $100,000, exclusive of interest, penalties and administrative costs. Consequently, even if DEEOIC believes that compromise, suspension or termination of recovery of such a debt is appropriate, the matter must be referred to the DOJ for determination.

f. 31 CFR Part 285 includes the provisions for transferring delinquent debts to the Department of the Treasury for collection.

g. In a case involving fraud on the part of the debtor or any other party having an interest in the claim, 31 CFR 900.3(a) provides that only DOJ has authority to compromise, suspend, or terminate collection action on such claims.

h. In cases that have been referred to the Office of the Inspector General (OIG) or the U.S. Attorney for reasons other than collection of the debt, the Policy Analyst (PA) will advise OIG before collection action is initiated in order to evaluate whether collection action would jeopardize an ongoing investigation or a legal action in progress.

3. Definition of Overpayment. An overpayment is any amount of compensation paid under 42 U.S.C. §§ 7384s, 7384t, 7384u, 7385s-2 or 7385s-3 to a recipient that, at the time of payment, is paid where no amount is payable or where payment exceeds the correct amount of compensation determined by DEEOIC.

4. Notification of EEOICPA Payment. Upon publication of a FD by the FAB that awards lump-sum compensation, designated payees receive notification of the allotted compensation payable. The FAB provides reference to payable amounts in the FD, along with sending Form EN-20 Acceptance of Payment to each payee specifying the amount of payable lump-sum compensation. To process the allocated lump-sum compensation for payment, a payee must provide necessary information on the EN-20, including bank routing and account numbers, to permit DEEOIC to process a payment. Payee signs and dates the form. Payments processed by DEEOIC direct money to a payee's designated checking or savings account via EFT, or in some unique situations with issuance of a paper check. With EFT or paper check, the deposit of payable funds into an account or negotiation of a paper check, is considered due notice of

payment absent affirmative evidence to the contrary. In the case of any improper payment received by either a claimant or other party, including survivors of deceased payees, estates, or joint-account holders, the party in receipt of the funds is to notify DEEOIC immediately.

When the FAB issues a FD accepting a medical condition, it also awards the payment of medical bills for that condition. The FAB may also issue a FD that awards only the payment of medical bills for an accepted condition.

5. Recovery of Funds. Upon receipt of information that suggests a payment processed by DEEOIC is in error or some other circumstances where the paid claimant is no longer entitled to the funds, DO or FAB staff is to bring the matter to the attention of the DO FO. This includes, but is not limited to, the incorrect amount paid; death of the employee prior to time of payment; or a person who has a joint bank account with a deceased claimant and withdraws EEOICPA funds prior to recovery of the funds. Chapter 32 – Coordinating State Workers' Compensation Benefits states that the DO FO will attempt recovery of the improperly paid funds. The DO FO will attempt recovery of the funds as follows:

a. Recoupment of EFT payment.

b. Stop payment of paper check.

c. Request the person in receipt of the funds to return the money.

If the DO FO is unsuccessful in recouping the funds, the DO will refer the claim to the NO.

6. Referral to NO. When a potential overpayment or debt is identified and the DO cannot recover the funds, the matter is referred to the DO Chief of Operations (COP) or FAB Manager for review. If the COP or FAB manager agrees that a potential overpayment or debt exists, he or she is to have a memorandum prepared to the attention of the Branch Chief for the Policy Branch describing the circumstances of the matter, including a description of any information relating to the overpayment or debt that may be helpful in recovery of the funds. Important details to include in the memorandum are the name of the individuals associated with the overpaid funds, any efforts taken to recover funds, descriptions of related communications or phone calls, or any other information as to the status of the overpayment or debt. Authority to issue overpayment decisions rests solely with the Policy Branch.

7. Identifying Overpayments. Overpayments occur whenever a payee or other party is in receipt of lump-sum compensation or payment of medical bills exceeding that for which they are entitled, and Treasury or DEEOIC could not recoup the overpaid funds through recovery effort as outlined in paragraph 5. Overpayment liability is the responsibility of anyone who is in receipt of funds to which they are not entitled under the EEOICPA.

a. Establishment of an overpayment. Overpayments can occur for a variety of reasons. Once FAB issues a FD and a named payee receives lump-sum compensation for a claim, evidence may later arise that requires action to vacate the decision through the issuance of a Director's Order. This can occur to correct a deficiency or to respond to new evidence. Once claim adjudication results in the publication of a new FD for the same claim, and the new payable lump-sum

compensation is less then what was previously paid to the payee, DEEOIC has to find that an overpayment exists. DEEOIC cannot establish an overpayment until the new FD concluding the correct entitlement to a payee is issued. The most frequent reasons for overpayments include the following:

(1) A claimant was paid compensation in error. This might result when the FAB issues a FD based on inaccurate or incomplete factual evidence. For example, a claimant received compensation, but the DEEOIC later discovered that the employee worked at a different location than previously established.

(2) The required tort offset or coordination with SWC benefits was either improperly applied or never applied. For example, a claimant does not notify the DO that he or she received SWC or money from a tort settlement. The DEEOIC then awards the claimant compensation without coordinating (offsetting) lump-sum compensation properly.

(3) A lump-sum award requires adjustment because additional eligible survivors emerge after payment of compensation. This results in an overpayment to the original eligible payee(s). For example, an eligible child of a deceased employee is awarded survivor benefits. The DO was not aware of additional survivors and awards the survivor the full amount of benefits available. Thereafter, another eligible child of the employee files a claim. The compensation must now be shared, and the original claimant is overpaid.

(4) A claimant dies after FAB awards compensation, but before receipt of the funds. For example, a survivor receives a FD, and DEEOIC issues a payment to the survivor's account. However, several days after the deposit, DEEOIC receives information showing that the survivor passed away before the payment was processed. As a payee is required by law to be alive at time of payment, the paid funds are now considered not due and must be returned to DEEOIC.

8. Review and Initial Notification. The PA reviews the overpayment memorandum from the DO or FAB, and all available evidence to verify the existence of an overpayment. The PA then calculates the exact amount of the overpayment.

a. Administrative Write-Off. If the amount of the overpaid funds is equal to or less than $2,500, the PA does not prepare an initial notice to the claimant. Rather, the PA recommends administrative write-off, regardless of the claimant's fault, since the cost of recovery action will exceed the expected recovery amount. The PA prepares a brief memorandum to the Unit Chief describing the reasons for the write-off.

Once the Unit Chief approves an administrative write-off, the PA prepares a memorandum to file. Exhibit 35-1 is a sample memorandum to file for this process. The PA writes off the overpaid amount without giving notice of the

overpaid funds to that claimant. Because an overpayment decision is not issued, it is not an official overpayment. Therefore, the PA does not enter it into the overpayment database or report it on the Treasury Report on Receivables (TROR). The PA enters the details of the administrative write-off into the administrative write-off spreadsheet located in the Policies and Procedures / Overpayments folder in the shared directory.

b. Determination of Fault. Once an overpayment is established, the PA determines whether the claimant bears any fault in the creation of the overpayment. The determination of fault depends on the circumstances surrounding the overpayment. The claimant must show good faith, and exercise a high degree of care in reporting events which may affect entitlement to or the amount of benefits. The degree of care may vary with the complexity of circumstances and a claimant's capacity to realize an overpayment has occurred. While this is not an exhaustive list, the following can be construed as fault in creating an overpayment:

(1) Claimant made an incorrect statement as to a material fact he or she knew or should have known to be incorrect.

(2) Claimant failed to provide information he or she knew or should have known to be material in nature.

(3) Claimant accepted payment that he or she knew or should have known to be incorrect.

c. Initial Notification. Initial notification to the overpaid claimant is required before DEEOIC can take any final action to recover an overpayment or adjust benefits. The PA prepares and signs a letter informing the claimant of the overpayment and the preliminary findings. The Unit Chief reviews the letter prior to its release. The initial notification includes the Response to Initial Overpayment Notice form and the Overpayment Recovery Questionnaire (Form OWCP-20). Form OWCP-20 is available online or via the DEEOIC shared directory.

The notification letter serves to:

(1) Notify the claimant that an overpayment exists and the exact amount of the overpayment.

(2) Provide the result of the preliminary finding of fault. If the PA makes a preliminary finding that the claimant was at fault in causing the overpayment, the initial notification letter will advise the claimant that DEEOIC cannot grant an overpayment waiver if that finding becomes final.

(3) Advise the claimant of his or her rights. The claimant has 30 days following the date of the overpayment notification letter to invoke rights to:

(a) Request a telephone conference.

(b) Challenge any finding of fault.

(c) Request waiver of recovery of the overpayment.

(d) Present written evidence challenging the existence or amount of the overpayment.

The filing date of the claimant's challenge to the overpayment is determined by the postmark date, or the date the request is received in the office or RC, whichever is the earliest determinable date. This includes the date that the CMR receives a document via the EDP.

Exhibit 35-2 is a sample initial overpayment notification letter used when the claimant is without fault in causing the overpayment. Exhibit 35-3 is a sample initial overpayment notification letter used when the claimant is at fault in causing the overpayment. If a delinquent debt was referred to Treasury, and Treasury obtains a current address upon receipt of a dispute by the claimant, DEEOIC may recall the debt from Treasury. The PA will then resend the overpayment notification to the claimant.

d. Notification of Federal Debt After Claimant's Death. In the event that a payment is processed and DEEOIC receives notification that the payee died prior to receipt of payment, it is the responsibility of the DO FO, in conjunction with the assigned CE, to attempt recovery of the payment. The DO will attempt recovery of the funds as outlined in paragraph 5 above. If a non-claimant is in receipt of EEOICPA compensation and fails to return the money, it is a federal debt and not an overpayment. That person must return the money. An example, this situation can occur when compensation is deposited into a joint bank account after a claimant has died, and the joint account holder withdraws the money. If the DO's attempts to recover the funds are not successful, and the evidence of record identifies the joint account holder's name and address, the DO will transfer the case to the NO for further recovery attempts. The PA will send a demand letter (without appeal rights) to the person requesting the return of the funds. If the person does not respond after 30 days, the PA will send a second and then a third demand letter in 30 day intervals. If the person does not respond within 30 days after the third demand letter, the PA will refer the debt to Treasury for collection. Exhibit 35-4 is a sample demand letter to a non-claimant.

9. Telephone Conferences. When requested by the claimant, the PA holds a telephone conference within 30 days of the date of the request for the conference. The PA also holds telephone conferences in cases where the financial data in the file is not clear or sufficient to make a decision about waiver or repayment.

a. Pre-conference Call. The PA holds a pre-conference call to give the claimant a clear explanation of the purpose and process of the conference and the obligations of all parties, and to schedule a time for the call. During the call, the PA:

(1) Explains the issues that the PA will address during the conference call (i.e., income, expenses, assets, transfer of assets, and liabilities). If a preliminary finding of "at fault" was issued, the PA explains how the decision was made and its implications, and invites the claimant to provide any information that could affect the preliminary determination;

(2) Describes the criteria used to make key decisions in the case (i.e., at fault finding, criteria for waiver, interest charges);

(3) Describes the evidence the claimant needs to collect in preparation for the conference call;

(4) Gives the claimant a chance to ask questions;

(5) Determines the best time for the conference; and

(6) Prepares the pre-conference checklist that verifies that the conference agenda items were discussed. (Exhibit 35-5)

b. During the Conference Call. The PA:

(1) Identifies him or herself;

(2) References the pre-conference call;

(3) States the purpose of the call;

(4) Advises the claimant that he or she will be taking notes and for that reason there will be periodic pauses while he or she is writing;

(5) Describes the specific focus of the call;

(6) Obtains the claimant's acknowledgement that he or she understands what the conference issues are and what the conference is about;

(7) Listens carefully to what is being said;

(8) Probes responses that are too general or not credible, or which conflict exists with other statements given or the evidence of file;

(9) Takes notes complete enough to capture the necessary information; and

(10) Confirms the accuracy of the statements recorded by reading them back to the participant(s) for confirmation.

c. After the Conference. The PA:

(1) Prepares a neutral Memorandum of Conference without findings, describing what transpired during the conference. (See Exhibit 35-6 for a sample Memorandum of Conference.) The language of the memorandum must be clear and non-technical. A sound Memorandum of Conference should:

(a) Identify and describe the issues that were discussed during the conference;

(b) Identify the PA who conducted the conference and who participated in the conference;

(c) Describe the position of DEEOIC and the claimant coming into the conference;

(d) Describe the explanation provided in the conference that is relevant to the issue;

(e) Describe what was said in the conference that is relevant to the issue;

(f) Describe the method used to confirm the accuracy of the information collected during the conference that is recorded in the Memorandum of Conference; and

(g) Describe any agreements reached in the conference.

(2) Sends the Memorandum of Conference to the conference participant(s) for review and comments. Exhibit 35-7 is a sample memorandum cover letter to the claimant. The PA allows 15 days from the date of the letter and memorandum for the claimant to provide comments. After the 15 day period, the PA makes findings on the issues for resolution and documents these findings in the final overpayment decision.

10. Consideration of Overpayment Waiver. When the claimant is not at fault in causing the overpayment, DEEOIC may waive recovery of all or part of an overpayment based on whether the claimant meets the financial criteria as stated in 10.a or 10.b. For further explanation of a partial waiver, see paragraph 10.b(2)(b) Example 2. A determination to waive recovery of an overpayment is based on the PA's review of a fully completed Form OWCP-20 and supporting documentation, and additional documentation or argument submitted by the claimant. Form OWCP-20 is designed to obtain extensive financial information, including income, expenses, and assets.

The burden of proof rests with the claimant to prove the conditions necessary to grant a waiver. The claimant must submit the supporting documentation within the required 30-day time period as stated in the initial overpayment notice or cover letter to the Memorandum of Conference. However, the claimant may request an extension of time when it is necessary to obtain the required documents. If the claimant does not submit the information within the allotted time, the

PA will prepare an overpayment FD denying the waiver. DEEOIC will not grant a waiver once the PA issues an overpayment FD, unless the claimant no longer lives at the address in the DEEOIC record, and did not receive the notification of the overpayment.

There are two types of overpayment waivers under the EEOICPA. The DEEOIC may grant a waiver of recovery of the overpayment if the claimant meets the criteria under "recovery would defeat the purpose of the EEOICPA" or "recovery would violate equity and good conscience." If the claimant does not meet either criterion, DEEOIC will pursue a return of the funds regardless of the fault finding.

a. Recovery Would Defeat the Purpose of the EEOICPA. The DEEOIC will not seek recovery of overpaid funds if that recovery would defeat the purpose of the EEOICPA. To defeat the purpose of the EEOICPA, the PA must find that the claimant requires substantially all current income to meet current ordinary and necessary living expenses and that the claimant's assets do not exceed a specified amount as determined by DEEOIC from data furnished by the Bureau of Labor Statistics (BLS).

When a claimant exceeds the limit for either disposable current income or assets, a basis exists for establishing a reasonable repayment schedule over a reasonable, specified period. It is the claimant's burden to show otherwise by submitting evidence that recovery of the overpayment would cause hardship of a nature sufficient to justify waiver.

(1) The PA determines the claimant's income based upon documents submitted. An individual's total income includes any funds which may reasonably be considered available for his or her use, regardless of the source. A spouse's income will not be considered available to the claimant unless the spouse was living in the household both at the time the overpayment was incurred and at the time waiver is considered. Income to be considered includes, but is not limited to:

(a) Wages and self-employment income.

(b) Government benefits.

(c) Regular payments (rent or pension).

(d) Investment income and alimony or child support payments.

(2) The PA reviews claimed ordinary living expenses. It is the claimant's burden to show that such expenses are reasonable and necessary. An individual is deemed to need substantially all of his or her current income to meet current ordinary and necessary living expenses if monthly income does not exceed monthly expenses by more than $200. The following can be considered as ordinary and necessary living expenses:

(a) Food, clothing, household and personal hygiene supplies, rent, mortgage payments, property taxes, utilities (e.g., electricity, gas, fuel, telephone, water), insurance (e.g., auto, life, accident, and health), vehicle — one or two allowable, expenses for one or two vehicles (e.g., loan payments with the date each will be paid off, gas, oil, maintenance), transportation expenses not included under vehicle expenses, and creditor payments (e.g., credit card debt or other debt made in monthly installments).

(b) Medical, hospitalization and similar expenses not reimbursed by insurance or other sources.

(c) Church and charitable contributions made on a regular basis. This does not include large one-time gifts made after receipt of the preliminary notice of the overpayment.

(d) Miscellaneous expenses (e.g., haircuts, newspapers) not to exceed $200 per month.

If the PA makes a finding that a type of expense is ordinary and necessary, it does not necessarily mean that the amount is ordinary and necessary. The burden is on the claimant to show that the expenses are reasonable and needed for a legitimate purpose.

If the PA determines that the amount of certain expenses is not ordinary and necessary, particularly regarding significant expenses for food, clothing, and vehicles, the PA must state in writing the reasons for the finding. The finding must be supported by rationale, which may include reference to recognized research data (such as current statistics from BLS) that show that the claimant's expenses exceed the average or range of expenses for the general population relevant to the claimant's circumstances.

The PA evaluates only the minimum periodic payment as determined by a creditor. Copies of the claimant's monthly billing for consumer debt will verify the minimum amount.

(3) An individual's assets should not exceed the resource base of $5,500 for an individual or $9,200 for an individual with a spouse or one dependent, plus $1,100 for each additional dependent, based on information from BLS. A spouse's assets will not be considered available to the claimant unless the spouse was living in the household both at the time the overpayment was incurred and at the time waiver is considered.

(a) Liquid assets may include (but are not limited to) cash, the value of stocks, bonds, savings accounts, mutual funds, and certificates of deposit.

(b) Non-liquid assets may include (but are not limited to) the fair market value of an owner's equity in property such as a camper, boat, second home and furnishing/supplies, vehicle(s) (i.e., any vehicles above the two allowed per immediate family), and jewelry.

Assets do not include the value of household furniture (primary residence), clothing, one or two vehicles, a home which the person maintains as the principal family domicile, or income-producing property, if the income from such property has been included in income.

b. Recovery Would Violate Equity and Good Conscience. If the claimant is not entitled to waiver under the "defeat the purpose of the EEOICPA" clause, the PA considers the "against equity and good conscience" clause. Even if the claimant does not raise the "equity and good conscience" reason in the claim for waiver, the PA applies it in his or her analysis nonetheless.

The PA reviews all pertinent financial information to determine if recovery of the overpayment will violate the concept of "equity and good conscience." This clause is divided into two parts, financial hardship and relinquishing a valuable right. To demonstrate such a violation it must be established that either:

(1) Recovery will cause the claimant to experience severe financial hardship. The PA evaluates financial records and compares income with expenses similar to the review conducted under paragraph 10.a to determine if repayment will cause severe financial hardship.

Recovery will be found to be "against equity and good conscience" when an individual who was not entitled to benefits would experience severe financial hardship in attempting to repay the debt. The criteria to be applied in making this determination are the same as those stated above in paragraph 10.a.

(2) The claimant has relinquished a valuable right or changed position for the worse. The PA must review pertinent financial and other evidence to determine either of the following:

(a) Based chiefly or solely on notification of payment, the claimant relinquished a verifiably valuable right and such right cannot be regained (e.g., left a job that cannot be regained, sold a business, retired, or other major life-changing financial decisions). When a claimant gives up a valuable right, his or her current ability to repay is not taken into consideration, as the forfeiture of the right is in itself the grounds for waiver.

For example, after being advised of entitlement to compensation, the claimant resigned his job and withdrew his contributions to his retirement fund, under the assumption that he was entitled to a

lump-sum award of $150,000. Three years later, it was discovered that his award was erroneous. The claimant had lost his retention rights, was unable to get his old job back, and could not secure other employment. Recovery of any of the overpayment would be "against equity and good conscience" in this situation because the individual gave up a valuable right.

(b) A decision was made resulting in a loss that verifiably worsened the claimant's condition, and such decision would not have been made but for the receipt of benefits. The claimant must show that if required to repay the overpayment, he or she would be in a worse position after repayment than would have been the case if the benefits had never been received in the first place.

Converting the overpayment into a different form, such as food, consumer goods, real estate, etc., from which the claimant derived some benefit, is not considered a loss. Converting the overpayment into a different form for the benefit of another person, such as a child or relative, may be considered as a loss if the claimant retains no ownership interest in the proceeds and has no ability to reclaim the proceeds.

Example 1: A claimant received a lump-sum award. Later the entire award is declared to be an overpayment. The claimant contends that he has changed his position for the worse, as he used the entire award to make a down payment on a larger home. The claimant has not met his burden in showing that he changed his position for the worse, since he has not established that he suffered any loss. He has simply converted the money into a different form. Conversion of a liquid asset into real or tangible property does not constitute a loss.

Example 2: A claimant is notified that he is entitled to $30,000. Upon receipt of the money, the claimant signs an application to rent a larger apartment and pays a $2,000 non-refundable deposit. He places the remainder of the award in a savings account. Before the claimant moves in, he is notified that the entire award is an overpayment. As a result, the claimant does not move into the new apartment and forfeits the deposit.

Since the claimant would not have signed an application to rent the apartment without the receipt of benefits, it would be inequitable to recoup the entire $30,000 overpayment. The claimant clearly suffered a $2,000 loss and repayment would put him in a worse position than if he had not received the initial award.

Given that the claimant suffered a $2,000 loss, and not a $30,000 loss, a partial waiver is a legitimate action is this case. The

claimant does not have the money to rent a larger apartment and had no intention of doing so until he received his award. Thus, the claimant relied on DEEOIC's action and it would be inequitable to recover that part of the overpayment. It would not be inequitable to recover that part of the overpayment that the claimant deposited in the bank. However, if the claimant were faced with additional expenditures arising out of the intent to move, those expenses would also be deducted from the overpayment.

Example 3: Suppose a claimant receives a $150,000 award and loaned a relative $25,000 to buy a house before he received notice of an overpayment. Since the claimant has not suffered a loss, equity and good conscience do not require waiving of this $25,000.

However, it would be inequitable to tell the claimant to recall the loan at once (further, the terms may not allow such action), and it would be inequitable to count the $25,000 as currently available assets. The interest the claimant receives on the loan as well as any sum he may receive on the principal should be considered income when determining the claimant's ability to repay the overpayment.

11. Overpayment Decisions. After weighing all the evidence and considering all the circumstances surrounding the overpayment, the PA prepares an overpayment decision. The decision outlines his or her findings, and how recovery of the overpayment is to be pursued, as outlined in this chapter and Chapter 36 – Debt Liquidation. If the decision does not waive the overpayment, the PA signs the decision. Before releasing the decision, the PA sends it to the Unit Chief for review and certification for publication. For overpayment decisions that waive any part of the overpayment, the Unit Chief signs the overpayment decision.

a. First Demand Letter. Where the PA finds that an overpayment debt exists following the initial notification to the claimant, the overpayment decision serves as the first demand letter. The overpayment decision outlines the facts surrounding the overpayment, provides a rationale as to why the overpayment is recoverable, and informs the claimant of the exact amount owed and the collection strategy to be used (i.e., payment in full, monthly payments, or collection from future entitlement).

The decision includes information advising the claimant that he or she has 30 days from the date of issuance of the overpayment decision to resolve the debt. The decision communicates to the claimant that if he or she does not take the necessary steps to resolve the debt within the 30 days, it will become a delinquent debt, and that DEEOIC will refer delinquent debts to Treasury or DOJ for collection. The decision must include the due process requirements outlined by Treasury. Exhibit 35-8 and Exhibit 35-9 are samples of overpayment decision first demand letters.

b. Waiver Approved. If the PA determines that a waiver is warranted under the "defeat the purpose of the EEOICPA" clause, the overpayment decision definitively waives the full amount of the overpayment. (See Exhibit 35-10) No further action is required on the part of the overpaid claimant. The PA will upload the decision in the case file and update the overpayment database. If the PA determines that the claimant meets the criteria under the "violate equity and good conscience" clause, the overpayment decision will advise the claimant regarding whether a full or partial waiver is granted. If a partial waiver is granted, the PA will advise the claimant of the collection steps and rights outlined in 11.a (See Exhibit 35-11).

12. Overpayment Database. When the PA makes a determination that an overpayment exists and sends an initial notice to the claimant, the PA enters the claimant information into the overpayment database. The information in the database includes the employee and claimant identifying information, overpaid amount, dates of notices, status of the debt, and balance of debt. The database is updated whenever the PA completes any action on the debt, records payments received and interest added, or refers the debt to Treasury for collection. The PA does not add interest on the debt once it has been referred to Treasury. The overpayment database is available to PA staff on the DEEOIC shared directory.

13. TROR and Debt Collection Activities. DEEOIC collects data on overpayments beginning with when the PA issues an initial notice to the overpaid claimant. The assigned PA enters overpayment data into the overpayment database. One of the functions of the database is assembling overpayment data for preparation of the TROR. The TROR is prepared quarterly and is based on the fiscal year (October 1 to September 30.) DEEOIC submits the quarterly TROR to OWCP by the seventh day of the month following the end of the fiscal year quarter. OWCP collects the data from all OWCP divisions, and sends the report to Treasury. Treasury has published an instruction booklet on how to prepare the TROR, which is available online.

CHAPTER 36 – DEBT LIQUIDATION

1. Purpose and Scope. The purpose of this chapter is to provide guidance for managing debts, recovery of the debt, compromise, suspension, and termination of debts. Specifically, the chapter contains procedures for collection actions, assessment of charges, waiver of interest, compromise, referral of delinquent debts to the U.S. Department of the Treasury (Treasury), suspension of collection actions of debts, and termination (write-off) of collection of debts.

2. Responsibilities. For cases with a potential overpayment of lump sum compensation, claims staff at the DO and/or FAB must refer the case file, along with a memorandum describing the overpayment, to the Chief of the Policy Branch. A Policy Analyst (PA) then processes and controls the actions taken with regard to evaluation of the overpaid claim. The PA takes preliminary and final actions with respect to issuing demand letters, pursuing collection of the debt, establishing and maintaining accounts receivable actions in the overpayment database, and monitoring the overpayment database to determine if referral to Treasury or termination of collection action may be appropriate.

a. If there is any indication of fraud on the part of the claimant or any other party with an interest in the claim, the PA consults with the SOL to determine appropriate action to be taken which may include referral to the OIG or DOJ. If applicable, the appropriate DEEOIC office will follow the program integrity analyst process.

A case involves fraud if an investigation is ongoing and is likely to lead to an indictment; if an investigation is pending; or if there has been a conviction in connection with the debt claim. Cases where DOJ has declined to seek an indictment or an acquittal has occurred are not considered fraud cases.

3. Management of Debt.

a. Notifying claimant of the debt. An overpayment of compensation does not become a "debt" and is not subject to recoupment until the PA issues a FD on the overpayment (first demand letter) to the claimant, which includes established due process procedures. Until that time, the PA may accept payment against the overpayment, but may not assess any charges or take any action to collect the funds owed by the claimant.

b. Follow-up demand letters. If the claimant does not respond to the first demand letter within 30 days of the date of the letter, or the claimant has responded but failed to agree to a reasonable collection strategy as outlined by the DEEOIC, the overpayment becomes a delinquent debt. The PA sends the claimant a second demand letter. Exhibit 36-1 is a sample of a second demand letter. If the claimant does not respond, or arrange to resolve the overpayment within 30 days of the second demand letter, the PA sends the claimant a third and final demand letter. Exhibit 36- 2 is a sample of a third demand letter.

c. No response to demand letters. If the claimant does not respond to the demand letters, the PA attempts to contact the claimant by telephone. The PA explains

who is calling and refers to the overpayment decision that described the overpayment. The PA asks the claimant to repay the funds in a lump sum. If the claimant cannot pay the full amount in a lump sum, the PA offers to set up an installment repayment plan for the claimant. Based on review of the case file, the PA must be prepared to propose a weekly or monthly installment amount. If the PA can reach an agreement with the claimant on an installment payment plan, the PA prepares a Repayment Agreement. The PA documents the details of the telephone call in ECS.

d. Further action. If the PA is unsuccessful in setting up a repayment plan, or if the claimant does not begin the agreed-upon payments, the PA refers the delinquent debt to Treasury for collection, as explained in Section 8 of this chapter.

e. Request for review of overpayment FD: After the PA has issued an overpayment FD; the claimant is not entitled to challenge that decision. Under DEEOIC's implementing regulations (20 CFR § 30.519(b)), the overpayment decision is not subject to any further administrative review. Exhibit 36-3 is a sample letter advising the claimant that the PA cannot undertake further review of the overpayment.

4. Recovery of Debt. The DEEOIC may employ various means of recovery of the debt after the PA sends the claimant an overpayment FD. The PA is authorized to recover the debt by appropriate collection methods that include repayment of the debt in full, reducing any further compensation payment due currently or in the future (statutory authority 42 U.S.C. 7385j-2), installment payments made by the claimant, or compromise on amounts to be collected. The PA pursues collection strategies in the following order, as appropriate:

a. Repayment in full. Debts are collected in one lump-sum whenever possible. If the claimant cannot pay in this manner, the PA may accept payment in installments.

b. Recovery from compensation entitlement. If the claimant does not refund the overpayment, and is entitled to additional compensation (current or in the future), the DEEOIC recovers the overpayment by reducing the compensation due. Collection action cannot begin until after the PA issues a final overpayment decision with an explanation of the recovery method. When the PA is able to recover a debt from subsequent payable compensation, the PA enters the amount collected into the overpayment database. In these scenarios, if a balance remains on the debt, the PA applies other collection strategies to recoup the balance due.

c. Installment payments and repayment agreement. If the claimant cannot repay the debt in full, the claimant is encouraged to enter into a Repayment Agreement to pay the debt in installments. The PA reviews the claimant's financial documents to determine a reasonable amount for regular payments. The PA takes into consideration the amount of the debt and the claimant's ability to repay. The PA should maximize the installment amount on any debt without severely curtailing funds available to a claimant to cover necessary living expenses. After the claimant and DEEOIC agree on the terms, the PA prepares a Repayment

Agreement and sends it to the claimant for signature. When the claimant returns the signed and dated Agreement, the Policy Unit Chief reviews the Agreement and determines if it is acceptable. If acceptable, the Policy Unit Chief signs and dates the Agreement. The PA sends the claimant a signed copy of the Agreement. The Agreement constitutes a legally enforceable agreement. The PA enters the Agreement date and each installment payment into the overpayment database. Exhibit 36-4 is a sample Repayment Agreement with a cover letter. The PA sends the claimant an annual status letter pertaining to the payments received, interest accrued, and the balance of the debt. Exhibit 36-5 is a sample repayment status letter. In assessing a claimant's financial circumstances for a Repayment Agreement, the PA considers several factors:

(1) Claimant's financial information. The PA evaluates the claimant's income, expenses, and assets for repayment ability. This information should include Form OWCP-20 and supporting documentation.

If detailed information about the claimant's financial status is not in the case file, the PA obtains the information. The PA may accept voluntary installment payments until detailed financial information becomes available.

The PA should not send the claimant a formal Repayment Agreement, consider waiver of charges, or compromise of principal until the claimant provides the documentation that clearly establishes his or her financial status for repayment of the debt. Failure of a claimant to provide this information could result in an action to refer the debt to Treasury for collection of the debt.

(2) Schedule of payments. The DOL's regulations concerning debt collection recommend that debt repayment be scheduled to recover the entire amount (including any interest or penalties) in three years. However, recovery in three years may not be practical if the claimant does not have appreciable income [29 CFR § 20.33(a)]. If the claimant requests a change in an Agreement already established, the PA evaluates the proposed repayment plan for reasonableness given the claimant's current financial status.

(3) Unreasonably small payments. If the claimant proposes installment payments in amounts so small that the debt will never be repaid, or will be repaid in an unreasonably long period (such that the claimant will become a "perpetual debtor"), the PA is to reject the proposal.

5. Assessment of Charges. The Debt Collection Act of 1982 authorizes the assessment of interest, administrative costs, and penalties on delinquent debts.

a. Interest. Interest begins accruing on the debt on the date the PA sends the claimant the overpayment FD (first demand letter). The PA calculates interest at the rate in effect on the date of the FD. The rate of interest assessed shall be the rate of the current value of funds to the Treasury as

published in the Federal Register. The Treasury Current Value of Funds Rate is posted annually on Treasury's website.

b. Court Order. In cases of court-ordered restitution, the Court Order takes precedence over the Debt Collection Act. Unless stipulated in the Court Order, charges may not be assessed on the part of the debt corresponding to the restitution amount set by the court.

6. Waiver of Interest Charges. Interest charges may be waived under three circumstances. Waiver of interest charges is mandatory under the provisions outlined in subparagraphs a and b below, and discretionary under the provisions outlined in subparagraph c below.

a. Full Payment Within 30 Days. If the principal is repaid in full within 30 days of the overpayment FD, the interest is waived. The PA may allow one additional 30-day period on a case-by-case basis for good cause shown. Acceptable reasons for the 30-day extension include (but are not limited to) situations where the claimant needs the additional time to liquidate assets or arrange financing to pay the debt, or where the claimant did not receive the FD in a timely manner (e.g., because of absence from home due to vacation or other sufficient reason).

b. Claimant Without Fault. Where the claimant is without fault in the creation of the debt and a repayment agreement has been established, interest charges are waived if:

(1) The monthly payment is so small that it does not cover the interest, or

(2) There is so little left after interest that the debt will not be paid off within the lifetime of the claimant as determined by actuarial tables.

The PA determines whether he or she can waive charges under this provision by completing the Waiver of Charges Worksheet. Exhibit 36-6 is a sample Worksheet.

If the claimant should later default on the repayment agreement, interest charges will again apply beginning with the date of default on the repayment agreement.

c. Cost of Recovery Exceeds Accrued Interest. The PA may waive interest charges if the full amount of the principal is repaid after interest charges have accrued, and the additional cost of recovering the interest is greater than the amount accrued.

7. Compromise. A compromise is an administrative means of disposing of a debt by accepting a partial settlement. A compromise differs from waiver of recovery of an overpayment in that a waiver is a formal decision negating the overpayment before it becomes a debt. The claimant has no legal right to settlement of a debt by compromise. Also, unlike a waiver, the claimant need not be without fault for compromise to be considered.

a. Reasons to Consider Compromise of a Debt.

(1) Compromise Due to Legal Issues. The PA may compromise a debt if the SOL notifies the PA that significant doubt exists as to whether the DEEOIC can establish its claim in court, and the claimant has offered partial repayment. This may occur because of a dispute about the law or facts of the case. However, the PA does not make a judgment about legal enforceability without the SOL's specific advice after review of the case.

(2) Compromise to Limit Repayment Period. Compromise to limit the repayment period may be necessary if the claimant is unable pay the full amount within a reasonable time due to financial hardship or based on life expectancy. In determining inability to pay, the PA may consider:

(a) The age and health of the claimant;

(b) Current and potential income;

(c) Inheritance prospects;

(d) The possibility that the claimant has concealed or transferred assets to avoid recoupment;

(e) The availability of assets or income for enforced collection.

b. The PA uses a specific mathematical formula to determine the amount to be compromised. The PA reviews the amount of the principal, monthly payment, and interest rate to determine whether compromise of accrued charges and/or principal is required. Divide the current principal balance (plus any accrued charges) by the monthly payment and multiply the result by the annual interest rate. If the result is less than 5.5%, no compromise is necessary, and the PA so indicates on the Compromise of Principal Worksheet. If the result is 5.5 or greater, the PA completes the Compromise of Principal Worksheet in its entirety to determine the amount to be compromised. Exhibit 36-7 is a sample of the Worksheet.

c. Types of Compromise.

(1) Compromise of Principal. The PA may consider a compromise of the principal amount of the debt as long as the principal (before compromise) does not exceed $100,000, and there is no indication of fraud. If the PA determines, by review of detailed financial information, that the maximum amount the claimant can afford per installment and the period required for repayment of the debt at this rate is extended by more than 35% due to the application of the charges, then the amount of the principal must be compromised so that the period required for repayment of the debt is not extended by more than 35%.

(a) Principal Over $100,000. If the principal amount of the debt (before compromise) exceeds $100,000, the case must be referred to DOJ with a recommendation for compromise of the debt. (31 CFR § 902.1.) The PRPU Chief certifies the Compromise of Principal Worksheet, and the Director of the DEEOIC reviews the case for authorization to refer the debt to DOJ. The compromise referral form can be obtained on the DOJ website.

(2) Compromise of additional charges. Compromise for the discharge or reduction of additional charges is different from compromise of principal. The PA must consider a compromise of charges in cases where the PA has determined that a certain amount is the most the claimant can afford to repay. Compromise of additional charges is mandatory where the repayment period must be limited. Under this policy, the PA considers a compromise of charges at the time the repayment agreement is established, unless charges are waived.

If the repayment period is sufficiently reduced by compromising only accrued charges, the PRPU Chief certifies the Compromise of Principal Worksheet, and the PA issues a Compromise Order to the claimant, regardless of the principal amount.

(3) Compromise in Consideration of Partial Payment. Regardless of whether it is required under the provisions of this chapter, the PA may consider a compromise as a means of disposing of a debt where collection would be extremely difficult, expensive, or create undue hardship on the claimant. To determine whether repayment would cause hardship, the PA assesses the claimant's financial status. The claimant must submit a current Overpayment Recovery Questionnaire (OWCP-20) if one has not been provided within the previous six months.

(a) Proposal. The claimant may propose that the DEEOIC be satisfied with partial recovery on the debt, or the DEEOIC may propose a compromise to the claimant. For example, compromise might occur if the claimant reported a liquid asset that exceeded the resource base, but was insufficient to cover the debt, and otherwise had only enough income to meet expenses. The compromise would provide for recovery of the amount available and forgiveness of the remainder.

d. Issuing a Compromise Order.

(1) Compromise Memorandum. If the PA finds that compromise is warranted, he or she prepares a memorandum to the PRPU Chief describing the financial circumstances of the claimant, the proposed compromise, and the considerations which led to the compromise recommendation. Exhibit 36-8 is a sample Compromise Memorandum. The PA attaches a Compromise Order for the Unit Chief's signature.

(2) Compromise Order. If compromise is approved by the PRPU Chief, the PA sends the Compromise Order to the claimant. The PA incorporates the information noted in the compromise memorandum into the Order to explain the basis for the compromise to the claimant. Exhibit 36-9 is a sample Compromise Order. The Compromise Order includes:

(a) The amount of each component of the debt (with separate amounts specified for principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable);

(b) The rationale for the determination that the debt cannot be waived;

(c) The rationale for any determination with respect to fraud;

(d) A brief explanation of the rationale for compromise (the Compromise of Principal Worksheet may be incorporated by reference);

(e) The amount to be accepted in full settlement of each component of the debt (with separate amounts specified for principal, accrued administrative costs, accrued penalty, and accrued interest, as applicable);

(f) The time and manner of payment; and

(g) A statement that the debt is not compromised or settled until full payment of the specified amount has been received by DEEOIC.

e. Compromise Approved. When a debt is compromised, the DEEOIC agrees to be satisfied with partial repayment. Even if the claimant's circumstances change, such that the reasons for the compromise are no longer valid, DEEOIC has officially forgiven the remainder of the debt, and will not pursue additional repayment unless the claimant defaults on a repayment agreement. Therefore, compromise should be undertaken only after the PA has a clear and accurate understanding of the claimant's financial circumstances, and ability or inability to repay the debt. The Compromise Order does not carry the right to a hearing.

f. Reporting Compromised Amount to the IRS. At the end of each year, the PA files IRS Form 1099G in cases where the debt has been compromised for reasons other than economic hardship, and a copy of the form is uploaded into the claimant's case file. The PA informs the claimant that such compromised debts will be reported to IRS as income.

g. Compromise Not Approved. If neither principal nor accrued charges are compromised under this provision, the PA files the Compromise of Principal Worksheet in the case file.

8. Referring Delinquent Debts to The U.S. Department of the Treasury. The Debt Collection Improvement Act of 1996, further amended by Public Law 113-101, provides that any non-tax debt or claim owed to the United States that has been delinquent for a period of 120 days be turned over to the Secretary of the Treasury for appropriate action to collect or terminate collection actions on the debt or claim. To facilitate this referral, Treasury has created the Debt Management Services (DMS), a division of the Financial Management Services Branch. The PA refers the debts to DMS via the FedDebt database. When a debt is referred, the DMS oversees all collection activity on the debt. Treasury adds additional charges to the principal and interest as an administrative cost of collection and penalties.

DMS provides government-wide debt collection services through the Cross-Servicing Program and Treasury Offset Program (TOP.) Debts referred for Cross-Servicing are eligible for referral to TOP by DMS. The Cross-Servicing Program includes skip trace services, administrative wage garnishment, referral of debts to the DOJ for litigation, and referral of debts to private collection agencies. TOP involves offsets of payments from a variety of federal programs, including offset of income tax refunds.

The PA must provide notification to the claimant prior to referral of a delinquent debt to DMS. The PA may refer a delinquent debt to Treasury prior to the 120 days as long as the PA has given the required notification to the claimant.

a. Notice to Claimant. At least 60 days prior to referral to Treasury, the PA sends the first demand letter (overpayment FD) advising the claimant that referral for collection action is possible. If the claimant does not respond within 30 days, the PA sends the follow-up demand letters. The demand letters include the required due process language for referring the debt to Treasury. Treasury will not accept debts where such notice has not been given to the claimant. The notice includes the following due process rights provided to the claimant:

(1) Inspect and request copies of records about the debt;

(2) Enter into a mutually agreeable written repayment agreement; and

(3) Request review of the amount of the debt, its past-due status, and whether the debt is legally enforceable.

b. Debt and Transaction Tracking. DMS tracks all debts and payments using FedDebt, which allows DMS to process debts as follows:

(1) Send a demand letter to each debtor;

(2) Process several debts for the same debtor and create multiple payment agreements for a debt;

(3) Record transactions, including how payments are applied (i.e., administrative fees, penalties, interest and principal);

(4) Allows users to update debt and/or debtor information, or recall a debt.

c. Credit Bureaus. The demand letters that the PA sends to the claimant inform him or her that Treasury may refer debts to credit bureaus. Under the Debt Collection Act of 1982, claimants whose accounts become delinquent are subject to reporting to private credit reporting bureaus.

d. Claimant files dispute with Treasury. If a claimant files a dispute with Treasury, Treasury will send the dispute to the PA. The PA must send a response to Treasury.

e. The PA can access the FedDebt System to track the status of the debt.

f. Debts not eligible for referral to Treasury. Treasury will not accept debts that are not final, covered by bankruptcy, already in private collection, in litigation, or with DOJ.

g. Return of debt. Treasury may return a debt to the DEEOIC if it has been collected in full, found to be uncollectible, covered by a bankruptcy filing, a compromise has been reached, or the claimant filed a dispute with Treasury and the circumstances require returning the debt to DEEOIC. Returned debts are sent to the PA for further action as necessary.

h. Referral to the DOJ. A component of Treasury's Cross Servicing program is referral of uncollected debts to DOJ for litigating, compromising, suspending and terminating collection.

(1) While the DOJ is considering a case, the PA keeps the debt open and annotates it as referred to DOJ.

(2) When collecting a debt under a DOJ agreement, the DEEOIC cannot charge interest or send billing notices.

(3) The PA Writes Off the debt when notified by DOJ that it will not take further action.

i. Interest on debt after referral. Once the PA refers a debt to Treasury, DEEOIC does not add additional interest to the debt. Treasury controls the debt. The principal and interest that was referred to Treasury is the amount DEEOIC uses for reporting purposes.

j. Administrative costs. When a debt is found to be delinquent and is referred to Treasury for collection, Treasury adds additional charges to the principal and interest as an administrative cost of collection and penalties.

9. Termination or Suspension of Collection Action of Debts. The DEEOIC may terminate or suspend the collection action of certain debts. If the principal amount of a debt exceeds $100,000, exclusive of interest, penalties, and administrative costs, the authority to terminate or suspend rests solely with DOJ. (31 CFR § 903.1.)

a. Termination of Collection Action. Cases in which collection is not likely to succeed are terminated. They include debts that have been returned by Treasury, situations where the claimant appears to have no assets or income which could be attached by a court; where the claimant's financial circumstances are such that hardship would result from recoupment; or where the SOL or the U.S. Attorney's Office states that the DEEOIC has a poor legal case against the debtor. When collection action is terminated, the PA enters the amount written off in the overpayment database, and closes the debt. Termination of collection action, or the "write-off" of a bad debt, is an administrative action which differs from waiver or compromise. Termination of collection action does not forgive the debt, since the DEEOIC may collect it at a later date. Generally, however, once a debt has been written off, collection actions are never resumed.

If the principal amount of the debt does not exceed $100,000, and there is no indication of fraud, the PA prepares a memorandum regarding termination of collection action where collection actions have brought no results. In the memorandum, the PA states the nature and amount of the debt, the efforts made to collect it, and the financial circumstances of the claimant, explaining why termination of collection action is warranted. The PRPU Chief signs the memorandum. If the principal amount of the debt exceeds $100,000, the DEEOIC refers the debt to DOJ with a recommendation to write-off the debt.

(1) Form 1099G. Depending on the location of the debt, either DEEOIC or Treasury files IRS Form 1099G for any debt written off for reasons other than economic hardship. The PA uploads a copy of the form into the case file and updates the overpayment database. DEEOIC may not collect the debt at a later date.

b. Suspension of Collection Action. Occasionally a claimant may ask that the debt be forgiven due to financial hardship. The PA may suspend collection action because of financial hardship, but reserves the right to resume collection action in the event of future claims or a change in the claimant's circumstances. Exhibit 36-10 is a sample letter advising a claimant of this action.

10. Recovery From Deceased Claimant's Estate. If the claimant dies before the debt is recovered, the PA reviews the case file to obtain information about the estate. Prompt action is essential because creditors who have not properly asserted a claim before the estate is closed may be precluded from any recovery. The PA follows the procedures outlines in Chapter 34 – Overpayment Process to recover the debt from the estate. The PA takes action to recover both established and newly discovered debts from an estate. However, once the estate is closed and the proceeds distributed, the PA must terminate collection efforts, as no other recourse exists to collect the debt. The PA prepares a memorandum to the file describing the situation and the outstanding debt is noted as unrecoverable. The PA terminates the debt in the overpayment database.

11. Court Ordered Restitution in Fraud Cases. When a claimant has been convicted of filing a false claim which resulted in an overpayment/debt due the government, the court often orders

the defendant/claimant to make restitution to the United States as a condition of probation. The amount of restitution may or may not be the full amount of the debt owed to DEEOIC.

a. "Global Settlement." If the Court Order states that the restitution amount will be in full satisfaction of the debt owed the United States (a "Global Settlement"), the Court Order takes precedence over the DEEOIC's administrative debt collection process.

   In such cases, if the restitution amount is less than the outstanding debt principal balance, the principal balance must be reduced to the restitution amount set by the court. Also, interest may not be applied to such debts unless stipulated in the Court Order. However, if the probation period ends and the claimant fails to make full restitution, the PA pursues collection of the full original debt amount.

b. Other Than "Global Settlement." If the Court Order does not represent a "Global Settlement," the PA continues to pursue collection of the full amount of the debt, taking credit for any restitution amounts received. Unless the Court Order stipulates assessment of interest, interest may not be applied to the restitution amount and any restitution payments received should be applied directly to the debt principal.

   In criminal cases, DEEOIC is sometimes asked to assist the DOJ in calculating the loss to the government in accordance with federal sentencing guidelines. This may involve calculating how benefits would have been paid if the claimant had fully advised DEEOIC. The PA processes all such requests.

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ABBREVIATIONS

Common abbreviations for EEOICPA terms are as follows:

AAW	Average Annual Wage
AMA's Guides	American Medical Association's Guides to the Evaluation of Permanent Impairment, 5th Edition
ANRSD	Amended NIOSH Referral Summary Document
AWE	Atomic Weapons Employer
BAS	Branch of Automated Data Processing Systems
BOTA	Branch of Outreach and Technical Assistance
BPA	Bill Processing Agent
CBD	Chronic Beryllium Disease
CDC	Centers for Disease Control
CE	Claims Examiner
CIS	Carcinoma in situ
CLL	Chronic Lymphocytic Leukemia
CMC	Contract Medical Consultant
CPT Code	Current Procedural Terminology
CCRT	The Center for Construction Research and Training (formerly The Center to Protect Workers' Rights)
DAR	Document Acquisition Request
DD	District Director
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DME	Durable Medical Equipment
DO	District Office
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
DR	Dose Reconstruction
DRGs	Diagnostic-Related Groups
ECS	Energy Compensation System
EDP	Energy Document Portal
EEOICP	Energy Employees Occupational Illness Compensation Program
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FAB	Final Adjudication Branch
FD	Final Decision
FECA	Federal Employees' Compensation Act
FO	Fiscal Officer
FOIA	Freedom of Information Act
FY	Fiscal Year
GPO	Government Printing Office
GPRA	Government Performance Results Act
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services

HP	Health Physicist
ICD	International Classification of Disease
IH	Industrial Hygienist
MHSU	Medical, Health & Science Unit
MMI	Maximum Medical Improvement
NCI	National Cancer Institute
NDC number	National Drug Code
NIOSH	National Institute for Occupational Safety and Health
NIOSH - IREP	NIOSH - Interactive RadioEpidemiological Program
NO	National Office
NRSD	NIOSH Referral Summary Document
OIS	OWCP Imaging System
OMB	Office of Management and Budget
OPM	Office of Personnel Management
ORISE	Oak Ridge Institute for Science and Education
OWCP	Office of Workers Compensation Programs
PCA	Payee Change Assistant
PEP	Program Evaluation Plan
PER	Program Evaluation Report
PII	Personally Identifiable Information
PM	Procedure Manual
POA	Power of Attorney
PoC	Probability of Causation
PTF	Payment Transaction Form
RC	Resource Center
RCC	Revenue Center Code
RD	Recommended Decision
RECA	Radiation Exposure Compensation Act
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SOAF	Statement of Accepted Facts
SOL	Office of the Solicitor
SSA	Social Security Administration
SWC	State Workers' Compensation
TBD	Technical Basis Document
TOX	Toxicologist
UPRP	Units of Policy, Regulations and Procedures
WCA	Workers' Compensation Assistant

FORMS

Below are listed the various forms used within the DEEOIC.

Form EE-1	Claim for Benefits under EEOICPA
Form EE-2	Claim for Survivor Benefits under EEOICPA
Form EE-3	Employment History for Claim under EEOICPA
Form EE-4	Employment History Affidavit for Claim under the EEOICPA
Form EE-5	Department of Energy Response to Employment History for Claim under the EEOICPA
Form EE-7	Medical Requirements under the EEOICPA
Form EE/EN-8	Smoking History Identification under EEOICPA
Form EE/EN-9	Racial/Ethnic Identification under EEOICPA
Form EE-10	Claim for Additional Wage-Loss and/or Impairment under the EEOICPA
Form EE/EN-11A	Impairment Benefits Response Form
Form EE/EN-11B	Wage-Loss Benefits Response Form
Form EE/EN-12	Beneficiary Annual Report Form
Form EE-13/EN-13	Request for Information with Respect to State Workers' Compensation Claims
Form EE/EN-16	Claimant Report Form
Form EE/EN-20	Acceptance of Payment under the EEOICPA
Form DL 1-520	Request under the Freedom of Information Act
Form ESA-67a	Privacy Act Record System Log of Disclosures
Form OWCP-04	Uniform Bill for Medical Expenses
Form OWCP-915	Claim for Medical Reimbursement
Form OWCP-957	Medical Travel Refund Request
Form OWCP-1500	Health Insurance Claim
Form SSA-581	Authorization to Obtain Earnings Data from the SSA

DEEOIC OFFICES

National Office - Washington, D.C.

U.S. Department of Labor, DEEOIC
200 Constitution Avenue, NW
Room C-3321
Washington, DC 20210

(202) 693-0081 (Main)
(202) 693-1465 (Fax)

District Office 1 - Jacksonville, Florida

U.S. Department of Labor, DEEOIC
400 West Bay Street, Room 722
Jacksonville, Florida 32202

(904) 357-4705 (Main)
(877) 336-4272 (Toll Free)
(904) 357-4704 (Fax)

District Office 2 - Cleveland, Ohio

U.S. Department of Labor, DEEOIC
1001 Lakeside Avenue, Suite 350
Cleveland, Ohio 44114

(216) 802-1300 (Main)
(888) 859-7211 (Toll Free)
(216) 802-1308 (Fax)

District Office 3 - Denver, Colorado

U.S. Department of Labor, DEEOIC
One Denver Federal Center
Building 53, Room B1501
Denver, Colorado 80225

(720) 264-3060 (Main)
(888) 805-3389 (Toll Free)
(720) 264-3099 (Fax)

District Office 4 - Seattle, Washington

U.S. Department of Labor, DEEOIC
300 Fifth Avenue, Suite 1050E
Seattle, Washington 98104

(206) 373-6750 (Main)
(888) 805-3401 (Toll Free)
(206) 224-1216 (Fax)

Final Adjudication Branch – Washington, D.C.

Final Adjudication Branch – Washington, D.C.
U.S. Department of Labor, DEEOIC
Final Adjudication Branch (FAB - National)
200 Constitution Avenue, NW
Room C-3305
Washington, DC 20210

(202) 218-6800 (Main)
(866) 538-8143 (Toll Free
(202) 513-6401 (Fax)

Final Adjudication Branch – Jacksonville, Florida

U.S. Department of Labor, DEEOIC
Final Adjudication Branch
400 West Bay Street, Suite 431
Jacksonville, Florida 32202

(904) 366-0397 (Main)
(877) 336-4272 (Toll Free)
(904) 357-4785 (Fax)

Final Adjudication Branch – Cleveland, Ohio

U.S. Department of Labor – DEEOIC
Final Adjudication Branch
1001 Lakeside Avenue, Suite 390
Cleveland, Ohio 44114

(216) 802-1449 (Main)
(888) 859-7211 (Toll Free)
(216) 802-1390 (Fax)

Final Adjudication Branch – Denver, Colorado

U.S. Department of Labor, DEEOIC
Final Adjudication Branch
One Denver Federal Center
Building 53, Room D2212
Denver, Colorado 80225

(720) 264-3062 (Main)
(888) 805-3389 (Toll Free)
(720) 264-3218 (Fax)

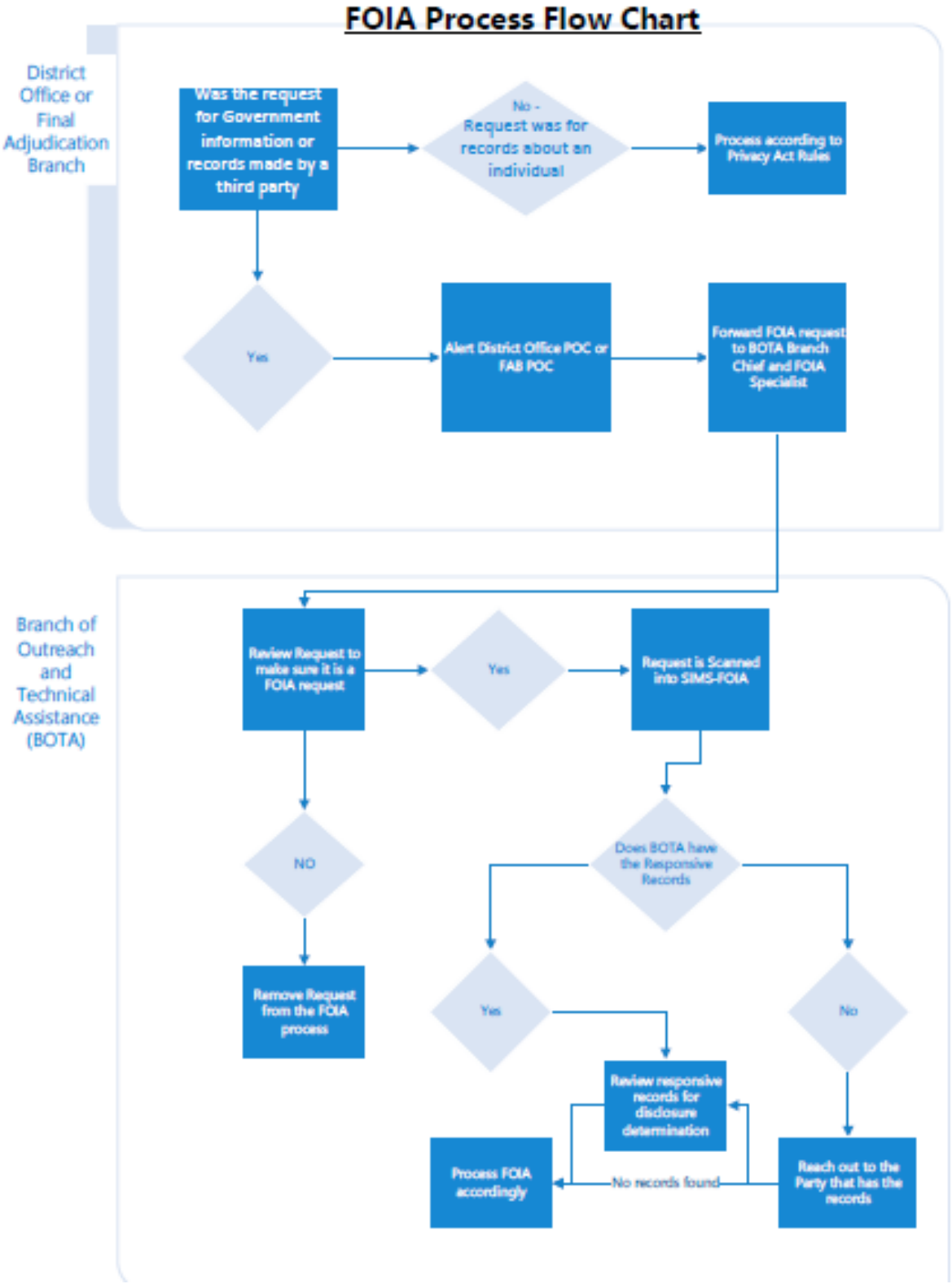
Final Adjudication Branch – Seattle, Washington

U.S. Department of Labor, DEEOIC
Final Adjudication Branch
300 Fifth Avenue, Suite 1050
Seattle, Washington 98104

(206) 373-6714 (Main)
(888) 805-3401 (Toll Free)
(206) 224-2506 (Fax)

DEEOIC References and Resources

- Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, 42 U.S.C. § 7384 et seq.
- CFR Parts 1 and 30 (Regulations) – Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, issued December 29, 2006.
- Executive Order 13179, signed December 7, 2000.
- Federal EEOICPA PM.
- Bulletins, Circulars and Program Memoranda.
- Guides to the Evaluation of Permanent Impairment, 5th Edition, American Medical Association.
- ICD9/10 coding manuals or online resources.
- NIOSH Regulations on dose reconstruction and probability of causation (42 CFR Parts 81 and 82, Guidelines for Determining the Probability of Causation and Methods for Radiation Dose
- Reconstruction Under the Employees Occupational Illness Compensation Program Act of 2000; Final Rules).
- The Federal Register publications listing covered facilities.
- User's Guide for the Interactive RadioEpidemiological Program (NIOSH-IREP).
- Interagency contacts or website links
- Shared Drive maintained by the NO.
- SEM.
- ECS User Guide and procedures
- OIS User Guide and indexing guidance


FOIA Process Flow Chart
District Office or Final Adjudication Branch
Was the request for Government information or records made by a third party
No - Request was for records about an individual
Process according to Privacy Act Rules
Yes
Alert District Office POC or FAB POC
Forward FOIA request to BOTA Branch Chief and FOIA Specialist
Branch of Outreach and Technical Assistance (BOTA)
Review Request to make sure it is a FOIA request
Yes
Request is Scanned into SIMS-FOIA
NO
Does BOTA have the Responsive Records
Remove Request from the FOIA process
Yes
No
Review responsive records for disclosure determination
Process FOIA accordingly
No records found
Reach out to the Party that has the records

Data Release Form

FOR ALL FILE COPY REQUESTS: This form must be completed and placed on the spindle in the claim file.

Employee Name: _____

File Number: _____

Assigned Claims Examiner: _____

Date of Request for File Copy:_____

Name of Requestor: _____

File Copy to be Sent to: _____

Initial Reviewer Name: _____

Initial Review Date: _____

Final Reviewer Name: _____

Final Review Date: _____

I have carefully reviewed the documents and/or electronic media being sent pursuant to this claimant request for a copy of file documents. To the best of my knowledge these documents and/or electronic media do not contain Personally Identifiable Information (PII) of other individuals aside from the requestor or any PII that has been redacted.

_____ _____
(CE, FAB, or NO Representative) (Date)

_____ _____
(Final Reviewer) (Date)

USPS Postmaster Address Request Letter

Postmaster Date:
City, State, Zip Code-9998

Dear Postmaster:

Address Information Request

Please furnish this agency with the new address, if available, for the following individual or verify whether or not the address given below is one at which mail for this individual is currently being delivered. If the following address is a post office box, please furnish the street address as recorded on the box-holder's application form.

Full Name: Claimant/Authorized Representative

Last Known Address: Number/Street Name
City, State, Zip Code

I certify that the address information for this individual is required for the performance of this agency's official duties.

_____
Signature of Agency Official

_____
Title

* *

FOR POST OFFICE USE ONLY

___ Mail is delivered to address given
___ Not known at address given
___ Moved, left no forwarding address
___ No such address
___ Other: (Specify) _____
_____
_____
_____
_____

New Address:
_____
_____
_____

Box Holder's Street Address:
_____
_____
_____

USPS Return Address: Postmark/Date Stamp

As per 39 USC 404…"the USPS does not disclose mailing information except in the following limited circumstances; Authorized disclosures include limited circumstances such as the following: (a) to other government agencies or bodies: when relevant to a decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or benefits"…

The correspondence in question fits within the aforementioned parameters and our agency is requesting the aforementioned information as formatted in the USPS Administrative Support Manual Section 352.44. Please respond to our office via return mail or fax with the aforementioned postal patron's new address/contact information.

If you have any questions regarding this letter, please call me at XXX-XXX-XXXX

Physical Address: US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

Sincerely,

[Name]
[Title]

Occupational History Interview

Energy Employees Occupational Illness Compensation Program Act (EEOICPA)
Occupational History Questionnaire (OHQ)

Section 1

Employee last 4 digits of SSN (SSN4)	xx-xxx-1234
Employee Name	Joseph E. Claimant
DOL District Office	Cleveland
Interview begun (date/time)	2020-07-31 10:07:00.0
Interviewer (ID) Name	Reggie C. Center
Interviewee Name	Joseph E. Claimant
Relationship To Employee?	Self
Consent To Interview?	Y e s
Interviewee is a survivor of the claimant?	N o

Section 2: DOE FORMER WORKER SCREENING PROGRAM

In Screening Program?	Y e s

Screening Program	Worker Population
Fernald (production or construction)	X - Production

Section 3: NON-DOE WORK HISTORY

Non-DOE Employer	Job Title / Description	Start Date	End date
Claimant stated that he worked for the City of Miamisburg, OH in the Municipal Water Department before starting at Fernald. .	Read meters. Marked City utility lines before construction work around them.	1950	1952
United States Armed Forces (Air Force)	Airman E-3 Aircraft maintenance	1948	1950

Section 4(A): DOE FACILITY

DOE or RECA Facility

Federal Materials Production Center (Fernald)

Unknown, Uncertain or *any* RECA Facility:

Section 4(B): EMPLOYERS

Name of Employer	Start Date	End date
National Lead	1956	1969

Section 4(C): UNION AFFILIATION

Is Union Member?	Y e s

Union

International Chemical Workers Union Council

Section 4(D): LABOR CATEGORY (While employed at a DOE Facility)

Actual Labor Category	Approximate dates of Employment
Laborer	1952-1954
Chemical Operator	1954-1969

Section 4(E):

Information for each job title from Section 4D	Frequency
Area, Facility, Building Number/Name or Description; Work Activity; Labor Category / Job Title; Toxins / Agents; Personal Protective Equipment (PPE) Years of Employment	Defined as Rarely: less than once per month Monthly: 1-2 times per month Daily: Daily or almost every day.

Laborer (1952 - 1954): Claimant stated that when he first started at Fernald he was a Laborer. He said the plant was still in startup mode and that he and many other workers were hired as laborers and then given the opportunity to move into better jobs as they got experience on the site. He said he worked mostly in Plant 6 Fabrication Building where he helped Machinists, Pipefitters and Millwrights get the large rolling and grinding equipment installed. He said he unpacked hardware, moved equipment and supplies, cleaned oils off equipment, did some janitorial work, went to Stores to get supplies, and helped the crafts as needed. The Claimant stated that he operated forklifts and small cranes. He said that Plant 6 did not start processing uranium metals until late 1953 about 6 months before he left the building. When that work started he said the building was hot due to the preheat furnaces and molten salt baths where the uranium metal was processed. He talked about fumes and smoke coming off the salt baths when the uranium was inserted and removed. He said he recalled the rolling mills being very contaminated and that controls got a lot stricter for clothing and gloves just before he left. He said he did not do processing work but was helping set up equipment nearby. The Claimant said he wore company clothing all the time consisting of cloth coveralls, shoes, safety glasses and work gloves. He said he wore a film badge that was changed out every month and that health physics technicians were in the building regularly to monitor equipment and floors. He said most of the time that he worked on new, clean equipment. The Claimant said he used trichloroethylene to wipe down the new equipment to remove oils and other substances; he said he used rubber gloves but no respirator. He said he recalled his coveralls getting wet from the trichloroethylene when he cleaned oil off some of the larger equipment. He said all the new equipment had oils on them to prevent rusting but he did not know what type oil it was. He talked about fumes from the forklifts being bad, especially in the winter when the building doors were closed.	Daily
Chemical Operator (1954-1969): Claimant stated that he was able to get a better paying job as a chemical operator in 1954. He was a trainee for about three months when he worked with Plant 4 Green Salt Plant chemical operators. He then became a chemical operator in that building. Over the 15 years he spent in the building, he said he performed multiple jobs involved with the production of Green Salt. He said he operated furnaces to convert uranium trioxide to green salt (uranium tetrafluoride). He described the work as being hot and dangerous. He said he was always concerned about leaks in the hydrogen system causing an explosion. He said the furnaces were not air-tight and leaked orange oxide, uranium dioxide, and green salt fumes. He said that he normally did not wear a respirator, but that Health Physics let him keep a respirator handy in case the fumes got too bad. He said he wore it often. He also said how dirty the orange oxide was. It was a powder that came to Plant 4 in hoppers that were then fed into the first furnace. To keep it from plugging, he said he had to stir the powder as it was fed to the furnace by a screw conveyor. He described the black dust from the powder getting on his skin and in his nose. He said respiratory protection was not normally used. He said he also worked on controlling the flow of ammonia that was added to the furnaces to reduce oxide on the surface of the green salt. He noted that the smell of ammonia was always present in the building. He said that his work on the Plant 4 hydrofluorination furnaces was probably the worst job he had at Fernald. The process generated hydrofluoric acid fumes. He said he operated the scrubber process that removed the acid from the fumes and then discharged the stream through a stack on the roof. He said the acid was very corrosive and that he had several skin burns that required trips to the plant medical facility. He said maintenance on the scrubbers was necessary all the time because the acid corroded the scrubber metal very quickly. The Claimant said that when he operated the hydrofluorination furnaces he also he had to go to Plant 7 about once a week to monitor nitrogen generators.	Daily

Section 5: EXPOSURE INFORMATION

Toxic Substance The applicant stated:	**Form of toxic substance?** (dust, gas, fume, solid, liquid)	**How exposed?** Inhalation, skin, eye, ...	**How did you/the employee use this substance?** The applicant stated:	**Exposure frequency and duration** Frequency, as defined below: Rarely: less than once per month Monthly: 1-2 times per monthv Daily: Daily or almost every day. The applicant stated:
METALS				
Uranium (see below)				Daily for 15 years
RADIOLOGICAL				
Uranium	Metal/Solid	Inhalation, Skin	Claimant stated that he worked with uranium powders and metal every day in Plant 4. He had skin contaminations several times when operating furnaces.	Daily for 3 years
PLASTICS / ADHESIVES/ RESINS				
No Known Exposure				
DUSTS / FIBERS				
Uranium	Dust	Inhalation, Skin	Claimant stated the was exposed to uranium dust especially when he operated the orange oxide reduction furnace.	Daily for 3 years
Environmental Dust	Dust	Inhalation	Claimant stated Plant 4 was very dirty and that he was potentially exposed to unknown toxic substances from other operations in the building.	Daily for 15 years

FUMES AND VAPORS				
Hydrogen Gas	Fumes	Inhalation	Claimant stated that hydrogen gas leaked from the furnaces in Plant 4.	Daily for 15 years
Diesel Gas Fumes	Fumes	Inhalation	Claimant stated he was exposed to diesel and gas fumes when using forklifts early in his work at Fernald.	Daily for 3 years
Ammonia Gas	Fumes	Inhalation	Claimant stated he was exposed to ammonia daily while operating Plant 4 furnaces.	Daily for 15 years
SOLVENTS AND LIQUIDS				
Trichloroethylene	Liquids	Inhalation, Skin	Claimant stated that as a Laborer he used buckets of Trichloroethylene to hand clean oils and residues from equipment being installed in Plant 6.	Daily for 3 years
OTHER TOXIC SUBSTANCES				
Unsure	Unsure	Unsure	Claimant stated that he is unsure of any other exposures to toxic substances or chemicals.	Unsure

Section 6: INCIDENTS

Incident Narratives
Site, Location (Area, Facility, Building Number/Name or Description); Work Activity; Labor Category/Job Title; Toxins/Agents; Date(s); Incident/Accident description

Claimant stated that while working in Plant 6 as a Laborer he developed seriously dry skin on his hands and arms that required medical attention. He said the Fermald medical facility told him he needed to always where rubber gloves when using trichloroethylene because it removed oils from the skin and caused severe dryness. He said that after that event he always wore gloves when cleaning equipment and parts and did not have further problems.

Claimant stated that while working in Plant 4 as a Chemical Operator he suffered HF acid skin burns to his face and hands several times that required medical treatment in the Fernald medical facility. Claimant stated that there was an explosion in the Plant 7 nitrogen generator plant about a year before he left Fernald. He said he was not injured but that a maintenance worker with him suffered lacerations from glass blown out of a control panel. The explosion was caused by ammonia that leaked into an electrical control panel.

Additional Information

Claimant stated that he does not have any additional information to provide.

Section 7: CONCLUSION

The claimant was asked whether all relevent occupational history information was addressed, and responded:

Yes

Interview Wrap-up

Caseworker reviewed OHQ with claimant. Claimant stated that he/she has no further information to add. Caseworker thanked the claimant for participating in the OHQ interview. A copy of the OHQ along with a DOL Confirmation Thank-You letter will be mailed to the claimant. When a case is created in ECS, the OHQ will be uploaded to the DOL Portal and included in the claimant's case file. Claimant was informed that after receipt and review of the OHQ form, additional information may be submitted in writing to the RC. Upon request of the claimant and receipt in the RC, the additional information will be uploaded to the claimant's casefile and associated with the OHQ.

Logging

OHQ last modified (date/time)	

Interview Confirmation Letter

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date:

Name
Address
City, State Zip Code

Dear Claimant,

Thank you for participating in an interview that allowed me to complete the attached Occupational History Questionnaire (OHQ). I have taken action to add this OHQ to your case file record. The information you have provided will assist in reaching a decision about your claim. Please review the completed OHQ to ensure that I have recorded your interview responses properly. If you have any additional information you wish to share or corrections to make to the OHQ, mail your submission to the following address:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

Sincerely,

Name
Resource Center Staff

Enclosed: Occupational History Questionnaire

DOL Letter to DOE Former Worker Program

Dear FWP POC Name:

(Survivor/Employee name) has submitted a claim for benefits under the Energy Employees Occupational Illness Compensation Program. (Mr./Ms./ name) has claimed that he/she (his spouse/Father/Mother Full Name) participated in the {Site Name} Former Worker Screening Program.

The Department of Labor is requesting copies of all records you have for (employee name) to assist us in the adjudication of the claim.

Attached is the signed EE-3 which authorizes the FWP to release records to the Department of Labor.

If you have any questions regarding this request, please contact me directly at (phone number).

Thank you for your assistance in this matter

Sincerely,

[Name]
[Title]

Employee:
Case ID:

AUTHORIZATION FOR REPRESENTATION/PRIVACY ACT WAIVER

To provide that a duly authorized representative serves only the interest of the claimant, DEEOIC will not recognize the designation of an authorized representative whom DEEOIC finds is directly benefitting financially as a result of his or her affiliation with a claim, aside from the fee authorized by law.

I, _____
(Name of Claimant)

_____
(Address of Claimant)

_____
(City, State, Zip of Claimant)

do hereby authorize:

_____
(Name of Representative/Person receiving records)

_____
(Address of Representative/Person receiving records)

_____
(City, State, Zip of Representative/ Person receiving records)

_____
(Phone Number of Representative/Person receiving records)

to (**check all that apply**):

_____serve as my representative in all matters pertaining to the administrative adjudication of my claim under the Energy Employees Occupational Illness Compensation Program Act of 2000 by the Division of Energy Employees Occupational Illness Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor.

_____receive copies of all factual and medical evidence contained in my claim filed under the Energy Employees Occupational Illness Compensation Program Act of 2000 from the Division of Energy Employees Occupational Illness Compensation, Office of Workers' Compensation Programs, U.S. Department of Labor.

I declare that the foregoing is true and correct. This authorization is effective on the date it is signed, and is effective until specifically revoked by me in writing.

_____ _____
(Signature of Claimant) (Date)

Powers of Attorney Memo for SOL Review

U.S. DEPARTMENT OF LABOR
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

DATE:

MEMORANDUM FOR: Counsel for
Energy Employees Compensation

FROM: Name -
Office Location-
Work Phone# -

SUBJECT: Power of Attorney Review
CASE ID -
PAYEE NAME -

POA STATE:

PRIORITY: Routine

Attached for your review is a document(s) that purports to grant an individual the authority to sign the EN-20 for the above named payee. Once you have completed your review, please forward your response to the Policy Branch for upload to OIS.

Attachments:

Completed EN-20 Form
POA or other legal documents (signed and dated)

Notification to Representative of Conflict of Interest

Date:

Claimant Name:
Case ID Number:

Representative Name
Address
City, State, Zip Code

Dear [Representative]:

According to our records, you have been designated as the authorized representative in the above case. As the authorized representative of the above claimant, you are expected to put your client's interests before your own private, non-representational direct financial interests in all of your dealings with the Division of Energy Employees Occupational Illness Compensation (DEEOIC). DEEOIC will consider you to have a prohibited "conflict of interest" if you could directly benefit financially from your client's Energy Employees Occupational Illness Compensation Program Act (EEOICPA) claim due to something other than your statutorily limited fee for representing your client in connection with his or her EEOICPA claim.

DEEOIC has received information that suggests a conflict of interest exists in this case. ***{Describe the evidence that suggests a conflict of interest. Be sure to include names, dates of letters, and all pertinent information to describe the evidence.}***

In light of this evidence, DEEOIC requests that you prepare a signed statement explaining your response to the above detailed evidence of a conflict of interest. Please submit your statement within 30 days from the date of this letter. Upon review of your statement, in conjunction with the evidence of record, DEEOIC will determine whether a conflict of interest exists in the case. If it is determined that a conflict of interest does exist, DEEOIC will no longer recognize you as the claimant's authorized representative unless the conflict of interest is eliminated. If you acknowledge that a conflict of interest does exist, you may resolve the conflict by either submitting a signed resignation as the claimant's authorized representative, or submitting evidence of the relinquishment of the charges, position, job, or duty creating the conflict.

Please contact the district office at XXX-XX-XXXX if you have any questions or concerns regarding this letter.

Sincerely,

[Name]
[Title]
[District Office]

SSA Contact Numbers

SSN Range (Last 4 digits)	Module Number	Help Desk Telephone No.
0000-0999	Mod 1	410-966-1247
1000-1999	Mod 2	410-966-5657
2000-3999	Mod 3	410-597-1045
4000-5999	Mod 4	410-966-8512
6000-7999	Mod 5	410-597-1061
8000-9999	Mod 6	410-597-1065

Sample Subcontractor Employment Memo

Note: In cases of subcontractor employment, the evidence varies greatly between employees and facilities, so there is no "one-size fits all." Sometimes proof of employment with SSA in conjunction with a DOE clearance and a job category that could only be performed on site (plumber) is sufficient, other times more is needed. What follows is an outline that attempts to include most everything, but keep in mind this is just a model. As long as the memo delineates the evidence used to support 1) employment with a company that had 2) a contract to perform services on site at a DOE facility and 3) the employee was so employed providing those services on that site during those years, then the memo is complete.

DATE:

MEMORANDUM TO: FILE

FROM: CE

SUBJECT: Subcontractor Employment

This is a case involving a claim of subcontractor employment. Mr. Johnson claimed subcontractor employment at (name of facility) for the following period(s) of time (list period claimed on claim form). He stated that he worked as a (name of trade, job title) for the following employers (list the names of the companies for whom he claims to have been employed) at (name of facility) doing (identify service on site). Evidence in the file regarding employment was submitted, and is summarized below (use only those items for which there is corresponding evidence).

DOE provided (and then specify what DOE provided, such as clearance records, infirmary records, dose records). List those here with the date of each record and any other pertinent information on the record, such as name of employer or location of work.

> Example 1: July 10, 1984 report from the BNL health unit reporting that he got something in his eyes while welding some pipe in the XX building.
> Example 2: DOE provided a clearance card indicating that Mr. Johnson was granted a "Q" clearance on June 10, 1984 to August 30, 1984. The clearance card identifies his employer as Smalls Mechanical Contractors, Inc.

Records from the SSA were also obtained. For the period claimed, they identify the following employers during the noted years (list).

> Example: 1985 Smalls Mechanical Contractors, Inc.

A review of the CPWR database was conducted and it showed (explain which subcontractors show up in database and for what periods of time, for example some case

files still have detailed union log sheets, some have news clipping about subcontractors linking them to a facility – all this needs to be delineated)

> Example: Smalls Mechanical Contractors, Inc. – CPWR BtComp database indicates that Smalls was a BNL subcontractor for the period of June 18, 1984 through August 30, 1985.

Other documentation submitted included (list anything else submitted in the case that bears on the question of whether the employee provided a service on site at the facility for a given employer during the years so employed)

> Example: A news clipping from the Tri-Cities Herald shows a photo of a ribbon-cutting ceremony at Hanford for the construction of XYZ and identifies Smalls Mechanical Contractors, Inc. as one of the subcontractors on the project.

The following affidavits were also submitted (list every single affiant and what they attest – OK to summarize…if same affiant attests more than once, that also needs to be noted, especially if the attestations are inconsistent with each other).

> Example: Paul Smith, work associate and friend, attested that the employee worked for Smalls Mechanical Contractors at BNL from June 1984 to August 1985. The work involved the cryogenics lab and the Isabelle project.

After reviewing all this documentation, I conclude that Mr. Johnson's employment for (list dates) is a covered DOE subcontractor. For this period, SSA records (or union records or whatever evidence is used) demonstrate he worked for (name of company), and according to CPWR, there was a subcontract in place between (company) and (facility) for (years). Additionally, there was an infirmary record from DOE which identifies Mr. Johnson as having been onsite during the period. His co-worker Mr. Smith also attested to the period…….

With regard to the period (dates), I find that the evidence falls short of meeting the standard for covered subcontractor employment because….and then give reason – no evidence of being onsite, no evidence of contract, dates don't match up.

List of SEC Designated Classes

Statutory SEC Classes

Site	SEC dates	Procedure Manual Chapter	Note:
Amchitka	12/01/65 - 01/01/74	Ch. 14	One day is sufficient
Oak Ridge Gaseous Diffusion Plant	09/44 - 12/31/87	Ch. 14	Radiation exposure presumed
Oak Ridge Gaseous Diffusion Plant	01/01/88 - 02/01/92	Ch. 14	Exposure not presumed - must show monitoring
Paducah Gaseous Diffusion Plant	07/52 - 02/01/92	Ch. 14	Radiation exposure presumed
Portsmouth Gaseous Diffusion Plant	09/54 - 02/01/92	Ch. 14	Radiation exposure presumed

* Details specific to each SEC class are outlined in their associated Bulletin/Circular or can be viewed at:

https://www.dol.gov/owcp/energy/regs/compliance/law/SEC-Employees.htm

Approved SEC Classes

Site/Class Name	SEC Class Dates	SEC Effective Date	Bulletin / Circular No. (Circulars are used in conjunction with PM Chapter 14.)
Allied Chemical	01/01/59 - 12/31/76	03/03/07	Bulletin No. 07-15
Ames Laboratory	01/01/42* - 12/31/54	09/07/06	Bulletin No. 07-01 - No longer relevant. It is subsumed under Circular 12-03.
Ames Laboratory	01/01/55 - 12/31/60	11/05/10	Bulletin No. 11-02 – No longer relevant. It is subsumed under Circular 12-03.
Ames Laboratory	08/13/42 - 12/31/70	11/17/11	Circular No. 12-03
Ames Laboratory	01/01/55 - 12/31/70	10/12/07	Bulletin No. 08-06 - No longer relevant. It is subsumed under Circular 12-03.
Ames Laboratory	01/01/71 – 12/31/89	02/01/18	Circular No. 18-03
Argonne National Lab – West	04/1/51 – 12/31/57	07/03/16	Circular No. 16-05
Area IV of SSFL	01/01/55 - 12/31/58	07/18/09	Bulletin No. 09-14
Area IV of SSFL	01/01/59 - 12/31/64	05/05/10	Bulletin No. 10-10
Area IV of SSFL	01/01/65 – 12/31/88	02/05/17	Circular No. 17-01
Baker Brothers (OH)	06/01/43 - 12/31/44	04/05/13	Circular No. 13-08
Battelle Labs, King Ave.	04/16/43 - 06/30/56	04/05/13	Circular No. 13-09
Battelle Labs, King Ave.	07/01/56 – 12/31/70	03/09/16	Circular No. 16-03
Bethlehem Steel	01/01/49 - 12/31/52	08/13/10	Bulletin No. 10-23
Blockson Chemical	03/01/51 - 06/30/60	10/03/10	Bulletin No. 11-01
Brookhaven Nat. Lab.	01/01/47 - 12/31-79	01/09/10	Bulletin No. 10-03
Brookhaven Nat. Lab.	01/01/80 - 12/31/93	06/10/12	Circular No. 12-12

BWXT (VA)	01/01/59 - 12/31/59 or 01/01/68 - 12/31/72	08/12/10	Bulletin No. 10-17
BWXT (VA)	01/01/85 - 11/30/94	02/05/11	Bulletin No. 11-05
CANEL	01/01/58 - 12/31/65	11/23/08	Bulletin No. 09-03
Canoga Avenue Facility	01/01/55 - 12/31/60	06/13/10	Bulletin No. 10-16
Clarksville	01/01/49 - 12/31/67	09/22/12	Circular No. 12-17
Clinton Engineer Works (TEC & CCC)	01/01/43 - 12/31/49	06/10/12	Circular No. 12-11
Combustion Engineering	01/01/65 - 12/31/72	04/02/08	Bulletin No. 08-21
DeSoto Avenue Facility	01/01/59 - 12/31/64	08/13/10	Bulletin No. 10-24
Dow Chemical (Madison Site)	01/01/57 - 12/31/60	07/22/07	Bulletin No. 07-25
Dow Chemical (Pittsburg, CA)	10/01/47 - 06/30/57	06/20/15	Circular No. 15-09
Downey Facility	01/01/48 - 12/31/55	08/12/10	Bulletin No. 10-19
Electro Metallurgical Corp.	08/13/42 - 12/31/47	06/10/12	Circular No. 12-09
Fernald	01/01/68 - 12/31/78	07/27/12	Circular No. 12-14
Fernald - all non-NLO contractor employees	01/01/51 - 12/13/83	10/30/13	Circular No. 14-02
Fernald - all workers, all areas	01/01/54 - 12/31/67	10/30/13	Circular No. 14-02
GE Evendale	01/01/61 - 06/30/70	09/30/11	Circular No. 11-11
General Atomics	01/01/60 - 12/31/69	10/25/14	Circular No. 15-02
General Atomics	01/01/60 - 12/31/69	03/18/07	Bulletin No. 07-17 – No longer relevant. It is subsumed under Circular 15-02.
Grand Junction Facilities	02/01/75 - 12/31/85	06/19/15	Circular No. 15-08
Grand Junction Operations Office	03/23/43 - 01/31/75	05/29/11	Circular No. 11-05
Hanford Site	01/01/84 - 12/31/90	06/21/15	Circular No. 15-07
Hanford	07/01/72 - 12/31/83	09/22/12	Circular NO. 12-16

Hanford	10/01/43 - 06/30/72	01/09/10	Bulletin No. 10-04
Hanford (100, 200 & 300 Areas during DuPont years of Operation)	Start of processing through 08/31/46	10/12/07	Bulletin No. 08-03 – No longer relevant. It is subsumed under Bulletin 10-04.
Hanford 300 Area: 9/1/1946-12/31/1961 or 200 Area (east & west) 1/1/1949-12/31/1968	Area specific - see definition	06/30/08	Bulletin No. 08-33 - No longer relevant. It is subsumed under Bulletin 10-04.
Harshaw	08/14/42 - 11/30/49	03/03/07	Bulletin No. 07-16
Hood Building	05/09/46 - 12/31/63	04/30/09	Bulletin No. 09-13
Hooker Electrochemical	07/01/44 - 12/31/48	10/22/15	Circular No. 16-01
Horizons (AWE, Cleveland, OH)	01/01/52 - 12/31/56	06/30/08	Bulletin No. 08-34
Idaho National Laboratory	03/01/70 – 12/31/74 01/01/75 – 12/31/80 01/01/63 – 02/28/70	07/03/16 12/22/17 07/21/19	Circular No. 16-04 Circular No. 18-02 Circular 19-04
Iowa Army Ammunition Plant "Line 1"	03/49 - 1974	06/19/05	Bulletin No. 05-06
Iowa Army Ammunition Plant "Radiographers"	05/48 - 03/49	09/24/05	Bulletin No. 06-04
Joslyn Manufacturing	03/01/43 - 12/31/47	04/05/13	Circular No. 13-07 – No longer relevant. It is subsumed under Circular 14-07.
Joslyn Manufacturing & Supply	03/01/43 - 07/31/48	04/26/14	Circular No. 14-07
Kellex Pierpont (AWE, Jersey City, NJ)	01/01/43 - 12/31/53	06/30/08	Bulletin No. 08-36
Lawrence Berkeley National Lab.	08/13/42 - 12/31/61	05/05/10	Bulletin No. 10-11
Lawrence Livermore Nat. Lab.	01/01/50 - 12/31/73	05/05/10	Bulletin No. 10-12
Lawrence Livermore National Laboratory	01/01/50 - 12/31/73	04/02/08	Bulletin No. 08-20 – No longer relevant. It is subsumed under Bulletin 10-12.

Lawrence Livermore National Laboratory	01/01/74 – 12/31/89	07/03/16	Circular No. 16-06
Linde Ceramics Plant	10/01/42 - 10/31/47	01/07/06	Bulletin No. 06-06
Linde Ceramics Plant	01/01/54 - 12/31/69	05/21/11	Circular No. 11-04
Linde Ceramics Plant	11/01/47 - 12/31/53	03/03/12	Circular No. 12-07
LOOW (DOE - Niagara Falls, NY)	01/01/44 - 12/31/53	10/29/09	Bulletin No. 10-02
Los Alamos National Lab. - RaLa exposure	09/01/44 - 07/18/63	12/09/06	Bulletin No. 07-11 – No longer relevant. It is subsumed under Bulletin -10-22.
Los Alamos National Laboratory	03/15/43 - 12/31/75	07/22/07	Bulletin No 07-23 and 08-08 – No longer relevant. It is subsumed under Bulletin 10-22.
Los Alamos National Laboratory	03/15/43 - 12/31/75	08/12/10	Bulletin No. 10-22
Los Alamos National Laboratory	01/01/76 - 12/31/95	01/06/13	Circular No. 13-03
Mallinckrodt Chemical Works	1942* -1948	05/12/05	Bulletin No. 06-03
Mallinckrodt Chemical Works	1949 - 1957	11/13/05	Bulletin No. 06-05
Mallinckrodt Chemical Works	all of 1958	02/15/09	Bulletin No. 09-09
Medina	01/01/58 - 01/01/66	09/22/12	Circular No. 12-18
Metallurgical Laboratory	08/13/42 - 06/30/46	02/15/09	Bulletin No. 09-07
Metals and Controls (AWE- MA)	01/01/52 - 12/31/67	01/09/10	Bulletin No. 10-05
~~**Monsanto Chemical Company**~~	~~01/01/43 - 12/31/49~~	~~03/18/07~~	Monsanto delisted as AWE on 2/6/2012. This SEC class no longer valid.
Mound Plant	10/01/49 - 02/28/59	04/02/08	Bulletin No. 08-19
Mound Plant	03/01/59 - 03/05/80	08/13/10	Bulletin No. 10-21
Mound Plant	09/01/72 - 12/31/72 & 01/01/75 - 12/31/76	01/06/13	Circular No. 13-04

Nevada Test Site (NTS)	01/27/51 - 12/31/62	07/26/06	Bulletin No. 06-16
Nevada Test Site (NTS)	01/01/63 - 12/31/92	05/05/10	Bulletin No. 10-13
Norton Co. (AWE - MA)	01/01/58 - 10/10/62	05/29/11	Circular No. 11-07
Norton Company (AWE - MA)	01/01/45 - 12/31/57	10/29/09	Bulletin No. 10-01
Nuclear Metals, Inc.	10/29/58 - 12/31/79	01/06/13	Circular No. 13-05
Nuclear Metals, Inc.	01/01/80 - 12/31/90	08/10/14	Circular No. 14-08
NUMEC (Parks Township)	06/01/60 - 12/31/80	06/30/08	Bulletin No. 08-37
NUMEC Apollo	01/01/57 - 12/31/83	11/29/07	Bulletin No. 08-12
Oak Ridge Hospital	05/15/50 - 12/31/59	01/09/10	Bulletin No. 10-07
Oak Ridge Institute for Nuclear Studies (ORINS)	05/15/50 - 12/31/63	12/09/06	Bulletin No. 07-09
Oak Ridge National Laboratory (X-10)	06/17/43 - 07/31/55	01/06/13	Circular No. 13-02
Pacific Proving Ground (PPG)	1946 - 1962	07/26/06	Bulletin Nos. 06-15 & 07-05
Pantex Pant (TX)	01/01/84 - 12/31/91	10/30/13	Circular No. 14-03
Pantex Plant (TX)	01/01/58 - 12/31/83	01/20/12	Circular No. 12-06
Pantex Plant (TX)	01/01/51 – 12/31/57	02/03/17	Circular No. 17-02
Piqua	05/02/66 - 02/28/69	01/09/10	Bulletin No. 10-06
Revere Copper and Brass	07/24/43 - 12/31/54	11/05/10	Bulletin No. 11-03
Rocky Flats - Neutron Areas	04/01/52 - 12/31/58	09/05/07	Bulletin Nos. 08-01 and 08-14 – No longer relevant. It is subsumed under Circular 14-05.
Rocky Flats - Neutron Areas	01/01/59 - 12/31/66	09/05/07	Bulletin Nos. 08-01 and 08-14 - No longer relevant. It is subsumed under Circular 14-05.
Rocky Flats Plant	04/01/52 - 12/31/83	01/11/14	Circular No. 14-05

S-50 (all workers)	07/09/44 - 12/31/51	12/09/06	Bulletin No. 07-08
SAM Laboratories (@ Columbia U)	08/13/42 - 12/31/47	06/30/08	Bulletin No. 08-35
Sandia National Lab. - Livermore	10/01/57 - 12/31/94	01/12/14	Circular No. 14-04
Sandia National Laboratories	01/01/49 - 12/31/62	09/09/11	Circular No. 11-10
Sandia National Laboratories	01/01/63 - 12/31/94	06/10/12	Circular No. 12-10
Sandia National Laboratories	01/01/95 – 12/31/96	10/18/18	Circular No. 19-01
Savanah River Site	01/01/53 - 09/30/72	03/03/12	Circular No. 12-08
Simonds Saw & Steel (NY)	01/01/48 - 12/31/57	02/05/11	Bulletin No. 11-04
Spencer Chemical Co. /Jayhawk Works (AWE, Pittsburg, Kansas)	01/01/56 - 12/31/61	09/14/08	Bulletin No. 08-42
St. Louis Airport Storage Site (SLAPS)	01/03/47 - 11/02/71	08/13/10	Bulletin No. 10-18
Standard Oil (NJ)	08/13/42 - 12/31/45	07/18/09	Bulletin No. 09-15
Texas City Chemical (TX)	10/05/53 - 09/30/55	02/05/11	Bulletin No. 11-06
Tyson Valley Powder Farm	02/13/46 - 06/30/48	04/30/09	Bulletin No. 09-12
U. of Rochester Atomic Energy Proj.	09/01/43 - 10/30/71	08/12/10	Bulletin No. 10-20
Ventron (AWE in Beverly, MA)	11/01/42 - 12/31/48	11/11/12	Circular No. 13-01
Vitro Mfg. (Cannonsburg)	08/13/42 - 12/31/57	02/15/09	Bulletin No. 09-08
Vitro Mfg. (Cannonsburg)	01/01/58 - 12/31/59	05/29/11	Circular No. 11-08
Vitro Mfg. (Cannonsburg)	01/01/60 - 09/30/65	11/17/11	Circular No. 12-04
W.R. Grace (Curtis Bay, MD)	05/01/56 - 01/31/58	11/17/11	Circular No. 12-01
W.R. Grace (Tenn)	01/01/58 - 12/31/70	07/22/07	Bulletin No. 07-24
Wah Chang	01/01/71 - 12/31/72	05/29/11	Circular No. 11-06
Westinghouse Atomic Power Development Plant (PA)	08/13/42 - 12/31/44	04/30/09	Bulletin No. 09-11

Westinghouse Electric (NJ)	08/13/42 - 12/31/49	05/05/10	Bulletin No. 10-14
Westinghouse Electric (Bloomfield NJ)	02/01/58 – 05/31/58 or 06/01/59 – 06/30/59	08/27/15	Circular No. 15-10
West Valley Demonstration Project	01/01/69 – 12/31/73	11/25/19	Circular 20-01
Winchester Engineering & Analytical Center	01/01/52 - 12/31/61	09/22/12	Circular No. 12-15
Y-12 (subsumes earlier class)	01/01/48 - 12/31/57	11/17/11	Circular No. 12-02
Y-12	03/01/43 - 12/31/47	09/14/08	Bulletin No. 08-41
Y-12	01/01/1958 – 12/31/76	03/28/19	Circular 19-02
Y-12	01/01/1977 – 07/31/1979	11/25/19	Circular 20-02
Y-12 Plant, "Radiological Activities"	03/43 - 12/47	09/24/05	Bulletin Nos. 06-04 & 06-11 – No longer relevant. Subsumed under Bulletin 08-41.
Y-12 Plant, "Thorium and Cyclotron workers"	01/48 - 12/57	09/07/06	Bulletin No. 07-04 – No longer relevant. Subsumed under Circular 12-02.

* Under the EEOICPA, the start date for covered employment at AWE, DOE or beryllium vendor facilities cannot pre-date August 13, 1942, which represents the date the Manhattan Engineer District was established, and thus no SEC class coverage can extend back prior to August 13, 1942. Please note, however, that RECA employment (for which there are no SEC classes) can commence as far back as January 1, 1942.

Sample Letter to Claimant Granting Medical Benefits for Unaccepted Reverse Consequential Condition (Medical Treatment of Underlying Primary Cancer)

[Date]

Case ID: [number]
Employee: [name]

[Claimant Name]
[Street Address]
[City, State, Zip]

Dear [name]:

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) regulation at 20 CFR § 30.400(a) states the following with regard to payment of medical bills for an unaccepted condition: "In situations where the accepted occupational illness or covered illness is a secondary cancer, such treatment may include treatment of the underlying primary cancer when it is medically necessary or related to treatment of the secondary cancer."

Accordingly, payment for medical treatment of your primary cancer [identify cancer] is covered when medically necessary or related to the treatment of your accepted secondary cancer. However, payment for medical treatment of your primary cancer under these circumstances does not constitute a determination by the Office of Workers' Compensation Programs that the primary cancer is an accepted illness under the EEOICPA.

For reimbursement of medical bills, I have enclosed form OWCP-915 (Claim for Medical Reimbursement). Carefully read and follow the instructions on the back of the form to ensure reimbursement of those bills.

Where to Send Your Reimbursement Form:

Send a copy of this authorization letter, the completed itemized Form OWCP-915, and any required receipts to our bill processing agent. For your convenience, I have enclosed a pre-addressed envelope and an extra copy of this authorization letter. Mail your information to:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If you have any questions, you may contact the district office at [phone number].

Sincerely,

[Name]
[Title]

Enclosure: OWCP-915 (Claim for Medical Reimbursement)

Statement of Accepted Facts

1. **Employee Information**
    a. Name:
    b. Case File Number:
    c. Date of Birth:
    d. Date of Death:
        i. If deceased, list Cause(s) of Death from Death Certificate

2. **Medical Information**
    a. Has an Occupational Health Questionnaire (OHQ) been completed? (Provide date)
    b. Claimed and Diagnosed Condition(s): (Provide date of diagnosis for each, if possible; if diagnosed condition is skin cancer, provide body location)
    c. List any accepted conditions (if applicable).
    d. Other medical information/conditions available for review by referral personnel (if appropriate): (Provide dates of Former Worker Protection (FWPP) Interview, authorized home health care periods, etc.)

3. **Employment Information - If Relevant - [**Provide a detailed description of the employee's verified and covered employment history – include where employee worked, date(s) of employment, job title(s), job duty(ies)].

4. **Occupational Toxic Exposure - If Relevant -** (Provide the occupational toxic substance exposures encountered by the employee and shown to have a potential health effect to the diagnosed condition; provide relevant information on the nature, extent and duration of such exposures)

5. **Claim History – If Relevant -** (Provide significant events such as date of filing of Part B and/or Part E, date submitted to NIOSH for dose reconstruction, Probability of Causation %, date of denial/acceptance, date of remanded claim, etc.)

6. **Other Information -** (Include any other information that may be useful to those conducting the referral evaluation)

7. **Claims Examiner Information**
    a. Submitting District Office:
    b. Claims Manager:
    c. Unit designation:
    d. Telephone Number:
    e. E-mail address:
    f. Date of referral:

8. **Verification of Review –** (Should be signed by District Office Director, or designee, indicating that the referral information has been reviewed and meets minimum criteria for submittal)

Exposure Worksheet

Employee Last Name/Case ID:

1. Covered Facility/Site Name:
2. Labor Category:
3. Dates for Labor Category:
4. Health Effect(s):
5. Explain exposure evidence used to determine likely exposures associated with the diagnosed health effect(s):
6. Provide the toxic substances established by the analysis of the above evidence:
7. Explain any policy established exposure presumptions based on the above:

1. Covered Facility/Site Name:
2. Labor Category:
3. Dates for Labor Category:
4. Health Effect(s):
5. Explain exposure evidence used to determine likely exposures associated with the diagnosed health effect(s):
6. Provide the toxic substances established by the analysis of the above evidence:
7. Explain any policy established exposure presumptions based on the above:

Exposure Worksheet Form Instructions

The purpose of the Exposure Worksheet is to document the evidence and information used by the CE to establish the toxins that an employee likely encountered. The Worksheet is used as a documentation tool for each case requiring an exposure analysis. The Worksheet, or equivalent documentation sufficient to support the CE's exposure assessment, is also required for any IH Referral.

Employee Last Name/Case ID:
Provide the employee's last name and case ID. This field will populate for each sheet if multiple sheets are utilized.

1. Covered Facility/Site Name:
Provide the covered DOE facility, AWE facility designated as a DOE facility for remediation, or Uranium Mine, Mill, Ore-Buying Station, or Transporter that has been established by the evidence. Each covered Facility/Site will be assessed independently and documented in a separate section even if the employee remained in the same labor category since each site may produce different results.

2. Labor Category:
Provide the labor category or job title that has been established by the evidence submitted by the employee/claimant, DOE, or official labor category or job title obtained from an alias search in SEM. A new exposure worksheet form is to be completed for each labor category, and will be assessed independently and documented in a separate section because different work duties and work processes may produce different results. The labor category or job title listed is used as the basis in describing the work performed by the employee and ultimately forming the basis for the toxins listed below. Labor categories that are progressive in nature can be listed together such as Electrician Apprentice, Electrician, Electrician Foreman, Electrician Supervisor, etc. For a Foreman or Supervisor over an hourly group, the profile for the group supervised is to be used. The CE seeks guidance through the SEM Mailbox if there is any question as to which profile to use.

3. Dates for Labor Category:
Provide the dates the employee was in that labor category or job title for that facility/site that can be reasonably established based on a thorough review of the evidence. The dates can be specific if that is known or at least by year. For progressive labor categories, specify the years for each progression to the next position in the series. For example: Electrician Apprentice 1954 - 1955; Electrician 1955 - 1960; Electrician Foreman 1960 - 1980.

4. Health Effect(s):
List the diagnosed condition that has a health effect link established by application of SEM or the opinion of a qualified physician. Since the employee's work processes and work duties remain the same for the identified facility/site and labor category, multiple health effects may be listed and considered within the same section. The CE will clearly specify in #6 which toxins are associated with each corresponding health effect.

5. Explain exposure evidence used to determine likely exposures associated with the diagnosed health effect(s):
Explain the sources of evidence used to establish the toxin(s) that are listed below for the condition(s) under review. Sources of evidence consist of employer provided data, SEM data, and employee/claimant provided evidence.

Explain how SEM was searched and provide enough detail to explain how aliases (health effects or labor category/work processes) were determined. Explain how other filtering parameters were established such as work processes and buildings. Explain any Direct Disease Link Work Processes (DDLWP) that may be established.

Indicate if the employee is considered a construction worker for the labor category under review and whether this guided the SEM search. An employee considered a "construction worker" for purposes of SEM is searched under "Construction (all sites)" and not the facility/site listed in #1. SEM provides a list of construction trades under the "Construction (all sites)" search capability and provides the option to search by alias. If the CE is unable to find the employee's labor category or job title and is unsure if "Construction (all sites)" is appropriate, the CE is to seek guidance through the SEM Mailbox. An employee is not considered a construction worker but a production worker if the employee worked for the main operating contractor or worked in a job that is not considered a construction trade such as an administrative positon.

Provide the buildings, areas, or locations that are reasonably determined from the evidence and where the employee performed the labor category or job title that is listed above. These will be buildings, areas, or locations where the employee was officially assigned and/or performed their work on a routine basis. The CE analyzes the evidence to make this determination. If the CE is able to determine this information and buildings, areas, or locations are used to filter or refine the SEM search, the CE explains how that was determined and how it affected the SEM search. If the evidence is insufficient to reasonably make this determination or the employee worked in a position that required him/her to work in multiple buildings or locations of the facility/site such as a laborer, painter, or other construction trade workers; an exhaustive list is not to be provided because the SEM search will not be further filtered by this search category.

Provide any relevant information that would be useful in explaining any complex scenarios. Complex scenarios can consist of cases that rely on other evidence to establish exposure that is not established by SEM or cases that rely on a medical opinion regarding the establishment of a health effect (i.e. not established by SEM or Toxicologist). For example, a physician provides an opinion linking the employee's condition (aggravate, contribute to, or cause) to a toxic substance.

Narrative Example: *The employee was a lab technician and based on the DAR records she was assigned to 772-F and 241-84H which is also known as the Effluent Treatment Facility Control Building. The employee indicated on her Separation Medical Interview that she worked in the F & H Labs. SEM was searched using the labor category of laboratory technician and COPD. The only processes/activities listed were chemistry laboratory activities which the employee was engaged in so no further filtering of work processes was needed. SEM was further filtered by the buildings the employee worked in and the resulting toxins were ammonia and chlorine.*

6. Provide the toxic substances established by the analysis of the above evidence:

Provide the toxin(s) that were most likely encountered based on the analysis above. If there are multiple conditions under review, indicate the condition before listing the associated toxins. The CE does not need to list each compound of a toxic substance. For example, if the following is provided in a SEM search: lead, lead II acetate, lead II nitrate, lead II oxide, etc. that can be simply listed as lead and counted as one toxin. However, if an employee/claimant or DAR document specifies exposure to a specific compound that compound is to be listed separately.

The assigned CE prioritizes his or her analysis to the top seven (7) toxins that the employee most likely encountered. If the CE produces a list greater than seven (7) based on the analysis of the evidence and utilization of proper SEM filtering techniques, the CE is to consult with the National Office IH to identify which toxins on the list of substances were most likely encountered and which would likely have the greatest impact on the claimant's claim, and include as many of those as is necessary.

7. Exposure Presumptions:

If any of the exposures or fact patterns establishes an exposure presumption, provide that information (e.g., asbestos for specified labor categories). If an exposure is presumed, such as asbestos, but the level still needs to be addressed by the IH, provide that information here. All employees that have been diagnosed with a condition associated with asbestos exposure are presumed to have had some level of exposure to asbestos. However, some labor categories during certain time periods still need a review by the IH to determine the level of exposure. The CE may also use this space to note any DDLWP's that will be used in the claim

DAR Form & Instructions

Document Acquisition Request Form (DAR)

U.S. Department of Labor
Office of Workers' Compensation Programs

This form is used to request specific documentation regarding DOE employees and DOE contractor employees at DOE covered facilities under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The DOE Operations Center will request the records specified by DOL from each facility. .

Employee Information (Completed by DOL)	
1. Name (Last, First, Middle Initial)	**2. Social Security Number**
3. Department of Energy Facility	**4. Employer Name** (If a subcontractor employee)

Types of Records Being Requested (Completed by DOL)	**Record Availability** (Completed by DOE)	
	Included on CD	**Unavailable**
☐ Radiological Dose Records	☐	☐
☐ Incident Or Accident Reports	☐	☐
☐ Industrial Hygiene and Safety Records	☐	☐
☐ Personnel Records	☐	☐
☐ Job Descriptions	☐	☐
☐ Medical Records	☐	☐
☐ Other: (specify)	☐	☐

Site Specific Exposure Questions (Completed by DOL)	**DOE Response**
Example: Was asbestos used in building X-333?	
1.	☐ YES ☐ NO
2.	☐ YES ☐ NO
3.	☐ YES ☐ NO
4.	☐ YES ☐ NO
5.	☐ YES ☐ NO
6.	☐ YES ☐ NO
7.	☐ YES ☐ NO

Certification (Completed by DOE)

By signing this form, the DOE is acknowledging that it has conducted a reasonable search of available records and that the information provided on this sheet and the electronic documentation provided on a compact disc (CD) accurately reflects the results of that search.

Print Name:	**Telephone No:** ( ) **Address:**
Signature:	**Date:**

Instruction Sheet for the Document Acquisition Request (DAR)

Block 1: The Department of Labor (DOL) Claims Examiner (CE) competes this block by either typing or legibly writing the name of the employee using Last Name, First Name, and Middle Initial. The CE also lists a maiden name if known.

Note: Attach a copy of the EE-1/2 and EE-3

Block 2: The DOL CE types or legibly writes the Social Security Number (SSN) of the employee in this block.

Block 3: The DOL CE types or legibly writes the claimed Department of Energy (DOE) facility identified by the claimant on the submitted Employment History Form (EE-3) (i.e., Portsmouth Gaseous Diffusion Plant).

Note: If the claimant indicates employment at multiple DOE sites, a separate DAR Form is completed for each DOE site claimed.

Block 4: The DOL CE places the contractor or subcontractor name in this block if a subcontractor or contractor is identified on the EE-3 (i.e., Grinnell Corporation).

Note: If the claimant indicates employment at a DOE site with multiple subcontractors, a separate DAR Form is completed for each subcontractor.

Block 5: [Types of Records Being Requested] The DOL CE determines from the case file documents (i.e., Occupational Health Questionnaire, EE-3, EE-4, medical evidence) which types of records are pertinent to the individual case and checks the appropriate block corresponding to the type of record needed.

Radiological Records: These documents are radiation exposure records based on readings from dosimetry badges or similar personal recording devices. They are generally taken at regular intervals over the employee's employment period.

Incident or Accident Reports specific to the employee: Any abnormal incidents or large plant accidental substance releases which effect the employee are documented in these types of documents (Safety and Security Records, unusual occurrence reports, off normal reports, effluent release information, Type A and Type B accident/investigation reports, etc.).

Industrial Hygiene or Safety Records: Documents in these categories could contain periodical inspection reports for health and safety purposes pertaining to the employee (i.e., Occupational Injury Files, Investigation Records, Security Records, Individual Industrial Hygiene assessments, Health Hazard Inventories, etc).

Pay and Salary Records: These documents include an employee's pay, salary, any workers' compensation claim or other documents affecting wage. Examples of records that may contain

this information include but are not limited to Official Personnel Files of Contractor Employees, Contractor Job Classification Manuals, Employee Award Files, Notification of Personnel Actions, Classification Appraisals Files, Wage Survey Files and Unemployment Compensation Records.

Job Descriptions: These are descriptions of the various employment positions at the plant or site and the duties required to perform the job; they are employee specific.

Medical Records: Personal medical histories of the employee if that employee visited the plant infirmary (i.e. Health Unit Control Files, Employee Medical Folder, etc.).

Other: This category is reserved for any other documentation the CE may feel necessary to request on a claim specific basis which do not fit into any of the other six categories. If this category is checked and a specific request listed by the CE, DOE personnel may contact the DOL CE for clarification of the request if necessary.

Block 6: [Record Availability] This block is completed by the DOE. The DOE DAR POC completing the form either checks the block "Included on CD" or check the block "Unavailable" depending on whether the DOE has any records related to that particular set of records. "Included on CD" also includes hard copy documentation in the event the DOE facility does not have imaging capability.

Block 7: [Site Specific Exposure Questions] This block is completed by the DOL CE by posing specific toxic substance exposure questions to the DOE. These questions could be gleaned from the claimant's EE-3, other documents in the case file and/or the Occupational Health Questionnaire completed by the Resource Center and is to be phrased in such a manner that DOE may provide a "yes or no" answer.

Block 8: [DOE Response] DOE may check "yes" or "no" to each site specific question posed by the CE.

Block 9: [Certification] This block is completed by the DOE DAR POC certifying the results of the records search. The DOE DAR POC prints his or her name, address and telephone number on the form and signs and dates it in the appropriate spaces. Prior to certifying the results of the records search, the DOE ensures that any clarification regarding the types of records DOL is requesting is made with the requesting DOL CE.

Exposure and Causation Presumptions with Development Guidance for Certain Conditions

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

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

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

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

2. Aplastic Anemia: Aplastic anemia may be associated with ionizing radiation and if a claim is presented for this condition, the CE considers the following.

a. Medical: The medical evidence establishes a diagnosis of aplastic anemia, ICD-9/ICD-10 code 284.89/D61.89.

b. Exposure: The level of radiation needed to have a causal relationship is 125 rem. This would be a documented accident or event indicating high or accidental radiation exposure.

c. Latency period: The latency period usually associated with the event or exposure and the onset of the condition is 6 months or less.

d. Causation and other considerations: If an employee has been diagnosed with aplastic anemia and there is evidence that an incident or accident took place within the medical, dosimetry, or incident reports, the case will be referred to the National Office Health Physicist for a review and causation determination. If the case does not present with the appropriate documentation to suggest high levels of occupational radiation, the CE reviews the case as a possible consequential illness if the employee has been treated with radiation therapy for an accepted cancer since radiation treatment associated with cancer can produce the level of radiation needed.

3. Asbestos (exposure presumption): The program recognizes that asbestos is a toxic material that was present in all Department of Energy (DOE) facility locations. The CE may accept the following presumptions regarding asbestos exposure when applicable to the medical condition under adjudication.

a. Asbestos exposure through December 31, 1995.

(1) CE is to consider the following labor categories to have had significant exposure to asbestos based on their job tasks.

- Automotive mechanic; Vehicle mechanic; Vehicle maintenance mechanic
- Boilermaker
- Carpenter; Drywaller; Plasterer
- Demolition technician; Laborer
- Electrical mechanic; Electrician; Floor covering worker
- Furnace & saw operator; Furnace builder; Furnace operator; Furnace puller;Furnace technician; Furnace tender; Furnace unloader
- Glazier; Glass installer; Glazer
- Grinder operator; Mason (concrete grinding); Tool grinder; Maintenance mechanic (general grinding); Welder (general grinding); Machinist (machine grinding)
- Insulation worker; Insulation trade worker; Insulator
- Ironworker; Ironworker-rigger
- Maintenance mechanic; Electrician; Insulator;
- Mason; Brick & tile mason; Concrete and terrazzo worker; Bricklayer, Tilesetter
- Millwright
- Heavy equipment operator; Operating Engineer
- Painter
- Pipefitter, Plumber steamfitter; Plumber/pipefitter; Plumbing & pipefittingmechanic; Plumbing technician, Steamfitter
- Roofer
- Sheet metal mechanic; Sheet metal fabricator/installer
- Welder; Welder burner; Welder mechanic
- Uranium Miner/Miller

b. For employment that does not qualify for the standard in "a.", the CE will assume the employee to have had some level of exposure to asbestos. However, the CE is to refer the case to an IH to determine the level, extent, nature and frequency of exposure; including whether the exposure was significant (high, moderate, or low) or not significant (incidental – occurring in passing only).

4. **Asbestosis**: Part E causation can be presumed for asbestosis once all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of asbestosis, the CE develops the case through use of an IH referral if appropriate (e.g. there are no established exposure presumptions) and by obtaining a medical opinion on causation.

a. Medical: A medical diagnosis of asbestosis.

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

c. Latency: The diagnosis of asbestosis was made at least 10 years after initial exposure to asbestos in covered employment.

5. Asthma: Work-related asthma includes: a) occupational asthma; or new onset asthma that is initiated by an occupational agent, and b) work-exacerbated asthma, which is established asthma that is worsened by work place exposures. The CE does not apply a toxic substance exposure assessment to a claim for work-related asthma, including the application of the SEM or IH referral process, because any dust, vapor, gas or fume has the potential to affect asthma. Given the scope of potential occupational triggers that can affect asthma, the CE relies exclusively on the assessment of the medical evidence by a qualified physician to arrive at a determination of compensability. The criteria for accepting a Part E claim for asthma are:

a. The employee has a period of covered Part E contractor or subcontractor employment.

b. A medical diagnosis for asthma should be made when the physician is able to identify the presence of intermittent respiratory and physiologic evidence of reversible or variable airways obstruction including post-bronchodilator reversibility on spirometry or positive methachloline challenge test. However, a physician can also rely on other clinical information to substantiate his or her diagnosis of asthma, such as the findings from a detailed medial history any physical examination. Documentation of recurrent symptoms of airflow obstruction of airway hyperresponsiveness, such as episodic cough, chest tightness or shortness of breath, or symptomatic improvement following treatment for asthma (e.g. inhaled bronchodilator or steroids) supports a diagnosis of asthma. Physical examination findings such as wheezing on lunch examination, nasal swelling and drainage, or use of chest muscles to breath also support a diagnosis of asthma. The response to inhaled bronchodilator administration has also been used as a measure of airway hyperresponsiveness. A 12% improvement in FEV1 of at least 200 mL after inhaled bronchodilator is how the American thoracic Society defines a significant improvement of hyperresponsive airways. However, a negative bronchodilator test does not rule out a diagnosis of asthma, especially if the patient is on medical treatment for asthma.

c. Once having established covered Part E contractor or subcontractor employment and a diagnosis of asthma, the following criteria are available to demonstrate that the employee has work related asthma (as defined above):

(1) A qualified physician, who during a period contemporaneous with the period of covered Part E employment, diagnosed the employee with work-related asthma or;

(2) After a period of covered employment, a qualified physician conducts an examination of either the patient or available medical records and he or she concludes that the evidence supports that the employee had asthma and that an occupational exposure to a toxic substance was at least as likely as not a significant factor in causing, contributing to or aggravating the condition. The qualified physician must provide a well-rationalized explanation with specific information on the mechanism for causing, contributing to, or aggravating the conditions. The strongest justification for acceptance in this type of claims is when the physician can identify the asthmatic incident(s) that occurred while the employee worked at the covered work site and the most likely toxic substance trigger. A physician's opinion that does not provide a clear basis for diagnosing asthma at the time of covered employment or the physician provides a vague or generalized opinion regarding the relationship between asthma and occupational toxic substance exposure will require additional development including the CE's request for the physician to offer further support of the claim. If the CE is unable to obtain the necessary medical evidence from the treating physician to substantiate the claim for work-related asthma, the CE will need to seek an opinion from a CMC. If a CMC referral is required, the CE will need to provide the CMC with the relevant medical evidence from the claim file and provide a detailed description of the employee's covered employment which must include each covered worksite, dates of covered employment, labor categories, and details about the jobs performed.

6. Bladder Cancer: Bladder cancer is associated with the toxic substances noted below. If a claim is presented for this condition, the CE considers the following

a. Medical: The diagnosis of bladder cancer has been established by the medical evidence.

b. Exposure: The minimum exposure associated with increased cancer risk is a full working year. The CE may consider the following when determining likely exposure.

(1) Direct Black: This substance was used at DOE in limited research and laboratory activities.

(2) MOCA: This substance is typically associated with explosives work and with plastics, adhesives and epoxy preparation.

(3) Benzo(a)pyrene: This substance was used extensively at the Lovelace Respiratory Research Institute for various inhalation studies; therefore, those involved in research work at this institute can be assumed to have had significant exposure. Other jobs and work processes that may be associated with this exposure are roofing, paving, firefighter training and sheet metal fabrication.

(4) O-Toluidine: This substance is used in various laboratory activities.

(5) Benzidine: This substance has been used at DOE sites for activities associated with painting, predominantly used in the production of dyes. Benzidine can be absorbed into the body by inhalation, skin absorption, ingestion, and skin and/or eye contact. In 1973, OSHA regulations effectively banned United States production of benzidine, and it has not been produced for commercial sale in the United States since 1974; however, benzidine can be imported and small amounts are still used to make benzidine-based dyes.

c. Causation: For those employees who were employed consecutively for a full working year in a position that would have involved significant exposure to one of the toxins identified in (b)(1-5) (as opined by an Industrial Hygienist), causation is presumed.

7. Chronic Obstructive Pulmonary Disease (COPD): Part E causation can be assumed if all of the following criteria have been met.

a. Medical: The diagnosis of COPD has been established by the medical evidence.

b. Employment/Exposure: The employee must have been employed for an aggregate of 20 years in a position that would have had significant levels of asbestos exposure. This can be accomplished by the following two ways:

(1) The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1995.

(2) An IH has provided a well-rationalized discussion of case-specific evidence opining an employee has had 20 years of significant asbestos exposure during any time period

c. Latency: The diagnosis of COPD was made after at least 20 years after initial exposure to asbestos in covered employment.

8. Hearing Loss: The Part E causation standard for hearing loss can be satisfied if the three following criteria (a, b and c) are satisfied:

a. Medical: The file contains a diagnosis of bilateral sensorineural hearing loss (conductive hearing loss is not known to be linked to toxic substance exposure).

b. Employment: The verified covered employment must be within at least one specified job category listed below (or any combination thereof) for a period of 10 consecutive years, completed prior to 1990. The labor categories are the following:

- Boilermaker
- Chemical Operator
- Chemist

- Electrician/Electrical Maintenance/Lineman
- Electroplater/Electroplating Technician
- Garage/Auto/Equipment Mechanic
- Guard/Security Officer/Security Patrol Officer (i.e., firearm cleaning activities)
- Instrument Mechanic/ Instrument Technician
- Janitor
- Laboratory Analyst/Aide
- Laboratory Technician/Technologist
- Lubricator
- Machinist
- Maintenance Mechanic
- Millwright
- Operator (most any industrial kind, the test being whether the operator position is one in which there is potential for solvent exposure)
- Painter
- Pipefitter
- Printer/Reproduction clerk
- Refrigeration Mechanic/HVAC Mechanic
- Sheet Metal Worker
- Utility Operator

Employees often present evidence that they were in a labor category that is the "equivalent" of one of those listed here. When a claimant makes a claim that a job the employee performed is synonymous to one of the qualifying labor categories listed above, and a CE conducted SEM labor category alias search does not provide assistive information, the CE can seek assistance in evaluating the claim by taking one of two actions.

(1) Referral to the SEM mailbox. The SEM team has access to site documentation that can assist in making determinations of equivalency, **or**

(2) Submission of an IH referral. After a review of the evidence submitted and through the use of their expert knowledge of industrial processes, an IH can opine whether jobs are equivalents.

In a case in which a finding of equivalency is established, DEEOIC staff may not use a finding in one case as a generalization for use in other claims, because of the variability of job tasks and labor categories across the DOE complex during the history of atomic weapons production.

c. Exposure: Evidence in the file must not only establish that the employee worked within a certain job category listed above, but that the employee was concurrently exposed to at least one of the specified organic solvents listed below:

- Carbon Disulfide
- Ethyl Benzene
- Methyl Ethyl Ketone

- Methyl Isobutyl Ketone
- N-hexane
- Styrene
- Toluene
- Trichloroethylene
- Xylene

In addition to thoroughly reviewing records from the case file to establish such exposure, the CE can also use SEM to identify the employee's potential exposure to one or more of the listed toxic substances during employment in one of the qualifying labor categories (prior to 1990). The CE must carefully screen the evidence to apply appropriate SEM search filters that correlate to the employee's work history, including labor category, work process or site/area filters. With a well-designed SEM search that correlates to the employee's work history in a qualifying labor category, any identified potential exposure to one of the noted toxins above is sufficient for the CE to accept for application in the hearing loss standard. The CE must make a similar finding separately for each labor category in which the employee worked for the continuous 10-year period prior to 1990. When necessary, the CE may also consult with a DEEOIC Industrial Hygienist to obtain assistance in determining if the evidence establishes the employee's exposure to one or more of the necessary toxic substances.

d. Challenges to the DEEOIC Standard. This standard described in this section represents the sole evidentiary basis a CE is to use in making a decision concerning whether it is "at least as likely as not" that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateral sensorineural hearing loss. Claims filed for hearing loss that do not satisfy the standard outlined in this section cannot be accepted, because it represents the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance. As is usual for all claims, the CE is to undertake development on any hearing loss claim that does not meet the criteria described in this procedure, which entails communicating to the claimant the evidence necessary to meet the standard (medical+employment+exposure). As part of that development, the CE is to notify the claimant of his or her ability to challenge the scientific underpinnings of the DEEOIC hearing loss standard.

If the claimant wants to challenge one or more of the criteria of the standard, the claimant has the burden of establishing, through the submission of probative scientific evidence, that the criteria used by the program do not represent a reasonable consensus drawn from the body of available scientific data. If a claimant seeks to argue that the standard is not based on a correct interpretation of available scientific evidence, or that a toxic substance that is not listed as having a health effect of hearing loss exists, he or she will need to provide probative epidemiological data to support the claim. At a minimum, the claimant must produce epidemiological evidence (medical health science journals, articles, periodicals or other peer-reviewed publications) that specifically identifies or references a toxic substance, as defined by DEEOIC's regulations, which the evidence describes as having a health effect of bilateral sensorineural hearing loss. If the entire published article(s) are not provided, then the citation(s) must include: Journal Name, Author Last Name, Year Article Published, Title of Article,

Volume (#) and Pages (#-#). Upon receipt of such evidence, the CE may refer the matter to the National Office Medical Health Science Unit for evaluation. The CE does not need to refer to the National Office cases where claim submissions do not present evidence that satisfies the minimal standard for consideration.

9. Kidney Cancer: Part E causation can be presumed for kidney cancer if all of the following criteria have been met. If the case does not meet the causation presumption as stated below but does have some indicators of TCE exposure and a diagnosis of kidney cancer, development is to include an IH referral if appropriate (e.g. an exposure presumption does not exist) and obtaining a medical opinion on causation.

a. Medical: A medical diagnosis of kidney cancer has been made.

b. Exposure: An employee must have been employed for 5 or more consecutive years prior to 1990 in a position that would have had significant trichloroethylene (TCE) exposure. This can be determined by an IH assessment or without the review of an IH if the employee meets all of the following employment criteria (exposure presumption):

(1) The employee was employed at one of the following facilities at which TCE use occurred extensively prior to 1990 and was most likely used for vapor degreasing and metalworking.

- Area IV of the Santa Susana Field Lab (ETEC)
- Argonne National Lab (East)
- Argonne National Lab (West)
- Brookhaven National Lab
- Dana Heavy Water Plant
- Dayton Project
- Electro Metallurgical
- Feed Materials Production Center (Fernald)
- Fermi National Accelerator Laboratory
- General Electric Company (Ohio)
- Hanford/PNNL
- High Energy Rate Forging Facility
- Idaho National Lab
- Iowa Ordnance Plant
- Kansas City Plant
- Lawrence Berkeley National Lab
- Lawrence Livermore National Lab
- Los Alamos National Lab
- Mallinckrodt Chemical Co., Destrehan Street Facility
- Mound Plant
- Nevada Test Site
- Oak Ridge GDP (K-25)

- Oak Ridge National Lab
- Paducah GDP
- Pantex Plant
- Pinellas Plant
- Portsmouth GDP
- Reduction Pilot Plant (Huntington)
- Rocky Flats Plant
- Sandia National Lab-Albuquerque
- Sandia National Lab-Livermore
- Savannah River Site
- South Albuquerque Works
- Stanford Linear Accelerator Center
- Tonopah Test Range
- Weldon Spring Plant (Mallinckrodt)
- West Valley Demonstration Project
- Y-12 Plant

(2) The employee worked at that facility prior to 1990.

(3) The employee worked in a labor category in which SEM indicates a potential for TCE exposure.

c. Latency: The employee was diagnosed with kidney cancer 20 years after initial exposure to TCE in covered employment.

10. Laryngeal Cancer: Part E causation can be presumed for laryngeal cancer when all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of laryngeal cancer, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of laryngeal cancer.

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

c. Latency: The diagnosis of laryngeal cancer was made at least 15 years after initial exposure to asbestos in covered employment.

11. Leukemia: Part E causation can be presumed for leukemia when all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but does have some indicators of benzene exposure and a diagnosis of leukemia, development is to include an IH

referral if appropriate (e.g. an exposure presumption does not exist) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of leukemia. The following ICD-9/ICD-10 codes are acceptable for this presumption: 202.40-202.48/C91.40-C91.42; 203.10-203.12/C90.10-C90.12; and all of 204/C91; 205/C92; 206/C93; 207/C94; and 208/C95.

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

c. Latency: The diagnosis of leukemia was made at least 365 calendar days after initial exposure to benzene in covered employment.

12. Lung Cancer: Part E causation can be presumed for lung cancer when all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of lung cancer, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of lung cancer.

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

c. Latency: The diagnosis of lung cancer was made at least 15 years after initial exposure to asbestos in covered employment.

13. Meningioma: Causation is presumed for those cases in which the employee is found to have received a dose of ionizing radiation at levels equal to or greater than 1 sievert (SV), but not below 1 SV. A review by a National Office health physicist is required to determine whether the radiation threshold has been satisfied.

a. Medical: The file contains a diagnosis of meningioma.

b. Exposure: A national office health physicist review is required in these cases to determine radiological exposure.

14. Mesothelioma: Part E causation can be presumed for mesothelioma once all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of mesothelioma, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of mesothelioma.

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 30 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

c. Latency: The diagnosis of mesothelioma was made at least 15 years after initial exposure to asbestos in covered employment.

15. Non-Hodgkin's Lymphoma: Part E causation can be presumed for non-Hodgkin's lymphoma when all (a-c) of the following criteria have been satisfied:

a. Medical: The file contains a diagnosis of non-Hodgkin's lymphoma.

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure with lindane (1,2,3,4,5,6-Hexachlorocyclohexane) for at least 56 days.

or

The employee was employed for an aggregate of 2 years in a position that would have had significant pentachlorophenol exposure.

c. Latency: For exposure to lindane, the diagnosis of non-Hodgkin's lymphoma was made at least 20 years after initial exposure to lindane (1,2,3,4,5,6-Hexachlorocyclohexane) in covered employment. Additionally, it is worth noting that, "experience from studies of cancer in humans indicates that the period from first exposure to the development of cancer is sometimes longer than 20 years."

For exposure to pentachlorophenol, the diagnosis of non-Hodgkin's lymphoma was made at least 10 years after initial exposure to pentachlorophenol in covered employment.

16. Ovarian Cancer: Part E causation can be presumed for ovarian cancer when all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of ovarian cancer, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: A medical diagnosis of ovarian cancer has been made.

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

c. Latency: The diagnosis of ovarian cancer was made at least 15 years after initial exposure to asbestos in covered employment.

17. Parkinsonism: Parkinsonism may be associated with toxic exposure. The CE develops claims for Parkinsonism, Parkinson's disease (PD) and any reasonable alias in the same manner. The CE performs a SEM search using available guidance and uses the health effect of "Parkinsonism" for any claim identifying Parkinsonism, PD, or any reasonable alias. SEM identifies the toxic substances currently linked to this condition. Part E causation can be presumed for "Parkinsonism" if all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but does have some indicators of exposure to a toxic substance associated with "Parkinsonism" and a diagnosis of Parkinsonism, Parkinson's disease (PD) and any reasonable alias, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of Parkinsonism, PD, or any reasonable alias.

b. Exposure: There is evidence of an acute occupational exposure to carbon monoxide (CO) that precedes the onset of "Parkinsonism." To establish such exposure, the CE requests or reviews the file for contemporaneous evidence of an incident requiring medical intervention that fits one of the following criteria:

(1) An incident involving acute occupational CO exposure that caused the claimant to lose consciousness at the time of the exposure.

(2) A documented incident involving significant CO levels and/or exposure sufficient to either cause loss of consciousness or a reduction in oxygen which could result in brain injury. (NIOSH and OSHA consider a CO level of 1200PPM to be "immediately dangerous to life and health," and this level would be considered evidence of a toxic level sufficient to cause loss of consciousness in an adult.)

(3) Documentation such as laboratory test results or other clinical records demonstrating blood gas levels consistent with a reduction of oxygen sufficient to cause injury to the brain; or admission records documenting treatment or observation arising from an occupational CO exposure. (A carboxyhemoglobin level of 20% or higher would be evidence of a blood gas level sufficient to cause brain injury.)

c. Latency: The employee was diagnosed with Parkinsonism, PD, or any reasonable alias following an incident of acute occupational CO exposure as described above in the exposure section.

d. Other development considerations: The CE may consider the following work processes and routes of exposure when developing a "Parkinsonism" claim.

(1) Toxic substances: 1018 Steel, Alumel, Aluminum 3S alloy, Galvanized steel, Hastelloy, Kovar, Tool steel, Uranium manganese alloy.

(a) Route of Exposure: Inhalation.

(b) Work processes:

- Heating, grinding or machining manganese or manganese alloys.
- Mining or crushing manganese alloys.
- Welding or cutting mild steel.

(2) Toxic Substance: Manganese.

(a) Routes of Exposure: Inhalation, skin.

(b) Work processes:

- Heating, grinding or machining manganese or manganese alloys.
- Mining or crushing manganese ores.
- Producing manganese metal.
- Welding or cutting manganese alloys.
- Manufacturing dry cell batteries.
- Silk-screen and other printing activities using manganese-bearing pigments.
- Painting activities using manganese-bearing pigments.

(3) Toxic Substances: Manganese II chloride, Potassium permanganate.

(a) Routes of exposure: Inhalation, skin.

(b) Work processes:

- Photographic processing.
- Chemical laboratory activities
- Production processes using chemicals containing manganese.
- Pouring chemical powders.
- Sewer and wastewater treatment.
- Using disinfectants.
- Sanitizing drinking water pipes and delivery systems.

(4) Toxic Substance: Carbon monoxide.

(a) Routes of exposure: Inhalation.

(b) Work processes:

- Photographic processing.
- Chemical laboratory activities.

- Production processes using chemicals containing manganese.
- Pouring chemical powders.
- Sewer and wastewater treatment.
- Using disinfectants.
- Sanitizing drinking water pipes and delivery systems.

18. Pleural Plaques: Part E causation can be presumed for pleural plaques once all of the following criteria have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of pleural plaques, development is to include an IH referral if appropriate (e.g. there are no established exposure presumptions) and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of pleural plaques.

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

c. Latency: The diagnosis of pleural plaques was made at least 10 years after initial exposure to asbestos in covered employment.

19. Radiation Induced Cataract: Cataracts may be associated with ionizing radiation. If a claim is presented for this condition, the CE considers the following.

a. Medical: The medical evidence establishes a diagnosis of cataracts, ICD-9/ICD-10 code 366.46/H26.8.

b. Exposure: The level of radiation needed to have a causal relationship is 500-800 rem directed towards the lens of the eye. This would be a documented accident or event indicating high or accidental radiation exposure.

c. Latency period: The latency period usually associated with the event or exposure and the onset of the condition is a year or less.

d. Causation and other considerations: If an employee has been diagnosed with cataracts and there is evidence that an incident or accident took place within the medical, dosimetry, or incident reports; the case will be referred to the National Office Health Physicist for a review and causation determination. If the case does not present with the appropriate documentation to suggest high levels of occupational radiation, the case is to be reviewed as a possible consequential illness if the employee has been treated with radiation therapy for an accepted cancer since radiation treatment associated with cancer can produce the level of radiation needed.

20. Radiation Sickness (Acute): Acute radiation sickness may be associated with ionizing radiation. If a claim is presented for this condition, the CE considers the following.

a. Medical: The medical evidence establishes a diagnosis of radiation sickness, ICD-9/ICD-10 code 990/T66.

b. Exposure: The level of radiation needed to have a causal relationship is 100-200 rem. This would be a documented accident or event indicating high or accidental radiation exposure.

c. Latency period: The latency period usually associated with the event or exposure and the onset of the condition is two weeks or less.

d. Causation and other considerations: If an employee has been diagnosed with acute radiation sickness and there is evidence that an incident or accident took place within the medical, dosimetry, or incident reports; the case will be referred to the National Office Health Physicist for a review and causation determination. If the case does not present with the appropriate documentation to suggest high levels of occupational radiation, the case is to be reviewed as a possible consequential illness if the employee has been treated with radiation therapy for an accepted cancer since radiation treatment associated with cancer can produce the level of radiation needed.

Industrial Hygienist Referral Form

1. Employee Information:

Name:		**Terminal:**	
Case ID:			
Date of Birth:			
Date of Death:			

2. Attachments:

SEM: ☐ Yes ☐ No	**OHQ:** ☐ Yes ☐ No	**DAR:** ☐ Yes ☐ No	**EE-3:** ☐ Yes ☐ No
Other:			
Note:			

3. Question(s) for IH:

4. Claims Examiner Information:

Date Referred:			
CE Name:			
CE Phone Number:			
CE Unit:		**CE Email Address:**	
Originating Office:			
Approved by:			

Industrial Hygienist Referral Form Instructions

The purpose of the Industrial Hygienist Referral Form and Referral Package is to provide vital information to the Industrial Hygienist (IH) after the CE has analyzed the evidence and explained the exposure analysis on the Exposure Worksheet or equivalent exposure assessment documentation. The IH provides a well rationalized report on the nature, frequency, and duration of the employee's exposures based on his/her specialized knowledge.

1. Employee Information:
Provide the employee's name, Case ID, date of birth, and date of death if applicable. Indicate "yes" for terminal if the employee or an eligible claimant on the case is considered terminal. Ensure all information provided is accurate.

2. Attachments:
Attach the Exposure Worksheet or equivalent. The worksheet, or equivalent documentation to support the CE's exposure assessment, is required for the IH referral. Indicate if SEM results, OHQ, DAR records, and/or EE-3 are attached.

For SEM, only include SEM results that provide affirmative results and show the date the search was performed. Do not include SEM results that merely exclude potential exposure (i.e., nothing for a labor category or work process filtered by health effect).

For DAR, only include records that are relevant to the exposure under review. Relevant documents include job/work process descriptions, description of work area or location, references to safety and health monitoring data, listing of potential toxic substance exposures or monitoring, medical records of exposure incidence or other toxic substance encounters, etc. Irrelevant documents include health physics or radiological data, wage or earning documentation, job performance ratings (unless they mention exposure data), general employment health monitoring or injury reports, memorandum or other communications of an administrative nature (unless they reference exposure), or general medical records relating to diagnosis and treatment of medical conditions.

If other documents are attached, indicate those under "Other". This would include any employee completed letters about exposure or work duties, affidavits or other similar documents completed by other sources. Any email traffic or documented phone calls between the IH regarding the toxins that were most likely encountered, most impactful for the claim, or other exposure guidance. Any SEM Mailbox guidance obtained about the employee's work or exposure.

If there are no attachments (SEM, OHQ, DAR, EE-3), in the note section indicate the reason the document is not included and/or provide any other relevant information regarding the attachments that may be useful to the IH.

3. Question(s) for IH:
The question(s) to the IH is to identify a specific set of chemical or biological toxins the employee most likely had exposure to as determined on the Exposure Worksheet (or equivalent documentation). No more than seven (7) toxins 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 is necessary.

Before sending referral to an IH, the CE should review the exposure presumptions that were established by the evidence and noted on the Exposure Worksheet (or equivalent documentation). The CE ensures these time periods or exposures are not included in the question unless evidence is submitted that warrants review. The question to the IH must be as specific as possible with regard to what information the CE requires for case adjudication. For example:

Given Mr. Perry's diagnosed condition of skin cancer and his work at the Paducah Gaseous Diffusion Plant from 1952-1960 as a machinist, what would be the nature, frequency, and duration of his exposure to mineral oil?

Based on Mr. Smith's diagnosed condition of chronic renal failure and his work at Hanford as an Electrician apprentice from 1/8/1956 - 1/10/1958; Electrician 1/11/1958 - 3/20/1962; and Electrician Foreman 3/21/1962 - 4/25/1985; what would be the nature, frequency, and duration of his exposure to lead?

4. Claims Examiner Information:
The CE will provide the date the referral was referred to the National Office (this date will equal the sent date used for ECS coding purposes), their name, phone number, Unit, email address, and their originating office. The Supervisor or other office designee that approved the referral will be listed. A wet signature is not required.

IH Referral Package:
The referral package will be consolidated into a single PDF document and saved in the following format: Employee Last Name – Case ID (Smith – 5001234). Save the package in the following order: (1) IH Referral Form (2) Exposure Worksheet, or equivalent (3) SEM printouts (4) OHQ (5) Relevant DAR records (6) EE-3 and/or (7) other affidavits or any other relevant supporting documentation. The CE must screen all material in the referral to ensure that information or document in referral package all relate to the case undergoing IH review.

Transmission of Referral Package:
Once all actions are complete, the referring CE or other designated staff person sends the IH referral PDF to the following email address: IH_Referrals@dol.gov. The subject line of the email must read, "IH Ref: (Employee Last Name and Case ID) – (DO) e.g., IH Ref: Jones 5001234-JAC. If the employee or eligible claimant on the case is terminal, also include "Terminal" in the subject line after the DO. If a referral package is updated or revised at any time and resubmitted, the CE indicates "Revised" in the subject line after the DO designation. If a referral package needs to be withdrawn at any time after submission, the CE is to "reply all" from the initial email and indicate "Withdrawn" in the subject line after the DO designation.

Sample Questions For Physician

Questions:

CE: Choose from options below or add your own

1. Impairment: Refer to PM Ch. 2-1300, Impairment Ratings for questions and instructions for CMC's conducting impairment evaluations.

2. Impairment: If it is not possible to complete an impairment rating based on the medical evidence we provided, please advise us what medical records and/or testing is required to complete the rating.

3. Diagnosis: In your opinion, do the medical records support a diagnosis of a medical condition? If so, please provide the first date of diagnosis, diagnosis, and the ICD code.

4. Causation: If a medical condition was diagnosed, in your opinion is it at least as likely as not that exposure to toxic substances during the course of employment at covered facility was a significant factor in aggravating, contributing to, or causing the employee's medical condition?

5. Causation: If so, please provide the earliest date of diagnosis(es) and ICD code of the condition you believe is related. Please provide the rationale and objective findings to support your conclusion that the condition(s) are related to exposure in the workplace.

Claims Examiner _____
(Printed Name)

_____ _____
(Signature) (Date)

ICD Codes and Corresponding Procedure Codes

V49.8	**File Reviews**
FR001	File Review
FR002	Supplemental File Review
FR003	Clarification of Diagnosis, Treatment, Tests
V49.8	**Impairment Ratings**
FR004	Impairment Evaluation
V68.89	**Wage-Loss**
WL001	Assessing Ability to Work/Wage-Loss
V68.2	**Second Medical Opinions**
SEP02	Second Medical Opinion (**includes physical exam and file review**)
FR002	Supplemental File Review
Cancl	Appointment Cancellation
V65.8	**Referee Referrals (Physical Exam or Written Exam)**
REFER	Physical examination which includes file review
REF01	File review only

Sample Letter to Claimant Regarding Second Opinion/Referee Physician

DEEOIC Case ID: (Case ID #
Employee Name: **(Employee Name)**

(Claimant Name)
(Street Address)
(City, State, Zip)

Dear (Mr/Ms Claimant):

This letter is in reference to your claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Under our regulations, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has the authority to refer an employee for a physical examination by a second opinion physician when it considers such a referral to be reasonably necessary.

Because it considers such a referral to be reasonably necessary for the proper adjudication of your claim, DEEOIC has arranged for you to be examined by a second opinion physician. Please review the attached letter for the time, date, and location of your scheduled appointment. DEEOIC will pay the out-of-pocket costs you incur in connection with the examination or any diagnostic testing. Travel costs to attend the examination are reimbursable upon submission of Form OWCP-957 (Attached).

DEEOIC recommends that you call the physician's office ahead of time to confirm your appointment. Providing the physician with your name, case ID #, and contact information, when you call, will help ensure that the process works as smoothly as possible.

Rescheduling the appointment is strongly discouraged and you should only do so in emergencies. Altering an appointment schedule can hinder our ability to take substantive action on your claim and promptly deliver services to you. If you are unavoidably prevented from keeping your appointment, you must immediately call your assigned claims examiner at the district office at Your Phone #. DEEOIC will evaluate any request to reschedule your appointment to determine whether you have submitted proof of one or more legitimate reasons to change the appointment.

If you do not attend the scheduled appointment, or cannot establish good cause for your failure to appear, DEEOIC will suspend claim adjudication and administratively close your claim. Reopening of the claim record will not occur until you agree to and attend a DEEOIC scheduled medical examination.

DEEOIC strongly encourages physicians to limit persons in attendance during the actual examination to one or two individuals. This would include a family member or designated authorized representative, and/or a health care professional, such as a RN/LPN, or CNA/HHA who is currently providing care to the patient. Ultimately, it is the examining physician's decision as to who can be present during the examination.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Should someone accompanying you disrupt the scheduled medical examination, DEEOIC will reschedule the exam with a different qualified physician. You will not be entitled to have that individual accompany you during the subsequent examination unless DEEOIC determines that exceptional circumstances exist.

We appreciate your cooperation in this matter. If you have any questions regarding the scheduled examination, please contact me at the address listed above or call Your Phone #.

Sincerely,

(YOUR NAME)

Enc: OWCP-957
Copy of Authorization Letter

NIOSH Referral Summary Document (NRSD)

Enter a "X" where appropriate

	Initial		Amendment		Supplement
Remarks (if Amendment or Supplement):					

1. DOL Case ID Number:

Case File Contact Information

2. Energy Employee (EE):

a. Name (First-Middle-Last-Suffix)		
b. Gender (Male or Female)		
c. Date of Birth (MM/DD/YYYY)		
d. Date of Death (MM/DD/YYYY)		
e. Address (Street, City, State, Zip)		
f. Phone Number and Type		

3. Survivor(s) (SV) (If applicable, create a table for each):

a. Name (First-Middle-Last-Suffix)		
b. Address (Street, City, State, Zip)		
c. Phone Number and Type		
d. Relationship to employee		
e. Currently eligible survivor (Y/N)		

a. Name (First-Middle-Last-Suffix)		
b. Address (Street, City, State, Zip)		
c. Phone Number and Type		
d. Relationship to employee		
e. Currently eligible survivor (Y/N)		

a. Name (First-Middle-Last-Suffix)		
b. Address (Street, City, State, Zip)		
c. Phone Number and Type		
d. Relationship to employee		
e. Currently eligible survivor (Y/N)		

4. Other Contact(s)(OC)(If applicable, create a table for each):

a. Name (First-Middle-Last-Suffix)		
b. Address (Street, City, State, Zip)		
c. Phone Number and Type		
d. Relationship to employee		

Medical and Employment Information

5. EE Covered Cancer Information (create a table for each cancer):

a. Primary [☐] or Secondary (metastatic) [☐]	
b. Cancer Description/Type	
c. Associated ICD-10 Code	
d. Date of Cancer Diagnosis	

6. Other Covered Condition:

a. SEC Cancer Claim, but filing for Non-SEC cancer medical benefits [☐]
b. Other claim for benefits scenario [☐]
c. Explain:

7. Energy Employee Verified Employment History:
(List all breaks in employment at the DOE or AWE Facility):

a. Employer / Facility Name	
b. Start Date	
c. End Date	
d. Employment Badge Number	
e. Dosimetry Badge No.	
f. Job Title	

8. Employment Verification Information Valuable to NIOSH:

a. ☐ DOE could not verify employment
b. ☐ Employment Verification based upon Affidavit or Other Credible Evidence.
c. ☐ Worked for a contractor/sub-contractor not listed in DOE Office of Worker Advocacy facility online database.

9. Other information relevant to dose reconstruction, if required:

a. If the claim is for **skin cancer** or a secondary cancer for which skin cancer is a likely primary cancer, list one or more of the following:	☐ American Indian or Alaska Native ☐ Asian, Native Hawaiian, or Pacific Islander ☐ Black ☐ White-Hispanic ☐ White-Non-Hispanic ☐ Not given
b. If the claim is for **lung cancer** or a secondary cancer for which lung cancer is a likely primary cancer, select one of the following (Note: Currently refers to time of cancer diagnosis):	☐ Never smoked ☐ Former smoker ☐ Current smoker (? cig/day) →☐ <10 cig/day →☐ 10-19 cig/day →☐ 20-39 cig/day →☐ 40+ cig/day

10. DOL Information:

a. District Office	
b. Claims Examiner Name	
c. Claims Examiner Phone Number	
d. Claims Examiner e-mail address	

Reviewed by:

_____ _____

Claims Examiner Date

INSTRUCTIONS FOR COMPLETING THE NRSD				
No.	**Title**	**Description**	**Example**	
N/A	NRSD Type	Enter an "X" next to the type of NRSD that is being submitted. If you select Amendment or Supplement enter Remarks (the reason and or data that has created the need for an Amendment/Supplement. For an Initial NRSD include all sections, unless they will be blank (i.e., other contact if there isn't one). For an Amendment include the employee's name, DOL case number, NIOSH tracking number, the tables that include changed information, and the DOL information (including the SrCE or journey level CE signature). For Supplements, include the DOL case number, NIOSH tracking number, and employee's name.		
1	DOL Case ID	Enter the case ID number	12345	
2	Energy Employee (EE)	The employee as listed on the EE-1/EE-2.		
a	Name	Enter the Employee's name as it is listed in ECS/Claim Form (First, Middle Initial, Last, Suffix)	Fred R. Flintstone, III	
b	Gender	Enter *Male* or *Female* as indicated in ECS/Claim Form	Male, Female	
c	Date of Birth	Enter the date of birth in MM/DD/YYYY format	01/31/1964	
d	Date of Death	***If applicable***, enter the date of death in MM/DD/YYYY format	11/01/2006	
e	Address	***If applicable***, enter the full address of the EE (Street, City, State, and zip code) Helpful Hint: Adding the +4 zip code may speed up mail delivery by several days (visit www.usps.com to find an address' +4 zip code).	710 Bedrock Dr., Aiken	
f	Phone Number and Type	***If available/applicable,*** enter the employee's 10 digit phone number. Refer to ECS for the EE-2. Type can include home, work, cell, day, evening, vacation home, etc.	865-123-9870	Home
3	Survivor(s) Data	***If applicable,*** enter the survivor's data for each survivor that has filed a Claim for Benefits, Form EE-2. If not applicable (the employee is living), delete these tables. If there are more than 3 survivors, copy and paste one table and add to the bottom, be sure to include a space between them.		
a	Name	Enter the Survivor's name (First, Middle Initial, Last, Suffix). Refer to ECS for the EE-2	Betty D. Flintstone	
b	Address	Enter the full address of the survivor (Street, City, State, and zip code). Refer to ECS or the EE-2.	710 Bedrock Dr., Aiken, SC 26175-0454	
c	Phone Number and Type	**If available**, enter the survivor's 10 digit phone number. Refer to ECS or the EE-2. Type can include home, work, cell, day, evening, vacation home, etc.	703-999-8000	Other
d	Relationship to Employee	Enter the survivor's relationship to the employee as selected on the EE-2	Spouse, Child, Grandchild	
e	Currently eligible survivor (Yes or No)	Enter Yes or No. Entering "Yes" means the survivor has met all the requirements to establish survivorship. Also note if the survivor is a "Part E Only" survivor (i.e., a non-spousal child). In cases of multiple survivors, indicate which survivor would prefer to be contacted by entering "Primary Contact" in the space provided.	Yes (Part E Only/Non-spousal Child)/Primary Contact	
4	Other Contact	**If applicable,** enter the Authorized Representative/Power of Attorney (POA) data. If not, delete this table. If there is more than one contact, copy and paste the table and add to the bottom, be sure to include a space between them.		
a	Name	Enter the Contact's name (First, Middle Initial, Last, Suffix)	Ira M. Lawyer, Jr.	
b	Address	Enter the full address of the survivor (Street, City, State, and zip code)	710 Bedrock Dr., Aiken, SC 26175-0454	
c	Phone Number and Type	**If available**, enter the survivor's 10 digit phone number. Type can include home, work, cell, day, evening, vacation home, etc.	703-999-8000	Work

d	Relationship to employee	**If known,** enter the contact's relationship to the EE	Lawyer
5	EE Covered Cancer Information	Enter the EEs verified diagnosed cancer(s). Create a table (copy, cut, paste); for each primary cancer or secondary cancer for which there is an unknown primary.	
a	Primary or Secondary	Place an "X" (by clicking) in the box that best describes the cancer (Primary or Secondary)	
b	Cancer Description/Type	Enter the cancer description from the pathology/operative report, etc.	Chronic myelomonocytic leukemia, in remission
c	Associated ICD-10 Code	Enter the ICD-10 code that best describes the cancer	C93.11
d	Date of Cancer Diagnosis	Enter the date of cancer diagnosis from pathology report, operative report, death certificate, etc. in MM/DD/YYYY format. The entire date is not required but preferred. List the month and year if the full date is not available. The year of diagnosis is required.	01/10/2001
6	Other Covered Condition	**If applicable,** place and "X" (by clicking) in the box(es).	
a	SEC Cancer Claim, but filing for Non-SEC cancer medical benefits	Select this box if the claim is an employee claim or a survivor claim where the employee filed initially, that is being or has been accepted for an SEC cancer; and there is a claim for a non-SEC Cancer.	Employee is accepted for SEC lung cancer; and now is filing for a non-SEC skin cancer.
b	Other claim for benefits scenario	If there is any scenario not "typical" (i.e., non SEC cancer/employment) and not covered in 6.a, select this box by clicking.	Part B survivor case accepted for CBD. Under Part E, cannot establish death link relating to CBD; death certificate lists lung cancer as cause of death.
c	Explain	Provide a detailed/specific explanation for the reason box 6.b was selected	For the example above: "Survivor already compensated under Part B, Dose Reconstruction will be to establish death link for Part E only."
7	Energy Employee Verified Employment History	Complete this section for all verified employment. Any breaks in employment seven days or more must be reported separately. Create another table by using copy, paste; remember to leave a space between them. It is not necessary to verify employment beyond the date of cancer diagnosis for the purposes of submitting the NRSD; however, once submitted, continue to complete employment verification for toxic exposure and other claimed illnesses. Remember that the verified employment may extend beyond the covered employment at a particular site. The CE must verify the covered dates for a site by going to the DOE Office of Worker Advocacy Covered Facility List (http://www.hss.energy.gov/healthsafety/fwsp/advocacy/faclist/findfacility.cfm).	
a	Employer/Facility Name	Enter the employer and Facility Name	Union Carbide/K-25
b	Uranium Mine/Mill	For RECA Section 5 workers, Enter Name of Uranium Mine/Mill	Climax Uranium Mill, Grand Junction, CO
c	Start Date	Enter the start date in MM/DD/YYYY Format	01/01/1956
d	End Date	Enter the end date in MM/DD/YYYY Format	12/31/1959
e	Employment badge number	**If available**, list the EEs employment badge number from the EE-3 or DAR.	10349
f	Dosimetry Badge No.	**If available**, list the EEs dosimetry badge number from the EE-3, DAR, or ORISE	10949
g	Job Title	**If available,** list the EEs job title (for the specific employment period) using information from the EE-3, DAR, or ORISE	Pipefitter

INSTRUCTIONS FOR COMPLETING THE NRSD				
8		Employment verification information valuable to NIOSH	Select these boxes, by clicking, if applicable.	
	a	DOE could not verify employment	Select this box if employment wasn't verified	
	b	Employment verification based on affidavit or other credible evidence		
	c	Worked for a contractor/sub-contractor not listed	If the employee worked for a contractor/subcontractor not listed on the DOE Office of Worker Advocacy Covered Facility List, select this box.	F.H. McGraw
9		Other information relevant to dose reconstruction	For skin cancer and lung cancer cases additional information regarding the following must be provided.	
	a	Ethnicity selection	For skin cancers, it is required that the District Office supply NIOSH with the EEs race/ethnicity. The method used to gather this information is EE/EN-9. If the claimant does not return the questionnaire within 60 days, the case will be administratively closed. However, if the CE can obtain the information from the EE's medical information or other credible source (i.e., DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired.	
	b	Smoking History	For lung cancer or a secondary cancer with an unknown primary cancer that includes lung cancer as a possible primary cancer, the CE must request the EEs smoking history using the EE/EN-8. If the claimant does not return the questionnaire within 60 days, the case will be administratively closed. However, if the CE can obtain the information from the EE's medical information or other credible source (i.e., DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired. If the employee is a current smoker (currently refers to time of cancer diagnosis), then the CE must select an additional box, which indicates the amount (per day) the employee smoked at the time of cancer diagnosis.	
10		DOL Information	Enter the requested information	
	a	District Office	Enter the CE's District Office	Cleveland, Denver, Jacksonville, Seattle
	b	Claims Examiner Name	Enter the CE's full name	John Q. Examiner
	c	Claims Examiner Phone No.	Enter the CE's direct dial phone number (not the toll free number)	(904)357-4795 x74307
	d	Claims Examiner e-mail address	Enter the CE's DOL e-mail address	examiner.john@dol/.gov
Reviewed by			A CE/SrCE must review the NRSD, sign, and date; affirming that to the best of her/his ability, they have reviewed the information provided and believe it to be accurate and correct.	
Note: A complete copy of the case file (including the Part D if available) via CD or other means of electronic submission, will be duplicated and sent with the NRSD to NIOSH.				

NIOSH Referral Letter to Claimant

Dear *[Insert Claimant Name]*:

We have received the necessary medical and employment information submitted in support of your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The next step in the adjudication of your claim is the dose reconstruction process. The National Institute for Occupational Safety and Health (NIOSH), an agency within the Department of Health and Human Services, administers this portion of the process. In order for NIOSH to proceed with the dose reconstruction, they must have access to your complete case record. Therefore, a copy of your case file is being referred to them.

Based on our review of your claim, we will report the following information to NIOSH:

Medical

- Cancer diagnosis type (nomenclature), *[Insert Diagnosis Code(s)]* and date of diagnosis

Employment

- Employer name, facility, and dates of employment (list each individually)

If you [*or the "the employee" when writing to a survivor]* had any other primary cancers, in addition to what is listed above, it is important that you send written medical records documenting an explicit diagnosis of any additional primary cancers, the type of cancer, and the date of its first diagnosis. Also, with regard to employment, if you [or "the employee" if writing to a survivor] had other covered employment, either before or after the dates shown above, or employment at another Department of Energy covered facility, please send us any evidence you have that supports this additional employment. Any such medical or employment evidence should be sent to your claims examiner at the mailing address provided below.

Once NIOSH receives your case record, they will send you a letter advising that they have received your information. The letter will contain information on dose reconstruction and what to expect from NIOSH in regard to your claim. NIOSH has informed us that the process of dose reconstruction can be time consuming because it relies on information that must be collected from a number of sources. NIOSH's first priority is to ensure the collected information is valid and that the assumptions used to estimate doses are fair, consistent, and well-grounded in the best available science.

Once NIOSH completes the dose reconstruction, they will send us the results, and we will apply a formula, using the NIOSH data, to determine whether your *[or the employee's]* claimed cancer is at least as likely as not (a 50% or greater probability) related to the covered employment. We will then notify you, in writing, regarding the status of your claim.

If you have specific questions regarding the status of the dose reconstruction, you may contact the NIOSH office by calling their toll-free number at **1-877-222-7570**. Any other questions regarding your claim should be addressed to your claims examiner at the mailing address below.

Sincerely,

[Name]
[Title]
{Insert Central Mailroom Address}

Examples of Rework Request

These examples do not cover all scenarios. Please use your professional judgment in conveying the most accurate and pertinent information necessary concerning how the DR was performed, and what modifications need to be made. Also, ensure that the appropriate ICD code with the condition description is included.

1. Additional cancer reported to the DO (employment history unchanged):

NIOSH DR for Karen Smith, 111-11-1111, (NIOSH 3450). Ms. Smith was employed at the Paducah Gaseous Diffusion Plant for several periods between 09/28/55 to 12/28/79. The DR was performed for two cancers: BCC (left preaurical area), diagnosed on 01/28/02; and SCC in-situ right ear, diagnosed on 9/17/02. The POC was 38.14%.

Subsequently, the DO received evidence of an additional verified cancer: SCC (right posterior inferior pinna), diagnosed on 07/31/03.

2. Cancers were incorrectly reported in the NRSD (employment history has not changed):

John M. Jones, 222-22-2222, (NIOSH 5678). Mr. Jones was employed at the Nevada Test Site from (09/01/65 to 03/3/73) and (11/19/79 to 09/30/87). The DR was performed for two cancers:

- Prostate cancer, diagnosed on 01/01/98
- Adenocarcinoma, Barrett's Esophagus, diagnosed on 11/15/01

The POC was 36.39%. We reviewed the case file and determined that the prostate diagnosis date and the Barrett's Esophageal cancer were incorrectly reported. The correct cancer information follows:

1. Prostate cancer, diagnosed on 04/08/98 - (diagnosis 4 months later than reported)
2. Adenocarcinoma, lower (distal) esophagus, diagnosed on 11/15/01

3. Corrections to employment (cancer unchanged)

Mary Smith, 333-33-3333 (NIOSH 91264). Ms. Smith worked at NTS for four periods from the 1950s to the 1970s. The DR was performed for astrocytoma, diagnosed on 03/19/77. Based on the employment used in the DR, the POC was 35.57%.

The DR used the following NTS employment dates, as reported in the NRSD:

1. 04/24/57 – 06/24/57
2. 07/09/60 – 01/18/63
3. 01/31/63 – 07/19/65
4. 07/26/<u>55</u> – 02/01/74

Subsequent to submitting the NRSD report, we received additional employment evidence to determine that employment period 4 above, should actually be 07/26/**65** - 02/01/74, resulting in about 5 years less verified employment than represented in the current DR.

4. Correction to cancers and employment history:

Tom Doe, 444-44-4444 (NIOSH 23679). The DO reported that Mr. Doe was employed at the Tonopah Test Range and Nevada Test Site (NTS) from 03/27/87 to 01/22/91. The DR was performed for esophageal cancer, diagnosed on 03/26/93. The POC was 2.35%.

We reviewed the case file and found that the cancer and the employment site and dates reported in the original NRSD were incorrect. Please replace the originally reported esophageal cancer, with the following two cancers:

- Squamous cell carcinoma of the right piriform fossa, diagnosed on 01/31/90
- Squamous cell carcinoma of the distal esophagus, diagnosed on 03/25/93

In addition, Mr. Doe was on leave without pay as of 01/22/90, although his actual termination date was 01/22/91. Therefore, the correct employment is: Solely at NTS (no Tonopah employment) from 03/27/87 to 01/22/90, one less year than originally reported.

5. Correction to reported cancers, and additional cancer (no changes to employment):

DR for James Johnson, 555-55-5555 (NIOSH 0432). Mr. Johnson was employed at NTS intermittently from 09/07/54 to 12/31/95. The NRSD reported 4 primary cancer sites for dose reconstruction: two (2) prostate cancers (right and left lobes), and two (2) BCCs, diagnosed in 10/97 and 04/99. The resultant POC was 51.05%.

Upon further review of the medical evidence, we determined that the two prostate cancers should only be reported as one, as the pathology report for both lobes was reported within the same two weeks, and there is no indication that the two lobes are separate primaries. We also determined that the 04/99 BCC was a recurrent cancer of the 10/97 BCC and should not be included in the DR. In addition, we received additional medical evidence of another verified cancer: SCC (scalp), diagnosed on 06/12/96.

Therefore the DR should be performed for the correct cancers as follows:

1. Prostate, diagnosed on 10/14/84
2. BCC (rt cheek), diagnosed on 10/23/97
3. SCC (scalp), diagnosed on 06/12/96.

6. Deletion of several cancers from a list of multiple cancers (no change in employment):

DR for Pete James, 666-66-6666 (NIOSH 3495). Mr. James was employed at the Pacific Northwest National Lab from 08/25/69 to 06/28/87. The DR was performed for eleven (11) cancers. The POC was 52.1%.

Upon further review of the medical evidence in the case file, we determined that only eight (8) of the original eleven (11) cancers are verifiable. Below is the list of the 11 initially reported cancers; the three (3) erroneous cancers are identified by strikethrough:

1. Seminoma of the R. Testicle, 06/01/77
2. ~~BCC R. Shoulder, 10/30/97~~
3. BCC R. Cheek, 10/30/97
4. SCC in situ, L. Temple, 02/24/98
5. SCC in situ, Scalp, 02/24/98
6. ~~SCC in situ, L. Forearm, 04/24/98~~
7. SCC in Situ, L. Dorsal Forearm, 06/23/98
8. SCC R. Cheek, 11/29/01
9. BCC L. Chin, 11/29/01
10. ~~BCC L. Cheek, 02/07/02~~
11. SCC in situ, L. Lateral Forearm, 06/30/03

The 8 DOL verified cancers are therefore:

1. Seminoma of the R. Testicle, 06/01/77
2. BCC R. Cheek, 10/30/97
3. SCC in situ, L. Temple, 02/24/98
4. SCC in situ, Scalp, 02/24/98
5. SCC in Situ, L. Dorsal Forearm, 06/23/98
6. SCC R. Cheek, 11/29/01
7. BCC L. Chin, 11/29/01
8. SCC in situ, L. Lateral Forearm, 06/30/03

7. Additional verified employment periods (employment in NRSD correct):

DR for Sam Jones, 777-77-7777 (NIOSH 3254). The DR was performed for liver cancer, diagnosed on 09/03/87. The POC was 22%. The DR Coversheet (dated 06/02/05) notes Mr. Jones' Hanford employment as: "06/29/54-07/12/77 (eleven periods of employment)." This is correct based on the employment originally reported in the NRSD by the DO.

We have subsequently received evidence of additional verified Hanford employment periods:

1. 01/01/53 to 12/31/53
2. 08/07/53 to 06/28/54
3. 01/30/62 to 04/15/62
4. 01/01/79 to 12/31/79
5. 01/01/80 to 12/31/80

Review of Dose Reconstruction Letter to Claimant

Dear Claimant Name:

We recently received the results of the dose reconstruction conducted by the National Institute for Occupational Safety and Health (NIOSH) in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act. After review of the dose reconstruction and the evidence received in support of your claim, it was discovered that [insert reason].

We determined that your claim must be returned to NIOSH so that they can review and revise the dose reconstruction, as appropriate, to include this information. This may not affect the outcome of your claim, but the information used in the dose reconstruction must accurately reflect what is shown in the evidence received by the district office. Your NIOSH tracking number xxxxx will remain the same. Your claim will receive priority consideration by NIOSH.

You will have the opportunity to review the revised dose reconstruction report, and will again be required by NIOSH to sign the OCAS-1 to acknowledge your receipt of the revised report and initial dose reconstruction results.

When NIOSH finishes its revised study and sends us the results, we will apply a formula to the dose reconstruction to determine whether the cancer(s) was at least as likely as not (50% or greater chance) related to the covered employment. We will then notify you in writing regarding the status of your claim.

If you have specific questions regarding the status of the dose reconstruction, you may contact the NIOSH office by calling toll free at 1-877-222-7570. Any other questions should still be addressed to this district office.

Sincerely,

[Name]
[Title]
[District Office Location]

cc: NIOSH Public Health Advisor

Primary Cancer Sites

Secondary Cancer	Likely Primary Cancers
Lymph nodes of head, face and neck	Malignant neoplasm of base of tongue, Malignant neoplasm of parotid gland, Malignant neoplasm of tonsil, unspecified, Malignant neoplasm of pharynx, unspecified, Malignant neoplasm of glottis, Malignant neoplasm of trachea, Malignant melanoma of lip, Unspecified malignant neoplasm of skin of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of thyroid gland
Intrathoracic lymph nodes	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast
Intra-abdominal lymph nodes	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of pylorus, Malignant neoplasm of hepatic flexure, Malignant neoplasm of head of pancreas, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of endocervix, Malignant neoplasm of prostate, Malignant neoplasm of unspecified kidney, except renal pelvis, Follicular lymphoma, unspecified, extranodal and solid organ sites
Lymph nodes of axilla and upper limb	Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast
Inguinal and lower limb lymph nodes	Malignant neoplasm of rectosigmoid junction, Malignant neoplasm of trachea, Malignant melanoma of lip, Unspecified malignant neoplasm of skin of lip, Malignant neoplasm of prepuce
Intrapelvic lymph nodes	Malignant neoplasm of hepatic flexure, Malignant neoplasm of rectosigmoid junction, Malignant neoplasm of trachea, Malignant neoplasm of endocervix, Malignant neoplasm of corpus uteri, unspecified, Malignant neoplasm of prostate, Malignant neoplasm of trigone of bladder
Lymph nodes of multiple sites	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of cardia, Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast
Lymph nodes, site unspecified	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of cardia, Malignant neoplasm of sigmoid colon, Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate
Lung	Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate, Malignant neoplasm of trigone of bladder, Malignant neoplasm of unspecified kidney, except renal pelvis
Mediastinum	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast
Pleura	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of

	unspecified ovary , Malignant neoplasm of prostate, Malignant neoplasm of unspecified kidney, except renal pelvis
Other respiratory organs	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of hepatic flexure, Malignant neoplasm of glottis, Malignant neoplasm of trachea, Unspecified malignant neoplasm of skin of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate, Malignant neoplasm of thyroid gland
Small intestine, including duodenum	Malignant neoplasm of duodenum, Malignant neoplasm of hepatic flexure, Malignant neoplasm of head of pancreas, Malignant neoplasm of trachea, Malignant neoplasm of connective and soft tissue of head, face and neck, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of unspecified ovary, Malignant neoplasm of unspecified kidney, except renal pelvis
Large intestine and rectum	Malignant neoplasm of hepatic flexure, Malignant neoplasm of rectosigmoid junction, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of unspecified ovary, Malignant neoplasm of prostate
Retroperitoneum and peritoneum	Malignant neoplasm of cardia, Malignant neoplasm of hepatic flexure, Malignant neoplasm of rectosigmoid junction, Malignant neoplasm of head of pancreas, Malignant neoplasm of trachea, Malignant neoplasm of peripheral nerves of head, face and neck, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of corpus uteri, unspecified, Malignant neoplasm of unspecified ovary
Liver, specified as secondary	Malignant neoplasm of cardia, Malignant neoplasm of hepatic flexure, Malignant neoplasm of rectosigmoid junction, Malignant neoplasm of head of pancreas, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast
Other digestive organs	Malignant neoplasm of upper third of esophagus, Malignant neoplasm of cardia, Malignant neoplasm of hepatic flexure, Malignant neoplasm of head of pancreas, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate
Kidney	Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of endocervix, Malignant neoplasm of prostate, Malignant neoplasm of trigone of bladder, Malignant neoplasm of unspecified kidney, except renal pelvis, Follicular lymphoma, unspecified, extranodal and solid organ sites
Other urinary organs	Malignant neoplasm of hepatic flexure, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of endocervix, Malignant neoplasm of unspecified ovary, Malignant neoplasm of prostate, Malignant neoplasm of trigone of bladder, Malignant neoplasm of unspecified kidney, except renal pelvis

Skin	Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant neoplasm of peripheral nerves of head, face and neck, Malignant melanoma of lip, Unspecified malignant neoplasm of skin of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of unspecified kidney, except renal pelvis
Brain and spinal cord	Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast
Other parts of nervous system	Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate, Follicular lymphoma, unspecified, extranodal and solid organ sites
Bone and bone marrow	Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of prostate
Ovary	Malignant neoplasm of hepatic flexure, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of unspecified ovary
Suprarenal gland	Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant neoplasm of nipple and areola, unspecified female breast
Other specified sites	Malignant neoplasm of hepatic flexure, Malignant neoplasm of trachea, Malignant melanoma of lip, Malignant neoplasm of nipple and areola, unspecified female breast, Malignant neoplasm of unspecified ovary, Malignant neoplasm of prostate, Malignant neoplasm of trigone of bladder

Glossary of Cancer Descriptions

Cancer Description
Malignant neoplasm of lip
Malignant neoplasm of tongue
Malignant neoplasm of major salivary glands
Malignant neoplasm of gum
Malignant neoplasm of floor of mouth
Malignant neoplasm of other and unspecified parts of mouth
Malignant neoplasm of oropharynx
Malignant neoplasm of nasopharynx
Malignant neoplasm of hypopharynx
Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
Malignant neoplasm of esophagus
Malignant neoplasm of stomach
Malignant neoplasm of small intestine, including duodenum
Malignant neoplasm of colon
Malignant neoplasm of rectum, rectosigmoid junction, and anus
Malignant neoplasm of liver and intrahepatic bile ducts
Malignant neoplasm of gall bladder and extrahepatic bile ducts
Malignant neoplasm of pancreas
Malignant neoplasm of retroperitoneum and peritoneum
Malignant neoplasm of other and ill-defined sites within the digestive organs and peritoneum
Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
Malignant neoplasm of larynx
Malignant neoplasm of trachea, bronchus and lung
Malignant neoplasm of pleura
Malignant neoplasm of thymus, heart, and mediastinum
Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs

Malignant neoplasm of bone and articular cartilage
Malignant neoplasm of connective and other soft tissue
Malignant melanoma of skin
Other malignant neoplasms of skin
Malignant neoplasm of female breast
Malignant neoplasm of male breast
Malignant neoplasm of uterus, part unspecified
Malignant neoplasm of cervix uteri
Malignant neoplasm of placenta
Malignant neoplasm of body of uterus
Malignant neoplasm of ovary and other uterine adnexa
Malignant neoplasm of other and unspecified female genital organs
Malignant neoplasm of prostate
Malignant neoplasm of testis
Malignant neoplasm of penis and other male genital organs
Malignant neoplasm of urinary bladder
Malignant neoplasm of kidney and other and unspecified urinary organs
Malignant neoplasm of eye
Malignant neoplasm of brain
Malignant neoplasm of other and unspecified parts of nervous system
Malignant neoplasm of thyroid gland
Malignant neoplasm of other endocrine glands and related structures
Malignant neoplasm of other and ill-defined sites
Secondary and unspecified malignant neoplasm of the lymph nodes
Secondary malignant neoplasm of the respiratory and digestive organs
Secondary malignant neoplasm of other tissue and organs
Malignant neoplasm without specification of site
Lymphosarcoma and reticulosarcoma
Hodgkin's disease
Other malignant neoplasms of lymphoid and histiocytic tissue
Multiple myeloma and other immunoproliferative neoplasms
Lymphoid leukemia
Myeloid leukemia
Monocytic leukemia
Other specified leukemia
Leukemia of unspecified cell type

Letter to Claimant Advising of Part B RECA Award Requirement

U.S. DEPARTMENT OF LABOR DEEOIC Central Mail Room
PO Box 8306
London, KY 40742-8306

Date:

Claimant Name
Street Address
City, State Zip

Uranium Worker:
RECA Claim No.:

Dear Claimant:

We are in receipt of the claim you filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The information you provided on your claim form indicates that **(uranium worker's name)** was a uranium worker.

The Denver District Office contacted the Department of Justice on **(Date Contacted)** to request verification that you have been approved for an award under Section 5 of the Radiation Exposure Compensation Act (RECA). On **(Date Replied)**, the Department of Justice confirmed that they have not received a claim from you under the RECA.

Uranium workers are not covered under Part B of the EEOICPA unless they have received a notice of award from the Department of Justice under Section 5 of RECA. The first step in pursuing a claim under Part B of the EEOICPA with the Division of Energy Employees Occupational Illness Compensation Program (DEEOICP) is to file a claim with the Department of Justice under Section 5 of RECA.

This letter serves as official notification that you have 60 days from the date of this correspondence to file a claim with the Department of Justice under Section 5 of RECA. It is your responsibility to provide this office with proof that you have filed with the Department of Justice under Section 5 of RECA.

If you do not file a claim with the Department of Justice or provide proof of filing to the DEEOICP within the allotted 60 days, this office will render a decision on your Part B EEOICPA claim. Your Part E claim is not dependent on a Section 5 RECA award and is presently under development.

The Department of Justice may be contacted at:

U.S. Department Of Justice
Radiation Exposure Compensation Program
P.O. Box 146
Ben Franklin Station
Washington, D.C. 20044-0416

Or by calling:

1-800-729-7327

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Sincerely,

[Name]
[Title]
[District Office]

Letter to DOJ for Section 4 RECA Claim Status

U.S. DEPARTMENT OF LABOR DEEOIC Central Mail Room
PO Box 8306
London, KY 40742-8306

Date:

US DEPARTMENT OF JUSTICE
RADIATION EXPOSURE COMPENSATION PROGRAM
P.O. BOX 146
BEN FRANKLIN STATION
WASHINGTON, DC 20044-0146 **[All letters to this address must be grouped together and sent via an overnight carrier]**

Re: Employee:

Dear:

The U.S. Department of Labor (DOL) received a claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) regarding the above-referenced employee. Please see the attached EE-1 or EE-2 claim form. The employee (or a beneficiary of the employee), has indicated that they are seeking benefits under the Radiation Exposure Compensation Act (RECA) Section 4.

To make a determination of eligibility under the EEOICPA, the Department of Labor requires information on the status of the RECA Section 4 claim. Please provide the following:

- Copy of any RECA Section 4 award or denial notice
- If a RECA Section 4 award was granted, but the claimant has elected to reject payment, provide DOL with a copy of the Acceptance of Payment form, indicating such election.

DOL appreciates your assistance. Please mail any correspondence or other documentation to the address listed above.

Should you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

[Name]
[Title]
[District Office]

Enclosures: EE-1 or EE-2

Sample Letter to Potential Survivor Advising of Right to File Claim

Dear Claimant Name:

We have been advised that you may be an eligible survivor of the above-named employee under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA).

Enclosed is Form EE-2, Claim for Survivor Benefits under EEOICPA. If you wish to be included in the claim for survivor benefits under our program, please complete the EE-2 form and return it to this office at the address noted above at your earliest convenience.

Once we receive your completed form, your claim will be added to the existing case file. We will use the Case ID number referenced above, so please include this Case ID number in any future correspondence or telephone inquiries concerning your claim.

If you have knowledge of other individuals who may also be entitled to claim benefits as a survivor of your [enter survivor's relationship to deceased], please include their contact information on the EE-2 form, including name, address, and telephone number (if known).

For claims under Part B of the EEOICPA, the definition of an "eligible survivor" and the order of payment are as follows:

1. If there is a living spouse (married to the employee for at least one year immediately before the death):

   a. Spouse receives entire amount;

   b. UNLESS there is at least one child of the employee who is a minor at the time of payment and not a child of the spouse – in which case half of the award goes to the spouse and the rest is split between all living minor children of the employee.

2. If there is no living spouse, the award will be given in the following order:

   a. Living children;
   b. If none of the above, to living parents of the employee;

   c. If none of the above, to living grandchildren of the employee;

   d. If none of the above, to living grandparents of the employee.

For claims under Part E of the EEOICPA, the definition of an "eligible survivor" and the order of payment are as follows:

1. If there is a living spouse (married to the employee for at least one year immediately before the death):

a. Spouse receives entire amount;

b. UNLESS there is at least one living child of the employee at the time of the payment who is also a "covered child" under Part E (i.e., under the age of 18 years at the time of the employee's death, or under the age of 23 years and continuously enrolled as a full-time student since attaining the age of 18 at the time of the employee's death, or any age and incapable of self-support at the time of the employee's death) and not a child of the spouse – in which case half of the award goes to the spouse and the rest is split between all "covered children" of the employee living at the time of payment.

2. If there is no living spouse, the award will be split between all "covered children" of the employee who are living at the time of payment.

Although there is no time limit for the filing of a claim for benefits under the EEOICPA, we ask that you respond to this request within 30 days from the date of this letter in order to prevent any delay in the adjudication and awarding of benefits for this case.

Also, please note that filing a claim does not guarantee your eligibility for benefits under the EEOICPA. Additional investigation will be required to determine if all statutory and regulatory requirements have been met before compensation can be awarded.

If you have any questions, please feel free to call or write us at the above address.

Sincerely,

[Name]
[Title]
[Office]

Enclosure: EE-2, Claim for Survivor Benefits
EE-3, Employment History
EE-7, Medical Requirements

Sample Alternative Filing Determination Letter

Date:

Employee:
Case ID:

Requester name
Address
City, State, Zip Code

Dear Mr./Mrs. Requester:

I am writing concerning the alternative filing request you filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) to receive a determination as to whether your **[employee relationship to survivor]** contracted an illness as a result of exposure to toxic substances while working at **[facility]**.

The following determination is intended to provide a measure of closure to you and your family, and should serve as recognition of your **[employee's relationship to the claimant]**'s extraordinary service and sacrifice on behalf of our country.

[Description of the findings]

Again, this assessment DOES NOT change your eligibility for benefits or establish causation under the Act, and is not subject to further agency or judicial review.

If you so desire, DOL will undertake full adjudication of the facts of this case. You will need to complete and submit a form EE-2 (which can be found on DOL's website at, http://www.dol.gov/owcp/energy/regs/compliance/EEOICPForms/ee-2.pdf, the District Offices, or any Resource Center) to begin the adjudication process. The outcome of a full investigation of the circumstances of the claim may not result in a change of your status as an ineligible survivor, and upon issuance of a final decision in your case, you still may not be entitled to EEOICPA benefits.

Sincerely,

District Director,
(City) Office

Not at MMI Letter

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date
Case ID Number:
Employee:

Name
Address
Address

Dear Mr./Mrs. Last Name:

I am writing to inform you that we are unable to make a determination on your claim for impairment benefits under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

In order to determine whether you have sustained a permanent impairment, the physician must conclude that your accepted condition is well stabilized and unlikely to improve substantially with or without medical treatment; this is called maximum medical improvement or MMI. The medical evidence shows your condition has not reached this state; therefore, we cannot determine your impairment rating at this time.

Your impairment claim will be administratively closed until your condition has reached MMI. At that time, please submit your physician's opinion and we will reopen your impairment claim and resume development.

If at any time you would like to discuss this issue further, please do not hesitate to contact our office, toll-free, at ( ) . If it is more convenient, you may visit one of our local resource centers for additional help.

Sincerely,

Printed Name
[Title]

Impairment Eligibility Letter to Physician

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date

CASE ID NUMBER:

EMPLOYEE:

Medical Provider
Street Adress
City, State, Zip Code

Dear Medical Provider;

Our office has determined that the above employee is eligible for an impairment evaluation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) in relation to the following accepted illness Insert name AND ICD-9/10 of covered illness.

Employee name has identified you as his/her choice to perform an impairment evaluation in relation to his/her covered illness. The Division of Energy Employees Occupational Illness Compensation (DEEOIC) will cover the cost of the impairment evaluation as long as the condition has reached a point where further improvement is not expected (Maximum Medical Improvement/MMI), or the employee is considered to be in the terminal stages of the illness. The evaluation must also be performed within one year of the date DEEOIC receives the completed impairment report, and not performed prior to Filing date (the date he/she filed for benefits under the EEOICPA). The evaluation must be performed in accordance with the 5th Edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment (*AMA's *Guides)*, with specific page and table references included in your report.

Physicians who perform impairment evaluations for the DEEOIC must hold a valid medical license and Board certification/eligibility in their field of expertise (e.g., toxicology, pulmonary, neurology, occupational medicine, etc.). The physician must also meet at least one of the following criteria:

- is certified by the American Board of Independent Medical Examiners (ABIME)
- is certified by the American Academy of Disability Evaluating Physicians (AADEP)
- possesses knowledge and experience in using the AMA's *Guides*
- possesses the requisite professional background and work experience to conduct such ratings

When your impairment evaluation has been completed, please submit a letter to establish that you meet the criteria listed above. If you do not possess either the ABIME or AADEP certification, please submit a statement certifying and explaining your familiarity and years of experience in using the AMA's *Guides*.

Physicians may bill impairment evaluation using CPT Code 99455 or 99456 with ICD-9 code V70.9.

Diagnostic services related to impairment evaluations must be billed with the appropriate CPT codes. Supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) must be submitted with the completed Office of Workers' Compensation Program (OWCP) Health Insurance 1500 Form (OWCP 1500). If you need a copy of the medical record in our case file to perform the impairment evaluation, please contact me. Reimbursement for these services will be in accordance with the OWCP fee schedule.

Electronic versions of OWCP-1500 and the Provider Enrollment Package are available on-line at:

OWCP-1500 – http://www.dol.gov/owcp/dfec/regs/compliance/OWCP-1500.pdf

Provider Enrollment Package - http://www.dol.gov/owcp/dfec/regs/compliance/OWCP-1168.pdf

If you have any questions regarding this letter or impairment ratings in general, please contact me directly at (XXX) XXX-XXX.

Thank you for your assistance.

Sincerely,

[Name]
[Title]

Enclosures:
Required Medical Evidence for Determining Impairment Rating By Specific ICD-9/10 Codes
Examiner note: print appropriate section from Impairment Documentation for ICD9 template

Impairment Rating Requirements

If you elect to file an impairment claim, you will be required to provide **Activities of Daily Living (ADL)**, along with the required medical records dated *preferably* within the last 12 months.

Reported ADLs must be described in sufficient detail to allow a physician to apply the information to the assessment of whole person impairment in accordance with the AMA's Guides to the Evaluation of Permanent Impairment 5th Edition. **For your convenience, please take the attached sample ADL Questionnaire to your treating physician for his/her completion.** Please remember your medical records and diagnostic examinations must include your current treatments and prescribed medications. **This information should be dated within the last 12 months. However, if you have no additional medical records to provide, please inform our office in writing, so that we can proceed with your impairment claim.**

Since you will not be physically examined by a Contract Medical Consultant (CMC), obtaining your current medical records and ADLs or equivalent record from your physician is important in determining your rating. The lack of medical information, could potentially affect your impairment rating. Below is an example of the ADL information needed from your physician, as referenced in the AMA's *Guides*, Table 1-2.

Table 1-2 Activities of Daily Living Commonly Measured in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Scales

Activity	Example
Self-care, personal hygiene	Urinating, defecating, brushing teeth, combing hair, bathing, dressing oneself, eating
Communication	Writing, typing, seeing, hearing, speaking
Physical activity	Standing, sitting, reclining, walking, climbing stairs
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling
Nonspecialized hand activities	Grasping, lifting, tactile discrimination
Travel	Riding, driving, flying
Sexual function	Orgasm, ejaculation, lubrication, erection
Sleep	Restful, nocturnal sleep pattern

Activities of Daily Living Questionnaire	**Name:**
	Case ID #:

Accepted Conditions	ICD-9/10 Code	Condition @ MMI[1]	**Rating Scale** (Each criteria is graded in level of dependence)
		☐ Yes ☐ No	1 – Performs independently without reminder or assistance 2 – Performs with assistance or reminders 3 – Unable to perform on own, even if assisted
		☐ Yes ☐ No	
		☐ Yes ☐ No	
☐ See attached if more than 3 conditions			

Is the claimant terminal? ☐ YES ☐ NO If YES, estimated timeframe: _____

Since the employee will not be physically evaluated for **impairment** by a Department of Labor physician, the following information regarding the employee's Activities of Daily Living (ADL) or equivalent information is required. Rate the activity based **only** on limitations caused or contributed to by the **accepted condition(s)**. Address all items using the above rating scale to determine the person's ability to perform the activity.

Self-Care / Personal Hygiene		**Rating**		**Additional comments concerning these activities**
	Dressing/undressing oneself			
	Eating			
	Meal preparation			
	Taking or managing medicine			
	Toileting – getting to and on/off toilet			
	Toileting – keeping self-clean and dry			
	Toileting – arranging clothes			
	Bladder/Bowel control			
	Brushing teeth			
	Combing/brushing hair			
	Bathing			
	Light housekeeping			

Communication		**Rating**		**Additional comments concerning these activities**
	Writing			
	Typing			
	Seeing			
	Hearing			
	Speaking			

Physical Activity		**Rating**		**Additional comments concerning these activities**
	Standing			
	Sitting			
	Reclining			
	Walking			
	Climbing Stairs			

[1] Condition has reached maximum medical improvement (MMI) i.e. well-stabilized and unlikely to improve with medical treatment or not required if an illness is in a terminal stage.

Sensory Function		Rating		Additional comments concerning these activities
	Hearing			
	Seeing			
	Tactile Feeling			
	Tasting			
	Smelling			

Other: Non-specialized hand activities		Rating		Additional comments concerning these activities
	Grasping			
	Lifting			
	Pulling/Pushing			
	Reaching up, down, out			
	Tactile Discrimination			

Travel		Rating		Additional comments concerning these activities
	Riding			
	Driving			
	Flying			
	Arranging travel for self			

Transferring In and Out of:		Rating		Additional comments concerning these activities
	Bed			
	Tub/Shower			
	Chair/Sofa			
	Vehicles			

Sexual Function		Yes	No		Additional comments concerning these activities
	Orgasm				
	Ejaculation				
	Lubrication				
	Erection				

Sleep		Yes	No		Additional comments concerning these activities
	Restful				
	Nocturnal Sleep Pattern				

Provide any additional comments to explain what this person can or cannot do in their daily life (if additional space is needed, please provide a typed narrative report and attach it to this questionnaire):

The information listed above is complete and accurate to the best of my knowledge:

_____

Physician's Printed Name

_____ _____

Physician's Signature ***Date***

Activities of Daily Living **Supplementary ADL Specific to: Breast Cancer**	**Name:** **Case ID#:**

Is the patient at MMI for breast cancer and if so what date? MMI ☐ Yes ☐ No Date: _____

1. Was removal of part or all of one or both breast required? If so, describe.

2. Is there resulting lymphedema in the affected arms? If so, describe severity. Is it partially or completely controlled with stockings?

3. Is there a resulting decrease of motion in affected extremities? If so, detail range of motion for those joints.

4. Is there any decrease in strength in the upper extremities? If so, describe on a scale of 0-5 with mention of involved motor nerves.

5. Is there decreased sensation in the affected extremities? If so, describe with mention of which sensory nerves.

6. Is there any intermittent or continuous pain of the chest wall? If so, describe.

7. Has there been metastasis? If so, describe.
Additional Comments:

Activities of Daily Living **Supplementary ADL Specific to: Skin Cancer**	**Name:** **Case ID#:**

Is the patient at MMI for skin cancer and if so what date? MMI ☐ Yes ☐ No Date: _____

1. Is the claimant limited to sun exposure? If so, describe.

2. Does the claimant have a significant deformity from the skin cancer affecting interpersonal relationships? If so, please describe.

3. Does the claimant have a deformity or scarring that limits range of motion of any joints? If so, please state joint and indicate range of motion.

4. Does the claimant require use of a prescriptive drug for the treatment of skin cancer, either intermittently or continuously? If so, please describe.

5. Does the claimant's skin cancer limit any ADL other than sun exposure? If so, please describe.

6. Has there been metastasis? If so, please describe.

Additional Comments:

Evidence to Support Impairment Rating for Certain Conditions

- **Disorder of the Thyroid gland** must have the following reported *within the past year* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history of site

- **Anemia** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Need for transfusion and the intervals involved
  - Current treatment(s) including prescriptions
  - Complete Blood Count with differential (CBC with Diff)

- **Tremor** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected:
    - Motor strength
    - Coordination
    - Dexterity
  - Functional Activity pertaining to Activity of Daily Living (ADL):
    - Buttoning shirt
    - Lacing shoes
    - Performing peg tasks
  - Current treatment(s)

- **Peripheral Neuropathy, Polyneuropathy** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the Upper Extremities
    - Motor strength
    - Coordination

    - Dexterity
  - Functional Activity pertaining to Activity of Daily Living (ADL):
    - Buttoning shirt
    - Lacing shoes
    - Performing peg tasks
  - Physical exam findings of the Lower Extremity
    - Motor strength
    - Coordination
  - Functional Activity pertaining to Activity of Daily Living (ADL): (Upper extremities)
    - Standing (with/without mechanical support and/or assistive device)
    - Walking
      - With/without assistance
      - Ability to start and stop walking
      - Limited to level surface
      - Difficulty with elevation/stairs
    - Loss of stature
    - Romberg Sign
  - Current treatment(s)
  - Electromyography (EMG)

- **Cataracts** must have the following reported *within the past year* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings
  - Current treatment(s)
  - Surgical procedure(s)
  - Visual Acuity testing, corrected
  - Visual Field testing

- **Hearing Loss** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Tympanometry
  - Speech Discrimination test
  - Pure Tone Audiogram of both ears

- **Chronic Sinusitis** must have the following reported *within the past twelve months* before impairment rating can take place:

Note from Physician with the following information:

- Current symptoms including: headaches, balance problems
- Physical exam findings of the area(s) affected
- Current treatment(s) including prescriptions
- Sinus CT

- **Allergic Rhinitis** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:

  - Current symptoms including headaches, balance problems
  - Physical exam findings of the area(s) affected
  - Current treatment(s) including prescriptions

- **Chronic Obstructive Pulmonary Disease (COPD) [Emphysema and Chronic Bronchitis] Asbestosis, and Other Chronic Respiratory Conditions** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information

  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Current treatment(s) including prescriptions
  - Pulmonary Function Test (PFT) with DL_{CO} with pre/post bronchodilator

- **Liver Disease** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:

  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history of site
  - Nutritional Status and/or restriction
  - Current treatment(s) including prescription
  - Liver Function Test (LFTs)

- **Upper Genitourinary Disease** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:

  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Any Biopsy information

- Surgical history
- Current treatment(s) including prescriptions
- Need for Dialysis and its schedule
- Nutritional Status and/or restrictions
- Kidney Function Test (Creatinine Clearance Test)
- Serum Creatinine
- Urine Analysis

- **Bladder Disease** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current signs/symptoms (frequency, nocturia, loss of control, urgency, dribbling)
  - Physical exam findings of the area(s) affected
  - Any Biopsy information
  - Surgical history
  - Current treatment(s) including prescriptions

- **Dermatitis, Skin Rash** must have the following reported *within the past twelve months* before impairment rating can take place:

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area in question
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Patch testing information when available

Cancers
(in alphabetical order)

All information has to be dated in the past 12 months including the diagnostic tests.

- **Bladder Cancer:**

  Note from Physician with the following information:
  - Current symptoms to include urinary frequency/nocturia, reflex activity of the bladder
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s)

- **Breast Cancer:**

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s)

- **Colon Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Presence of any stomas
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)

- **Esophageal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Presence of any stomas
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area

- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s)

- **Gallbladder Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage, and jaundice
  - Presence of any stomas
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Liver Function Tests (LFTs

- **Hodgkin's Lymphoma:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Complete Blood Count (CBC) with differential
  - Pathology report *if available*

- **Hypo-pharyngeal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Presence of any stomas
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. *Complete this task* ***with and without*** *use of assistive device for speech.*

- **Laryngeal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage

- Physical exam findings
- Surgical history to the area
- Presence of any stomas
- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s)
- Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech
  - ✓ Audibility
  - ✓ Intelligibility
  - ✓ Functional Efficiency

- **Leukemia:** *[includes Acute/Chronic Lymphocytic Leukemia (ALL/CLL) and Acute/Chronic Myelocytic Leukemia (AML/CML)]*

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any liver or spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Complete Blood Count (CBC) with differential
  - Liver Function Tests (LFTs)

- **Liver Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage, presence of jaundice
  - Physical exam findings of the area(s) affected including presence of ascites
  - Surgical history to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Liver Function Tests (LFTs)

- **Lung Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Pulmonary Function Test (PFT)

- **Multiple Myeloma:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Complete Blood Count (CBC) with differential

- **Myelodysplastic Syndrome:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings including any spleen abnormalities
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Complete Blood Count (CBC) with differential

- **Nasal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Presence of any stomas
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech.
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

- **Nasopharyngeal:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Presence of any stomas
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table 11-8 from Guides to

the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech.
- ✓ Audibility
- ✓ Intelligibility
- ✓ Functional Efficiency

- **Kidney Cancer:** *See Renal Cancer*

- **Pancreatic Cancer:**

Note from Physician with the following information:
- Current symptoms including weight loss and percentage, and jaundice
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Surgical History to the area
- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s)
- Liver and Pancreatic Function Tests

- **Pharyngeal Cancer:**

Note from Physician with the following information:
- Current symptoms including weight loss and percentage
- Physical exam findings of the area(s) affected
- Remission status and number of years in remission
- Presence of any stomas
- Surgical History to the area
- Activities of Daily Living (ADLs) to include any limitation on diet
- Current treatment(s
- Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech.
  - ✓ Audibility
  - ✓ Intelligibility
  - ✓ Functional Efficiency

- **Polycythemia Vera:**

Note from Physician with the following information:
- Current symptoms including nutritional status, weight loss and percentage
- Physical exam findings including any spleen abnormalities
- Activities of Daily Living (ADLs)
- Current treatment(s)
- Complete Blood Count (CBC) with differential

- **Prostate Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage along with urinary control and sexual function after surgery *if prostatectomy was performed*
  - Physical exam findings including pain induced by metastatic lesions
  - Activities of Daily Living (ADLs)
  - Surgical history to the affected area
  - Current treatment(s)

- **Renal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Need for dialysis and schedule
  - Kidney transplant
  - Surgical history to the affected area
  - Presence of any stomas
  - Activities of Daily Living (ADLs)
  - Current treatment(s)
  - Kidney Function Test (Creatinine Clearance Test)
  - Serum Blood Urea Nitrogen (BUN) and Creatinine
  - Urine Analysis

- **Skin Cancer:**

  Note from Physician with the following information:
  - Current symptoms
  - Physical exam findings of the area(s) affected
  - Physical exam findings of the area in question
  - Activities of Daily Living (ADLs)
  - Current treatment(s)

- **Small Intestinal Cancer: (**duodenum, jejunum, ileum**)**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Presence of any stomas
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet

- Current treatment(s)

- **Thyroid Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs)
  - Current treatment(s) and presence of other illnesses allowing for only partial hormone replacement

- **Tongue Cancer:**

  Note from Physician with the following information:
  - Current symptoms including weight loss and percentage
  - Physical exam findings of the area(s) affected
  - Remission status and number of years in remission
  - Surgical History to the area
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech.
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

- **Tracheal Cancer:**

  Note from Physician with the following information:
  - Current symptoms including nutritional status, weight loss and percentage
  - Physical exam findings
  - Surgical history to the area
  - Presence of any stomas
  - Activities of Daily Living (ADLs) to include any limitation on diet
  - Current treatment(s)
  - Description of the Voice/Speech detailing: using the Table 11-8 from Guides to the Evaluation of Permanent Impairment 5th Edition. Please complete this task **with and without** use of assistive device for speech.
    - ✓ Audibility
    - ✓ Intelligibility
    - ✓ Functional Efficiency

Breast Impairment Letter

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation

Date

CASE ID#:
EMPLOYEE:

Medical Provider
street address
City, State, zip

Dear Medical Provider;

The above-named employee filed a claim for whole body impairment as a result of breast cancer under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) requires impairment determinations to be performed in accordance with the 5th Edition of the American Medical Association's *Guide to the Evaluation of Permanent Impairment* (AMA's *Guides*). Moreover, to ensure that the employee's impairment is fully rated, several factors must be considered and included in the evaluation report. These factors include: (1) the unilateral or bilateral absence of the breast; (2) the loss of function of the upper extremity, including range of motion, neurological abnormalities and pain, etc.; (3) skin disfigurement; and (4) other physical impairments affecting activities of daily living.

We would greatly appreciate a detailed narrative report from you, based on your examination that addresses the following:

1. Has maximum medical improvement been reached? If so, what is the approximate date? DEEOIC defines maximum medical improvement as when the claimant's condition is unlikely to improve substantially with or without medical treatment.

2. Is there surgical absence of the breast(s)? Surgical absence of a breast is rated in accordance with AMA's *Guides*, section 10.9, page 239 and is assigned a maximum of 5% of the whole person.

3. A description of the surgical site (if any) and mention of infections, ulcerations, grafts and any other factors that have affected the size and aspect of the scar and the presence of other skin abnormalities. If a rating for skin disfigurement/abnormalities is needed please use Chapter 8 in the AMA's *Guides*.

4. The effects of radiation or other therapies on any organ system represented by clinical findings and/or tests, as well as the ability to perform activities of daily living.

5. Other physical impairments related to the underlying condition including those mentioned under number 4 above. These need to be well documented and ratable under the AMA's *Guides*.

6. Your recommended percentage of impairment including a rationalized opinion as to how you arrived at the total impairment. This includes how you arrived at the impairment figure, referencing applicable tables and sections of the AMA's *Guides*. It is important that you respond to each of these questions to ensure that the patient receives the maximum percentage of impairment allowed by the AMA's *Guides* for his/her work-related condition. The rating should be performed on the patient's current level of impairment. Please note that the DEEOIC allows for periodic re-evaluations for future increases in permanent impairment.

Payment for the impairment evaluation and required diagnostic tests are covered by the DEEOIC. Physicians may bill impairment evaluation using CPT Code 99455 or 99456 with ICD-9 code V70.9. Diagnostic services related to impairment evaluations must be billed with the appropriate CPT codes. Supporting documentation (e.g. medical reports, evaluation reports, assessment reports and diagnostic testing results) must be submitted with the completed Office of Workers' Compensation Program (OWCP) Health Insurance 1500 Form (OWCP 1500). Reimbursement for these services will be in accordance with the OWCP fee schedule.

If you have any questions or concerns regarding this letter or impairment ratings in general, please contact me directly at (XXX) XXX-XXXX.

Thank you for your assistance.

Sincerely,

[Name]
[Title]

Normal Social Security Retirement Age Table

Normal retirement age is the age at which an employee may receive unreduced Social Security retirement benefits. This age varies by date of birth and is set by section 216(1) of the Social Security Act, 42 U.S.C. 416(1). In general, persons born during or before 1937 are eligible for unreduced Old Age, Survivors, and Disability Insurance (OASDI) (i.e. Social Security) retirement benefits at age 65. The eligibility age increases in two-month increments for persons born between 1937 and 1960 until it reaches 67, which is the age at which persons born during or after 1960 become eligible for unreduced OASDI retirement benefits.

- The normal retirement age is age 65 for a covered Part E employee born on 1/1/38 or earlier.
- For a covered Part E employee born on 1/2/38 or later, please refer to the chart below for the normal retirement age respectively:

If the Birth Date is...	The Normal Retirement Age is...
1/2/38 thru 1/1/39	65 years and 2 months
1/2/39 thru 1/1/40	65 years and 4 months
1/2/40 thru 1/1/41	65 years and 6 months
1/2/41 thru 1/1/42	65 years and 8 months
1/2/42 thru 1/1/43	65 years and 10 months
1/2/43 thru 1/1/55	66 years
1/2/55 thru 1/1/56	66 years and 2 months
1/2/56 thru 1/1/57	66 years and 4 months
1/2/57 thru 1/1/58	66 years and 6 months
1/2/58 thru 1/1/59	66 years and 8 months
1/2/59 thru 1/1/60	66 years and 10 months
1/2/60 and later	67 years

FAX COVER SHEET TO SSA

Department of Labor
Program – DEEOIC | Job Code - 8015
Primary Fax: 904-359-9294 |Secondary Fax: 904-359-9294

Itemized Statement of Earnings (581) Reject fax

TO:	**Social Security Administration** **Planning Automation and Training Staff/HSS**	**FROM:**	
FAX:	**410-966-4210**	**PAGES:**	
PHONE:	**(410) 966-6995 || Donald Fair**	**DATE:**	
RE:	**Itemized Statement of Earnings (581) Reject** **Reject Reference #**	**CC:**	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: [Your comments here]

Sample Listing of Medical Conditions with Likely Secondary Disorders

Disorders secondary to Chronic Beryllium Disease (CBD) or its treatment due to steroid use (such as Prednisone)

- Airflow obstruction/wheezing (asthma-like presentation of CBD)
- Right heart failure, Cor pulmonale
- Pulmonary hypertension
- Respiratory infections (Pneumonia, Acute Bronchitis)
- Spontaneous Pneumothorax
- Deconditioning secondary to chronic lung disease
- Joint Aches (this is a symptom)
- Hyperuricemia, Gout
- Hypercalcemia/hypercalciuria
- Granulomatous Hepatitis
- Skin Nodules/Ulceration
- Aggravation of sleep apnea due to hypoxemia of CBD
- Weight gain
- Elevated blood pressure
- Elevated Cholesterol and abnormal lipids
- Liver function abnormalities
- Blood sugar change
- Diabetes
- Eye/vision problems such as cataracts, glaucoma, and visual acuity changes
- Gastrointestinal conditions such as gastric reflux or peptic ulcers
- Psychiatric or psychological conditions such as depression or anxiety
- Skin problems such as thrush or other fungal infections
- Metabolic changes such as folic acid depletion
- Decreased immune response leading to infections and viruses
- Decreased bone density leading to osteoporosis/osteopenia

Disorders secondary to Silicosis

- Hypoxemia
- Right heart failure, Cor pulmonale
- Pulmonary Hypertension
- Deconditioning secondary to chronic lung disease
- Progressive Massive Fibrosis
- Silicotuberculosis

Disorders secondary to prednisone treatment

- Cataracts
- Glaucoma
- Visual acuity changes

- Diabetes Mellitus
- Osteoporosis
- Osteopenia
- Gastric reflux
- Peptic ulcers
- Elevated blood pressure
- Elevated cholesterol
- Abnormal lipid profiles
- Sleep disorders
- Weight gain
- Myopathy, dermal atrophy
- Increased intracranial pressure

Other disorders

- Oral thrush and other fungal infections secondary to inhaled steroids, immunosuppression
- Folic acid depletion secondary to Methotrexate
- Infections due to immunosuppression (bacterial and viral)
- Post-herpetic neuralgia secondary to Herpes Zoster
- Flare due to immunosuppression
- Tinnitus – this condition is typically synonymous with sensorineural hearing loss. Tinnitus can be considered as a separate, stand alone condition or as consequential to sensorineural hearing loss.

Sample Letter Decision

Date: Case ID:
Employee:

Name
Address
City, State, Zip Code

Dear XXXXX:

This letter is in reference to your claim to receive medical benefits to treat your Lymphedema as a consequential illness resulting from the treatment for your accepted condition of breast cancer, under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Medical evidence includes a letter dated January 1, 2015, in which Dr. John Smith stated that you have been diagnosed with breast cancer and had to undergo a radical mastectomy. As such, you developed lymphedema as a result of your radical mastectomy.

Based on Dr. Smith's statement, the medical evidence is sufficient to establish that your lymphedema is a result of treatment for your covered illness, breast cancer and is accepted as a covered consequential illness under Parts B and E of the EEOICPA guidelines. Medical benefits are approved for the treatment of your lymphedema (ICD-9 Code 457.1) retroactive to July 1, 2013, the date of filing for your breast cancer.

Covered medical services are payable in accordance with fee schedules and medical policy of the EEOICPA. The policy includes coverage of medical appointments, hospitalizations, appliances, supplies and drugs that are prescribed by a qualified physician and approved by the EEOICPA.

When you receive medical treatment you should show this letter to the medical provider you wish to designate as your treating physician and any other authorized medical provider who may treat you for your covered illnesses. Most physicians, hospitals, durable medical equipment providers, and other health care providers will bill the EEOICPA directly so that you will not have to pay for medical treatment covered under the Program. To bill directly, providers must be enrolled in the program. For information about enrollment and billing procedures, providers may contact the Program at the address and telephone number listed at the end of this letter.

Note: If the EEOICPA pays less than the billed amount (in accordance with the fee schedule), you are not responsible for payment of the difference to a provider. Providers (and claimants) may submit requests for reconsideration of fee determinations in writing, with accompanying documentation to the address supplied at the end of this letter.

The EEOICPA will reimburse you for the cost of covered services/items that you have personally paid, providing that you submit appropriate documentation to the Program's billing address. However, bills and requests for reimbursement must be sent to EEOICPA within one

year after the end of the calendar year in which the service or supply was provided, *or* within a year after the end of the calendar year in which the condition was accepted, whichever is later.

To request reimbursement of medical expenses associated with treatment of your accepted illnesses you are required to complete and submit the **OWCP-915 form, Claim for Medical Reimbursement.** You should also complete and submit the **OWCP-957, Medical Travel Refund Request** form with appropriate receipts when seeking reimbursement for travel expenses covered under the program. Both OWCP-915 and OWCP-957 forms (copies enclosed for convenience) include instructions for when you should complete these forms and the documentation required to process your request for reimbursement.

All requests for reimbursement of covered treatment related expenses including travel are to be mailed to:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If providers have questions regarding submission or payment of bills, or require any other medical bill program assistance, they may contact a representative at toll free 1-XXX-XXX-XXXX.

Sincerely,

_____ _____
(Name) Date
Claims Examiner

_____ _____
(Name) Date
Supervisor

Enclosures:

Sample Recommended Decision, Accept

EMPLOYEE: **[NAME]**

CLAIMANT: **[NAME]**

CASE NUMBER: **XXXXXXXX**

DATE OF ISSUANCE: **XX/XX/XXXX**

RECOMMENDED DECISION

This is a Recommended Decision of the district office concerning your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). The district office recommends acceptance of your claim for skin cancer under both Part B and Part E of the EEOICPA, and recommends that you be awarded lump-sum compensation under Part B of $150,000.00, as well as medical benefits under Parts B and E of the Act.

STATEMENT OF THE CASE

The evidence of record shows that on June 24, 2006, you filed a claim for benefits under both Parts B and E of the EEOICPA, claiming that you had developed skin cancer as a result of your employment at a Department of Energy (DOE) facility. A pathology report of February 27, 2001 provided confirmation of diagnosis with basal cell carcinoma (BCC) of the left arm.

You claimed that you worked as a scientist at the Savannah River Site (SRS) in Aiken, S.C., from September 1, 1974 through May 1, 2004. The DOE was able to verify your employment at the SRS with E.I. DuPont from September 1, 1974 until June 1, 1989; and with Westinghouse from May 1, 1989 to February 28, 2004.

In development of your Part B claim, the district office forwarded relevant claim documentation to the National Institute for Occupational Safety and Health (NIOSH) for a radiation dose reconstruction. NIOSH used this information to estimate your exposure to occupational radiation and complete a dose reconstruction report. With the return of the completed dose reconstruction, the district office then applied the does estimate in a calculation to determine the probability that your cancer was related to exposure to radiation during your employment at the SRS. In this case, the probability was calculated to be 57.6%, which exceeds the 50% requirement for compensability.

EXPLANATION OF FINDINGS

The issue for determination in this case is whether you are eligible to receive benefits under Part B and Part E for the claimed conditions of skin cancer.As outlined above, the district office verified your employment with E.I DuPont and Westinghouse, both known DOE contractors at the SRS. Additionally, medical evidence submitted in support of your claim established your diagnosis with skin cancer. Accordingly, you meet the employment and diagnostic criteria of the EEOICPA.

In order for your Part B claim to be compensable, it must be established that the claimed skin cancer was "at least as likely as not" (a 50% or greater probability) related to occupational exposure to radiation. In your case, the district office used the results of a dose reconstruction to calculate a probability of causation (PoC) of 57.6. This exceeds the 50% threshold for compensability. Accordingly, the district office recommends acceptance of your Part B claim.

With regard to your Part E claim, the evidence shows that you worked as a contractor employee at the SRS site, a requirement for a compensable Part E claim. In addition, with the finding of a compensable Part B occupational illness, the same illness is accepted as work-related under Part E. As you have qualifying contractor employment, and the evidence of record establishes that you have a qualifying occupational illness, the district office also recommends acceptance of that your Part E claim.

Finally, in accordance with EEOICPA regulations, you have submitted Form EN-16, declaring that you have neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which you are eligible to receive compensation under the Act. You also declared that you have neither filed for nor received any state workers' compensation benefits on account of the claimed illness. Lastly, you have declared that you have neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

CONCLUSIONS OF LAW

Based on the above, the district office recommends acceptance of your claim for benefits for the condition of skin cancer be accepted under both Part B and Part E of the Act. It is recommended that you be awarded lump-sum compensation of $150,000.00 under Part B of the EEOICPA, as well as medical benefits for this illness under Parts B and Part E, commencing the date of claim filing.

Prepared by:

_____ _____
(Name of Appropriate Signatory) Date
(Title)
(District Office)

Sample Recommended Decision, Denial

EMPLOYEE: **[NAME]**

CLAIMANT: **[NAME]**

CASE NUMBER: **XXXXXXXX**

DATE OF ISSUANCE: **XX/XX/XXXX**

RECOMMENDED DECISION

This is a Recommended Decision concerning your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). The district office recommends a denial of your Part E claim for liver disease.

STATEMENT OF THE CASE

The history of your claim shows that you have filed for and received several final decisions regarding medical conditions you claimed as being related to occupational exposure to toxic substances. As part of the development of those prior claims, the district office has accepted that you worked for a Department of Energy (DOE) contractor at the Lawrence Livermore National Laboratory (LLNL). Specifically, you were an administrative assistant between July 18, 1989 and September 1, 1994.

Recently, you filed a claim for the condition of liver disease. Along with your claim, you submitted a narrative report from your treating physician confirming your diagnosis with sarcoidosis of the liver. Additionally, you submitted a printout of toxic substances known to be present at LLNL, noting that both trichloroethylene and vinyl chloride were present at LLNL and claiming both contributed to the onset of liver disease.

The DEEOIC evaluated all information available with regard to known links between chemical or biological agents and the development of liver sarcoidosis. This included reviewing employment, occupational and medical evidence in your case. Moreover, claims staff searched the Site Exposure Matrix (SEM) for any information on sarcoidosis. The SEM is an electronic repository of known toxic materials at covered DOE facilities, along with information on the known health effects of those exposures. None of the research conducted produced any compelling evidence to document that you were potentially exposed to any toxic substance, including trichloroethylene and vinyl chloride, during your employment, that are linked to sarcoidosis.

To provide you additional opportunity to support your claim, the DEEOIC asked you to supply any evidence that might assist with the analysis of your claim. In particular, the district office requested you submit evidence to show that, during your employment at LLNL, you were exposed to any toxic substance linked to liver disease. No response from you was forthcoming.

EXPLANATION OF FINDINGS

As outlined above, the district office finds that you worked at the LLNL as an administrative assistant between July 18, 1989 and September 1, 1994.

Medical evidence submitted in support of your latest claim is sufficient to allow the district office to find that you have sarcoidosis of the liver, which a physician diagnosed in 2010. Accordingly, you meet the employment and diagnostic criteria under Part E of the Act.

The issue for determination in this case is whether there exists sufficient evidence that occupational exposure to a toxic substance was "at least as likely as not" a significant factor that caused, contributed to, or aggravated your diagnosed condition of sarcoidosis. A toxic substance is defined under the Act as any biological, chemical or radioactive material that has the potential to cause illness or death.

Research of case evidence and all other available resources did not reveal any known scientific link between any biological or chemical exposure and the onset of sarcoidosis. Further, case records contained no reference or other information linking your liver disease to a specific toxin to which you, as an administrative assistant, would have been exposed while working at LLNL.

With regard to your assertions that trichloroethylene and vinyl chloride are linked to liver disease, our research has found no such scientific consensus. As mentioned, you were asked to submit probative evidence to support such a link'; however, you did not provide any further evidence for the district office evaluate. Moreover, research of records obtained from the DOE, including medical or employment records, revealed no evidence of your exposure to either trichloroethylene or vinyl chloride or any other hazard that is known to induce liver disease. The Site Exposure Matrix (SEM), which provides scientifically scrutinized information on the health effects of various toxins encountered at LLNL, also provided no data to show that an administrative assistant at LLNL had the potential to encounter any toxic substance in performance of their duties that is linked to sarcoidosis.

Given the lack of information we were able to obtain regarding your claim, you were notified of the need for evidence, specifically evidence linking your illness to a toxin you encountered at LLNL. These requests also explained that you ultimately bore responsibility for providing the evidence necessary to establish your claim. Unfortunately, you provided no response.

After reviewing all available evidence, there is presently no basis to conclude that occupational exposure was "at least as likely as not" a significant factor in aggravating, contributing to or causing your diagnosed disease of sarcoidosis. As such, the district office has to recommend that your Part E claim for liver disease be denied.

CONCLUSIONS OF LAW

Based on the above, is the district office recommends a denial of your claim for liver disease under Part E of the Act.

Prepared by:

_____ _____
(Name of Appropriate Signatory) Date
(Title)
(District Office)

NOTICE OF RECOMMENDED DECISION

The accompanying Recommended Decision provides an explanation of a proposal to accept or deny a claim you have filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). This decision does not represent a final agency determination regarding your entitlement to any benefit. The Final Adjudication Branch (FAB) must now evaluate the recommendation and issue a decision to finalize it or not. It is important for you to read the Recommended Decision and the guidance contained in this notice carefully. Any correspondence or evidence submitted to the Division of Energy Employees Occupational Illness (DEEOIC) in response to the issuance of the Recommended Decision should identify clearly your name and Case Identification Number.

IF YOU WISH TO OBJECT TO THE RECOMMENDED DECISION:

You MUST file your objections within sixty (60) days from the date of the Recommended Decision by writing to the FAB at:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

To obtain an informal oral hearing on your objections, at which time you will have the opportunity to present both oral testimony and written evidence in support of your claim, you MUST request a hearing when you file your objections. **If you have special needs (e.g., physical handicap, dates unavailable, driving limitations, etc.) relating to the scheduling (time and location) of the hearing, those needs must be identified in your letter to the FAB requesting a hearing.** In the absence of such a special need request, the FAB scheduler will schedule the hearing and will notify you of the time and place. If you do not include a request for a hearing with your objections, the FAB will consider your objections through a review of the written record, which will also give you the opportunity to present written evidence in support of your claim. If you do not file any objections to the Recommended Decision within the 60-day period, the FAB will consider your right to challenge the recommendation waived for all purposes and it may proceed to finalize the Recommended Decision.

IF YOU AGREE WITH THE RECOMMENDED DECISION:

Should you agree with the Recommended Decision and wish for the FAB to finalize it without change, you may waive your right to object. To do this, you need to complete Option #2 on the attached ***Waiver***. If you wish to object to only part of the Recommended Decision, and waive any objections to the remaining parts of the decision, you may do so by completing Option #1. Submit the completed waiver to FAB at the above address. Once FAB receives a completed waiver, it will proceed to issue a Final Decision affirming the parts of the Recommended Decision to which you agree prior to the end of the 60-day objection period.

REPORTING REQUIREMENT FOR RECOMMENDED ACCEPTANCES

For any recommendation to award benefits, you must immediately report the receipt of State Workers' Compensation (applies to Part E benefits only) and/or Tort (lawsuit) settlements (applies to both Part B and Part E benefits) under the following scenarios:

State Workers' Compensation -- if you receive or have received any benefit from a state workers' compensation program for any of the same conditions recommended for acceptance under Part E. This includes any benefits received after the issuance of this Recommended Decision.

Tort Actions -- if anyone receives or has received any form of benefit (money, medical benefits, etc.) based on a lawsuit claiming that the employee was harmed from the same type of exposure (e.g. asbestos, radiation, beryllium, or any other toxic substance) upon which the claim is being recommended for acceptance. This includes any benefits received after the issuance of this Recommended Decision.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Waiver

Case Number:
Employee:
Claimant:
Date of Decision:

U.S. Department of Labor, DEEOIC
Attn: Final Adjudication Branch
P.O. Box 8306
London, KY 40742-8306

Dear Sir or Madam:

(Option 1)

I, _____, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights **only** as those rights pertain to the portion of my claim recommended for acceptance. I do, however, reserve my right to object to the findings of fact and/or conclusions of law contained in the Recommended Decision that recommend denial of claimed benefits.

I understand that should I choose to file an objection, I may either attach such objection to this form or submit a separate written objection to the address listed above within 60 days of the date of issuance of the Recommended Decision.

_____ _____
Signature Date

(Option 2)

I, _____, being fully informed of my right to object to any of the findings of fact and/or conclusions of law contained in the Recommended Decision issued on my claim for compensation under the Energy Employees Occupational Illness Compensation Program Act, do hereby waive those rights.

_____ _____
Signature Date

(**NOTE ON WAIVER:** If you wish to file a waiver of objections, please select and sign **only one** of the above options. Select Option 1 to waive your right to object to the portion of your claim recommended for acceptance but reserve your right to object to the recommended denial of benefits. Select the Option 2 to waive your rights to object to ALL findings and conclusions.)

SAMPLE HEARING NOTICE TO CLAIMANT WHO FILED AN OBJECTION

RE: NOTICE OF HEARING

Dear Claimant Name:

A hearing has been scheduled concerning the above referenced claim under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 *et seq*. (EEOICPA). The hearing will begin promptly at TIME AM/PM on DAY, DATE at the following location:

BUILDING NAME
STREET ADDRESS
CITY, ST ZIP-CODE
(XXX) XXX-XXXX (for directions only)

Please bring a photo I.D. so that you may be admitted into the building.

The specific issue to be addressed at the hearing: [If it is a Part E hearing request: The issue to be addressed at the hearing is whether you are entitled to compensation and benefits under Part E of the EEOICPA. If it is a Part B and Part E hearing request: The issues to be addressed at the hearing are whether you are entitled to compensation and benefits under Part B and Part E of the EEOICPA.]

You must inform me of any person other than your authorized representative that will be attending the hearing with you not later than XXXXXX (1 week prior to the date of the hearing). Please be aware that in such circumstances, all claimants who have requested this hearing must sign a "WAIVER OF RIGHTS TO CONFIDENTIALITY." Additionally, I will need to determine whether proper room arrangements can be made to accommodate the number of people expected to attend the hearing.

Please be advised that the security requirements of the XXXXXXXX (Federal Building) require me to provide a list of all attendees. Anyone not on the list will not be admitted to the building and will not be able to attend the hearing.

The hearing is an informal process, and I am not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. During the hearing, you may state your arguments and present new written evidence and/or testimony in support of the claim. Oral testimony will be made under oath or affirmation and is recorded. The recording of the hearing proceedings is then transcribed and placed in the record. You will be provided a copy of the hearing transcript. <u>You or anyone else present may not make your own video or audio recording of the hearing.</u>

I determine the conduct of the hearing and may terminate the hearing at any time I determine that all relevant evidence has been obtained or because of misbehavior on the part of the claimant and/or representative, or any other persons in attendance at or near the place of the hearing.

[Add this paragraph if the hearing concerns the POC] Since the issues raised relate to the dose reconstruction process, it is important for you to know that the National Institute for Occupational Safety and Health (NIOSH) has full authority under the regulations to complete the dose reconstruction as prescribed in its rules. The dose reconstruction is used by the Department of Labor to determine the probability that the claimed cancer is related to employment at a covered facility. During the hearing, I am not authorized to address NIOSH methodology and therefore will not be in a position to discuss the way in which NIOSH prepares the dose reconstruction. You may present your objections at the hearing, including any evidence or information you wish to submit and all arguments, evidence and information will be entered into the record. However, I can discuss only issues of a factual nature regarding the information you provided to NIOSH, and which that agency used to perform the dose reconstruction.

I have attached additional information regarding the hearing procedures for your review. If you have any questions concerning these procedures, please feel free to contact me at (xxx) xxx-xxxx.

Sincerely,

[Name]
[Title]

Enclosure

HEARING PROCEDURES

BEFORE THE DATE OF THE HEARING: Before the date of the hearing, please submit any additional evidence that you wish me to consider. However, if such evidence is submitted on the date of the hearing or within thirty (30) days after the hearing, it will still be carefully considered and made part of the record. You must notify me at least one (1) week prior to the date of the hearing if persons other than claimants involved with the case, to include any properly appointed authorized representatives, will be attending the hearing. Please be aware that in such circumstances, all claimants who have requested this hearing must sign a "WAIVER OF RIGHTS TO CONFIDENTIALITY." Additionally, I will need to determine whether proper room arrangements can be made to accommodate the number of people expected to attend the hearing.

The hearing is an informal process, and I am not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. During the hearing, you may state your arguments and present new written evidence and/or testimony in support of the claim. Oral testimony will be made under oath or affirmation and is recorded. The recording of the hearing proceedings is then transcribed and placed in the record. You will be provided a copy of the hearing transcript. You may not make your own video or audio recording of the hearing.

NO POSTPONEMENT WILL BE GRANTED UNLESS EXTREMELY COMPELLING CIRCUMSTANCES EXIST: If you are hospitalized for a reason which is not elective, or where the death of your parent, spouse, or child prevents attendance at the hearing, a postponement may be granted upon proper documentation. Please contact the Final Adjudication Branch at (XXX) XXX-XXXX, if an emergency arises. If a postponement cannot be granted, the request for a hearing will automatically convert to a request for a review of the written record. If you do not appear at the scheduled time and place, the request for a hearing will automatically convert to a request for a review of the written record.

WITHDRAWAL OF REQUEST FOR HEARING: At any time after requesting a hearing, you can request a change to review of the written record by making a written request to the Final Adjudication Branch. Once such a change is made, no further opportunity for a hearing will be provided, and I will review the written record.

HEARING BY TELEPHONE: If you would like to have a hearing by telephone, please contact the Final Adjudication Branch at (XXX) XXX-XXXX. Any testimony presented at the telephone hearing will be made under oath or affirmation and the testimony will be recorded by a court reporter and made part of the record. Telephone hearings can not be conducted on cell phones.

REPRESENTATION: You may designate a person to represent you to help you prepare your case and/or present your case at the hearing. Your representative can be an attorney, but he or she need not be. There are rules concerning the maximum fee an attorney can charge you.

AFTER THE HEARING: I will furnish a transcript of the hearing to you (at no charge) within a few weeks after the hearing. You will then have twenty (20) days from the date it is sent to submit any comments to me. You will also have thirty (30) days after the hearing is held to submit additional evidence or argument, unless an extension is granted. Only one such extension may be granted. After the hearing, I will study the record and make findings based on the evidence, including testimony taken at the hearing, and issue a written decision.

SAMPLE HEARING NOTICE TO CLAIMANT WHO DID NOT FILE AN OBJECTION

Dear Claimant Name:

A hearing has been scheduled concerning the above referenced claim under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended, 42 U.S.C. § 7384 et seq. (EEOICPA or the Act). The file indicates that you did not file an objection to the recommended decision of the district office. However if you wish, you may participate in the hearing. The option to participate by telephone is available, but you must let me know immediately. The hearing will begin promptly at TIME AM/PM on DAY, DATE at the following location:

BUILDING NAME
STREET ADDRESS
CITY, ST ZIP-CODE
(XXX) XXX-XXXX (for directions only)

Please bring a photo I.D. so that you may be admitted into the building.

The specific issue to be addressed at the hearing: [If it is a Part E hearing request: The issue to be addressed at the hearing is whether you are entitled to compensation and benefits under Part E of the EEOICPA. If it is a Part B and Part E hearing request: The issues to be addressed at the hearing are whether you are entitled to compensation and benefits under Part B and Part E of the EEOICPA.]

You must notify me at least one (1) week prior to the date of the hearing if persons other than claimants involved with the case, and a properly appointed authorized representative, will be attending the hearing. Please be aware that in such circumstances, all claimants who have requested this hearing must sign a "WAIVER OF RIGHTS TO CONFIDENTIALITY." Additionally, I will need to determine whether proper room arrangements can be made to accommodate the number of people expected to attend the hearing.

Please be advised that the security requirements of the XXXXXXXX (Federal Building) require me to provide a list of all attendees. Anyone not on the list will not be admitted to the building and will not be able to attend the hearing.

The hearing is an informal process, and I am not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. During the hearing, you may state your arguments and present new written evidence and/or testimony in support of the claim. Oral testimony will be made under oath or affirmation and is recorded. The recording of the hearing proceedings is then transcribed and placed in the record. You will be provided a copy of the hearing transcript. <u>You or anyone else present may not make your own video or audio recording of the hearing.</u>

I determine the conduct of the hearing and may terminate the hearing at any time I determine that all relevant evidence has been obtained or because of misbehavior on the part of the claimant and/or representative, or any other persons in attendance at or near the place of the hearing.

[Add this paragraph if the hearing concerns the POC] Since the issues raised relate to the dose reconstruction process, it is important for you to know that the National Institute for Occupational Safety and Health (NIOSH) has full authority under the regulations to complete the dose reconstruction as prescribed in its rules. The dose reconstruction is used by the Department of Labor to determine the probability that the claimed cancer is related to employment at a covered facility. During the hearing, I am not authorized to address NIOSH methodology and therefore will not be in a position to discuss the way in which NIOSH prepares the dose reconstruction. You may present your objections at the hearing, including any evidence or information you wish to submit and all arguments, evidence and information will be entered into the record. However, I can discuss only issues of a factual nature regarding the information you provided to NIOSH, and which that agency used to perform the dose reconstruction.

I have attached additional information regarding the hearing procedures for your review. If you have any questions concerning these procedures, please feel free to contact me at (xxx) xxx-xxxx.

Sincerely,

[Name]
[Title]

Enclosure

WAIVER OF RIGHTS TO CONFIDENTIALITY

I, _____, (File Number _____), residing at _____, am aware that persons other than claimants involved in the above case or their authorized representative may be present at a hearing convened under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) on _____, at _____ AM/PM in _____, in the State of _____.

I have requested the presence of these persons, or accept their presence at this proceeding, and I hereby waive any right to confidentiality of records, documents or other materials contained in files maintained by the Office of Workers' Compensation Programs and disclosed during the hearing. I further waive any right to privacy under the Privacy Act of 1974 in the disclosure of records, documents or other materials related to my claim that may be released during the course of the hearing.

Acknowledged and signed this _____day of _____, 2009.

_____
(signature)

WAIVER OF RIGHTS TO CONFIDENTIALITY (MEDIA)

I, _____, (File Number _____) residing at _____, am aware that representatives of the print and/or broadcast media may be present at a hearing convened under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) on _____, at _____ AM/PM in _____, in the State of _____.

I have requested the presence of these persons, or accept their presence at this proceeding, and I hereby waive any right to confidentiality of records, documents or other materials contained in files maintained by the Office of Workers' Compensation Programs and disclosed during the hearing. I further waive any right to privacy under the Privacy Act of 1974 in the disclosure of records, documents or other materials related to my claim that may be released during the course of the hearing.

Acknowledged and signed this _____day of _____, 2009.

_____

(signature)

SAMPLE HEARING SCRIPT FOR A HEARING INVOLVING NIOSH DR ISSUES

CONVENING THE HEARING

I. OPENING, AUTHORITY, AND NARRATIVE

We will now open the record. Today is _____, and it is _____AM/PM. My name is _____ and I have been designated to conduct this hearing and to receive the objections of EMPLOYEE/CLAIMANT. (At this point indicate whether or not claimant is represented by counsel or other authorized representative). This case is identified under claim number xxx-xx-xxxx and carries docket number xxxx-2008.

This hearing is convened under the Energy Employees Occupational Illness Compensation Program Act (I will make future references to it as the Act), and is governed by the provisions of Title 20, Section 30.314 of the Code of Federal Regulations. These regulations provide claimants with the right to object to a recommended decision of a district office. While this hearing is informal and not governed by rules of evidence, I will administer an oath or affirmation to every person providing testimony today. I will first review the history of your claim as it appears in the written record. You may then present testimony, argument, and any additional evidence addressing the merits of your claim.

On DATE OF FILING, you submitted an EE-(1 or 2)form to the NAME OF LOCATION district office claiming benefits under the Act. On your EE-1/2 form, you claimed LIST FORM OF CANCER as the claimed condition related to employment under the Act. You also submitted an EE-3 form indicating employment at LIST FACILITY, DATES OF EMPLOYMENT AND COVERED PERIOD FOR FACILITY. You submitted evidence establishing your employment at NAME FACILITY and submitted BRIEFLY OUTLINE MEDICAL EVIDENCE establishing a cancer diagnosis.

Since YOUR/THE EMPLOYMENT did not qualify YOU/THE EMPLOYEE for membership in the special exposure cohort, the DISTRICT OFFICE forwarded your claim file information to the National Institute for Occupational Safety and Health (hereinafter referred to as NIOSH) for radiation dose reconstruction. The district office undertook such an action pursuant to the instructions set out in the regulations governing the Act. The Act and implementing regulations mandate that when a claimant with covered employment establishes a cancer diagnosis, NIOSH will prepare a radiation dose reconstruction. The Department of Labor then applies a formula to the dose reconstruction in order to determine whether the employee's cancer is as least as likely as not related to the covered employment.

NIOSH provided a report of the dose reconstruction and DISTRICT OFFICE found that there was a % probability that YOUR/THE EMPLOYEE'S cancer was causally related to employment under the Act. As such, it was determined that the cancer was not found to be at least as likely as not related to employment under the Act. Accordingly, the DISTRICT OFFICE issued its recommended decision on DATE OF RD recommending denial of your claim for benefits under the Act.

II. STATEMENT OF OBJECTION AND NIOSH DISCLAIMER

On DATE OF OBJECTION, you filed your objection to the recommended decision and requested an oral hearing. You have objected specifically that the NIOSH dose reconstruction failed to show enough exposure so the DO could find that YOUR/THE EMPLOYEE'S cancer was at least as likely as not related to YOUR/THE EMPLOYEE'S employment.

At this time I would like to say something about the NIOSH dose reconstruction. NIOSH is given full authority under the regulations that govern the Act to conduct the dose reconstruction used by the Department of Labor to determine the probability that a cancer is related to employment. I am, therefore, not in a position to discuss the way in which NIOSH goes about preparing the dose reconstruction report. However, I can discuss issues of a factual nature regarding the information you provided to NIOSH, and challenges to the application of NIOSH's methodology. I am here to take your objections and enter them into the evidence of record, but I am not permitted to consider objections to NIOSH methodology at this time.

III. ADMINISTER OATH AND TAKE EVIDENCE

As stated previously, while the hearing is designated as an informal process, anyone giving testimony today is required to do so under Oath. Mr./Ms. Claimant, will you please raise your hand? (Administer Oath: "Do you swear/affirm to tell the truth in the testimony you are about to give in these proceedings today?"

Mr/Ms. Claimant, will you please, for the record, state your full name and address, and then proceed to give your testimony for the record.

AT THIS POINT, ALLOW THE CLAIMANT TO GIVE ORAL TESTIMONY AND ENTER SUCH DOCUMENTS AS THE CLAIMANT MAY DESIRE INTO THE RECORD AS EVIDENCE. IDENTIFY AND MARK EACH AND EVERY EXHIBIT AND NUMBER EACH EXHIBIT SEQUENTIALLY.

IV. CLOSING

Before closing, I will advise Mr./Ms. Claimant of what will transpire from this date forward. These proceedings will be transcribed, and a copy of the transcript will be provided to you. I will leave the record open for another 30 days for you to submit any additional evidence. You also have 20 days from the date of mailing of the transcript to offer any corrections or comments on the transcript. Any such additional evidence or comments will be included in the record and considered, along with your hearing testimony and all of the evidence already in the record, prior to issuance of the final decision. If there is no other testimony to be given in this matter, I will close the hearing. It is now _____A.M/P.M. and this hearing is closed.

SAMPLE LETTER TO POSTMASTER

Postmaster
Any Town, Any State 12345-9998

Dear Postmaster:

Agency Control Number (if applicable):_____

Date:_____

Address Information Request

Please furnish this agency with the new address, if available for the following individual or verify whether or not the address given below is one at which mail for this individual is currently being delivered. If the following address is a post office box, please furnish the street address as recorded on the box-holder's application form.

Name: _____

Last Known Address _____
_____
_____

I certify that the address information for this individual is required for the performance of this agency's official duties.

_____
Signature of Agency Official

_____
Title

* * * *

USPS Return Address:

Postmark/Date Stamp

As per 39 USC 404…"the USPS does not disclose mailing information except in the following limited circumstances; Authorized disclosures include limited circumstances such as the following: (a) to other government agencies or bodies: when relevant to a decision concerning employment, security clearances, security or suitability investigations, contracts, licenses, grants or benefits"…

The correspondence in question fits within the aforementioned parameters and our agency is requesting the aforementioned information as formatted in the USPS Administrative Support Manual Section 352.44. Please respond to our office via return mail or fax with the aforementioned postal patron's new address/contact information.

If you have any questions regarding this letter you can call me at my direct number xxx-xxx-xxxx.

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]
Fax Number: xxx-xxx-xxxx

Sincerely,

[Name]
[Title]

SAMPLE CHANGE OF ADDRESS LETTER

Date:_____

File #: Claim Number
Employee:_____
Claimant:_____

Name of Claimant
Address (Line 1)
Address (Line 2)
Address (Line 3)

Change of Address

This will notify you of my change of address to the following:

_____
Name

_____
Address

_____
City/State/Zip

_____
Phone Number

Other Information:

_____ _____
Signature Date

SAMPLE FINAL DECISION - ACCEPTANCE

Dear Claimant Name:

Enclosed please a Final Decision on your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The district office recommends acceptance of your claim for Burkitt's lymphoma under both Part B and Part E of the Act.

I have enclosed the Acceptance of Payment form (EN-20), which is required before the Office of Workers' Compensation Programs can issue payment to you. You must complete the form in permanent ink and there can be no cross outs or other marks. Do not use white out or correction tape. Any alteration of the form will result in it being rendered unusable for purposes of issuing payment. If you make a mistake or need another form, please contact the district office handling your claim. You must submit the form with an original signature. Faxes or another copied version of the EN-20 is not acceptable. A second copy of the form is attached in case a mistake is made. Only one form needs to be returned. Please check with your financial institution before returning the form to us to verify the routing number and your account number so that your money arrives promptly and to the correct account.

Please email the completed and signed original EN-20 to:

U.S. Department of Labor, DEEOIC
P.O. Box XXXX
City, State ZIP

Please be advised that the final decision on your claim may be posted on the agency's website if it contains significant findings of fact or conclusions of law that might be of interest to the public. If it is posted, your final decision will not contain your file number, nor will it identify you or your family members by name.

Any future correspondence, inquiries, or telephone calls should be directed to the (District Office) district office. Thank you for your cooperation.

Sincerely,

[Name]
[Title]
Final Adjudication Branch

EMPLOYEE: **[Name]**

CLAIMANT: **[Name]**

FILE NUMBER: **[Number]**

DOCKET NUMBER: **[Number]**

DECISION DATE: **[Date]**

NOTICE OF FINAL DECISION

This decision of the Final Adjudication Branch (FAB) concerns the above claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA or the Act), as amended, 42 U.S.C. § 7384 *et seq*. For the reasons set forth below, the claim for benefits under Part B and Part E of the Act for Burkitt's lymphoma is approved.

STATEMENT OF THE CASE

On February 6, 2012, the claimant filed a Form EE-1 under the Act. He claimed that he developed non-Hodgkin's lymphoma as a consequence of his employment at multiple Department of Energy (DOE) facilities.

In support of his claim, he submitted a Form EE-3 indicating that he was employed at the Hanford Plant in Richland, Washington from 1976 to 1987, and at the Savannah River Site (SRS) in Aiken, South Carolina from June 1984 to July 1985. A representative of DOE confirmed that he was employed at Hanford by the Bechtel Corporation, a DOE subcontractor, from December 6, 1982 to December 30, 1983, by the J.A. Jones Company, a DOE subcontractor, from January 27, 1987 to February 28, 1987 and by Kaiser Engineers Hanford, a DOE contractor, from May 1, 1987 to May 1, 1987. Also, union dispatch records and occupational medicine records provided by the DOE establish that the claimant was employed at Hanford by the Bechtel Corporation from June 2, 1977 to May 23, 1978. In addition, radiation exposure monitoring records provided by the DOE establish that he was employed at the SRS, a DOE facility, by B.F. Shaw Company, a DOE subcontractor, from February 26, 1984 to June 23, 1985.[2]

Also in support of his claim, the claimant submitted a hematopathology report, signed by Dr. Jonathan Roller, documenting a diagnosis of non-Hodgkin's lymphoma on February 1, 2011.

[2] Hanford is a covered DOE facility from 1942 to the present. The SRS is a covered DOE facility from 1950 to the present. *See* DOE Office of Worker Advocacy Covered Facility List at: http://www.hss.doe.gov/healthsafety/fwsp/advocacy/faclist/showfacility.cfm (verified by the FAB on February 21, 2012).

A subsequent oncology visit report from Dr. Thomas Jacobsen, dated February 27, 2012, confirms a specific diagnosis of Burkitt's lymphoma, a form of non-Hodgkin's lymphoma, based on the particular characteristics of the malignant lymphocytes.

On October 9, 2012, the Seattle district office issued a recommended decision to accept the claim for Burkitt's lymphoma under Parts B and E of EEOICPA, finding that the claimant is a member of the Special Exposure Cohort (SEC) who was diagnosed with a specified cancer after beginning employment at a DOE facility. The district office also recommended that the claimant be awarded compensation in the amount of $150,000.00 under Part B, and medical benefits for the treatment of Burkitt's lymphoma retroactive to February 6, 2012 under both Part B and Part E of the Act.

The claimant submitted a Form EN-16, dated October 16, 2012, declaring that he had neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which he would be eligible to receive compensation under the Act. He also declared that he had neither filed for nor received any state workers' compensation benefits on account of the claimed illness. And finally, the claimant declared that he had neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

On October 22, 2012, FAB received the claimant's written notification indicating that he waived all rights to file objections to the findings of fact and conclusions of law in the recommended decision.

Based on an independent review of the evidence of record, FAB hereby makes the following:

FINDINGS OF FACT

1. On February 6, 2012, the claimant filed a claim for benefits under the Act for non-Hodgkin's lymphoma due to employment at DOE facilities.

2. The claimant was employed at Hanford, a DOE facility, by the Bechtel Corporation, a DOE subcontractor, from June 2, 1977 to May 23, 1978 and December 6, 1982 to December 30, 1983, by the J.A. Jones Company, a DOE subcontractor, from January 27, 1987 to February 28, 1987 and by Kaiser Engineers Hanford, a DOE contractor, from May 1, 1987 to May 1, 1987. In addition, he was employed at the SRS, a DOE facility, by B.F. Shaw Company, a DOE subcontractor, from February 26, 1984 to June 23, 1985.

3. The claimant was diagnosed with Burkitt's lymphoma, a form of non-Hodgkin's lymphoma, on February 1, 2011.

4. The claimant has neither filed a tort suit nor received any settlement or award from a claim or suit related to an exposure for which he would be eligible to receive compensation under the Act. He has neither filed for nor received any state workers'

5. compensation benefits on account of the claimed illness, and he has neither pled guilty to nor been convicted on any charges of having committed fraud in connection with an application for or receipt of benefits under the Act or any other federal or state workers' compensation law.

Based on these findings of fact, FAB hereby makes the following:

CONCLUSIONS OF LAW

If a claimant waives any objections to all or part of the recommended decision, FAB may issue a final decision accepting the recommendation of the district office, either in whole or in part. 20 C.F.R. § 30.316(a) (2012). The claimant waived his right to file objections to the findings of fact and conclusions of law in the recommended decision.

Under Part B of the Act, an individual is a "covered employee with cancer" if that individual is a member of the SEC who contracted a specified cancer after beginning employment at a DOE facility. 42 U.S.C. § 7384l(9)(A).

On August 23, 2012, the Secretary of Health and Human Services designated the following class of employees for addition to the SEC in a report to Congress:

> All employees of the DOE, its predecessor agencies, and their contractors and subcontractors who worked at Hanford in Richland, Washington, from July 1, 1972 through December 31, 1983, for a number of work days aggregating at least 250 work days, occurring either solely under this employment, or in combination with work days within the parameters established for one or more other classes of employees in the SEC.

See EEOICPA Circular No. 12-16 (issued September 22, 2012).

The claimant was employed at Hanford by a DOE subcontractor for a period in excess of 250 work days between July 1, 1972 and December 31, 1983. Therefore, he is a member of the SEC. Also, Burkitt's lymphoma is a specified cancer, provided the onset of the condition occurred at least five years after the initial exposure to radiation during covered employment. 20 C.F.R. § 30.5(ff)(5)(ii). The claimant began working at Hanford on June 2, 1977, and was diagnosed with Burkitt's lymphoma on February 1, 2011. Therefore, he was diagnosed with a specified cancer over 5 years after beginning employment at a DOE facility.

Accordingly, the claimant is a "covered employee with cancer" under Part B in accordance with 42 U.S.C. § 7384l(9)(A), and his Burkitt's lymphoma is an "occupational illness" in accordance with 42 U.S.C. § 7384l(15). As such, he is entitled to compensation in the amount of $150,000.00 and medical benefits under Part B, retroactive to February 6, 2012; the date of filing.

Further, since the claimant was employed by DOE contractors and subcontractors at covered DOE facilities during covered time periods, and given the acceptance of his Part B claim, that acceptance is treated for the purposes of Part E of the Act as a determination that he contracted his illness through work-related exposure to a toxic substance at a DOE facility. 42 U.S.C.

§ 7385s-4(a). As such, the FAB finds that the claimant is also a "covered DOE contractor employee" under Part E, and his Burkitt's lymphoma is a "covered illness" under Part E. As a covered DOE contractor, the claimant is also entitled to medical benefits for his Burkitt's lymphoma under Part E.

In summary, the claim for benefits under Part B and Part E of EEOICPA for Burkitt's lymphoma is approved. The claimant is awarded $150,000.00 under Part B and medical benefits for the treatment of Burkitt's lymphoma, retroactive to February 6, 2012, under Part B and Part E of the Act.

Washington, D.C.

_____
Name
Hearing Representative
Final Adjudication Branch

Sample Medical Benefits Letter

Date

[Insert Claimant Name]
[Insert Claimant Address]

Dear *[Insert Claimant Name]*:

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), you are entitled to medical benefits for treatment of your [*FAB: Insert Medical Condition, (ICD-Code), and effective date]*. Covered medical services are payable in accordance with the fee schedules and medical benefits policies established under the Division of Energy Employees Occupational Illness Compensation (DEEOIC). Your medical benefits coverage includes payment to medical providers for care of your accepted work-related illness, such as medical appointments, hospitalizations, home and residential health care services (see attached Notice Regarding Home and Residential Health Care), medical appliances, supplies, and prescription medications.

Within the next few weeks, you will be receiving additional information regarding your medical benefits coverage. This will include a medical benefits identification card, along with an informational brochure explaining when and how to use your identification card. You will need to show this card to your physician, or other enrolled medical provider, as it contains billing instructions explaining how physicians, hospitals, durable medical equipment suppliers, or other health care providers, can bill DEEOIC directly, so that you will not have to pay for medical treatment out-of-pocket. There are no deductibles for services or equipment as long as a DEEOIC enrolled medical provider bills for the services.

HOW TO OBTAIN REIMBURSEMENT FROM DEEOIC

To obtain reimbursement for out-of-pocket medical expenses associated with treatment of your accepted condition, follow these steps:

1. Sign up now for direct deposit. DEEOIC and the Department of Treasury request that you complete and return the attached *Direct Deposit Sign-Up Form 1199A*. Payment by direct deposit ensures prompt and safe delivery of your funds to the checking or savings account of your choice.

Mail your completed Direct Deposit Sign-Up Form to:

U.S. Department of Labor
OWCP/DEEOIC
PO Box 8306
London, KY 40742-8306

2. Make claim for reimbursement of out-of-pocket medical expenses associated with treatment of your accepted condition by completing Form OWCP-915 *Claim for Medical Reimbursement;* or, complete and submit Form OWCP-957 *Medical Travel Refund Request* for obtaining reimbursement of travel costs associated with care for your accepted condition. DEEOIC will only reimburse travel costs directly to you, including any authorized costs associated with a travel companion. I have attached both forms for your convenience. Each form includes instructions for completion and identifies additional documentation required for reimbursement, if applicable.

Please mail your completed reimbursement requests to:

U.S. Department of Labor
Energy Employees Occupational Illness Compensation Program
P.O. Box 8304
London, KY 40742-8304

In order for providers to bill DEEOIC directly, they must enroll with our bill processing agent (BPA). For questions and information about enrollment and billing, providers should contact our BPA at: 1-844-493-1966. Our agent can explain the Program to your provider(s) and supply them with the necessary forms required for submitting bills for reimbursement. Billing information is also available at the following OWCP website address: *https://owcpmed.dol.gov*.

If you have questions about the submission or payment of bills, or require any other medical bill program assistance, contact a representative with our BPA, toll free, at 1-866-272-2682.

Sincerely,

[Name]
[Title]

Enclosures:
Notice Regarding Home and Residential Health Care
Form EE-17A
SF1199A
OWCP-915
OWCP-957

Note: if the DEEOIC pays less than the billed amount (in accordance with the fee schedule), you are **not** responsible for payment of the difference to a provider. Providers and claimants may submit requests for reconsideration of fee determinations in writing, with accompanying documentation, to the address supplied in this letter.

Division of Energy Employees Occupational Illness Compensation (DEEOIC)
NOTICE REGARDING HOME AND RESIDENTIAL HEALTH CARE

As a beneficiary under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), you are eligible for many medical benefits, including Home and Residential Health Care. It is important that you receive accurate information about your medical benefits, so we are providing you with important information about how to obtain Home and Residential Health Care (HRHC).

- Authorization for HRHC allows for reimbursement of those medical costs linked to caring for your accepted work-related illness. You do not have to apply for HRHC authorization until you and your physician agree that you require in-home care.

- You, or your authorized representative, can initiate a request for HRHC, at any time, by completing, signing, and returning the attached Form EE-17A. Mail your completed form to:

  US Department of Labor – DEEOIC
  [Central Mailroom Address]
  [City, State Zip Code]

  You can also fax your form to your district office, your nearest Resource Center, or upload the form to the DEEOIC EDP portal at - www.dol.gov/owcp/energy/regs/compliance/claimant_medprovider_resources/claimant_edp.htm

- Upon receipt of your EE-17A, DEEOIC will contact your designated physician to request the medical information the program needs to authorize your claim for HRHC.

- **DEEOIC neither endorses nor sponsors any home health care provider, or any other entity providing medical services.** You are free to choose any licensed provider of home health care services, as long as that provider completes the DEEOIC enrollment process. Moreover, you are free to change home health care providers at any time.

DEEOIC will ask your physician to specify the level of care you require to tend to your accepted illness (skilled nursing care, home health aide, etc.); the frequency and the duration of the care required (i.e., number of hours per day or week for each type of care); and the period for which you will require in-home care. To respond, your physician must conduct a face-to-face (in person) assessment of your HRHC needs within 60 days of the submission of medical evidence used to support a request for HRHC.

In conducting a review of HRHC requests, DEEOIC may seek clarifying information from your designated physician. It may also seek the input of nurse consultants or independent medical examiners in assessing the medical necessity of a request for HRHC.

If you have questions about the HRHC authorization process, contact your district office Claims Examiner or your assigned Medical Benefits Examiner.

CLAIM FOR HOME HEALTH CARE, NURSING HOME, OR ASSISTED LIVING BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Instructions	
To claim for home health care, nursing home or assisted living benefits, please indicate below which benefits you are claiming, provide the requested contact information for your treating physician, sign and date the bottom of this form and mail it to: DOL DEEOIC Central Mail Room Correspondence, P.O. Box 8306, London KY 40742-8306. DO NOT WRITE IN SHADED AREAS.	OMB Control No: 1240-0002 Expiration Date: 03/31/2022

Employee's Information	
Name (Last, First, Middle Initial)	**Social Security Number:** **XXX-XX- _ _ _ _**
Address (Street, Apt. #, P.O. Box)	**DEEOIC Case ID#:**
(City, State, Zip Code)	**Telephone Number(s)** Home: ( ) - Other: ( ) -

Type of Medical Benefit Claimed (Check appropriate box)

I hereby request Home Health Care, Nursing Home, or Assisted Living benefits that are directly related to my DEEOIC accepted condition(s) and ordered by my treating physician. I acknowledge it is my responsibility to ensure that all requested medical documentation is submitted in support of my claim for these benefits.

☐ **Home Health Care** ☐ **Assisted Living** ☐ **Nursing Home**

Treating Physician of Record	
Physician Name (Last, First, Middle Initial)	**Telephone Number(s):** Office: ( ) -
Address (Name of Facility, Street, Suite #, P.O. Box)	Other: ( ) -
(City, State, Zip Code)	**Note:** Your physician must be either an M.D. or D.O.

Employee Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain benefits provided under EEOICPA, or who knowingly accepts benefits to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both. Any change to the information provided on this form, once it is submitted, must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. **I authorize any physician or hospital (or any other person, institution, corporation or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.**

Employee Signature _____ Date _____

Page 1

Form EE-17A
January 2015

Privacy Act Statement
In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (4) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (5) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.
Public Burden Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are required to respond to this collection to obtain EEOICPA benefits (20 CFR 30.403). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-17A. **DO NOT SUBMIT THE COMPLETED FORM TO THIS ADDRESS.**

INSTRUCTIONS for 1199A Form

Section 1 (To be completed by Payee)

A. Type or print your name, address and telephone number.

B. Type or print your name.

C. Type or print your 9-digit social security number.

D. Check the type of account you want your funds deposited into.

E. Type or print the account number you want your funds deposited into

F. (Completed by Agency)

G. Leave Blank

Sign and date the form.

Section 2 (Completed by Agency)

Section 3 (To be completed by your financial institution)

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☒ Other DEEOIC *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS
Division of Energy Employees Occupational Illness Compensation	U.S. Department of Labor OWCP/DEEOIC P.O.Box 8306 London, KY 40742-8306

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

Reset

NSN 7540-01-058-0224 **GOVERNMENT AGENCY COPY** 1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

SF 1199A (Back)

BURDEN ESTIMATE STATEMENT

The estimated average burden associated with this collection of information is 10 minutes per respondent or recordkeeper, depending on individual circumstances. Comments concerning the accuracy of this burden estimate and suggestions for reducing this burden should be directed to the Financial Management Service, Records Management Branch, Room 135, 3700 East-West Highway, Hyattsville, MD 20782. THIS ADDRESS SHOULD ONLY BE USED FOR COMMENTS AND/OR SUGGESTIONS CONCERNING THE AMOUNT OF TIME SPENT TO COLLECT THIS DATA. DO NOT SEND THE COMPLETED PAPERWORK TO THE ADDRESS ABOVE FOR PROCESSING.

PRIVACY ACT NOTICE

Collection of the information in this Direct Deposit Sign-Up form is authorized by 5 U.S.C. § 552a, 31 U.S.C. § 3332(g), and Executive Order 9397 (November 22, 1943). Your social security number and the other information requested will allow the federal government to process your direct deposit. Your social security number is requested to ensure the accurate identification and retention of records pertaining to you and to distinguish you from other recipients of federal payments. This information will be disclosed to the Department of the Treasury and its fiscal and financial agents, and other federal agencies, as necessary to process your direct deposit. This information may also be disclosed to a court, congressional committee or another government agency as authorized or required to verify your receipt of federal payments. Although providing the requested information is voluntary, your direct deposit cannot be processed without it.

PLEASE READ THIS CAREFULLY

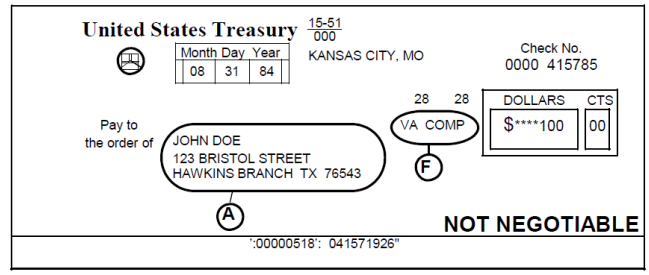
All information on this form, including the individual claim number, is required under 31 USC 3322, 31 CFR 209 and/or 210. The information is confidential and is needed to prove entitlement to payments. The information will be used to process payment data from the Federal agency to the financial institution and/or its agent. Failure to provide the requested information may affect the processing of this form and may delay or prevent the receipt of payments through the Direct Deposit/Electronic Funds Transfer Program.

INFORMATION FOUND ON CHECKS

Most of the information needed to complete boxes A and F in Section 1 is printed on your government check:

(A) Be sure that payee's name is written exactly as it appears on the check. Be sure current address is shown.

(F) Type of payment is printed to the left of the amount.



SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS

Joint account holders should immediately advise both the Government agency and the financial institution of the death of a beneficiary. Funds deposited after the date of death or ineligibility, except for salary payments, are to be returned to the Government agency. The Government agency will then make a determination regarding survivor rights, calculate survivor benefit payments, if any, and begin payments.

CANCELLATION

The agreement represented by this authorization remains in effect until cancelled by the recipient by notice to the Federal agency or by the death or legal incapacity of the recipient. Upon cancellation by the recipient, the recipient should notify the receiving financial institution that he/she is doing so.

The agreement represented by this authorization may be cancelled by the financial institution by providing the recipient a written notice 30 days in advance of the cancellation date. The recipient must immediately advise the Federal agency if the authorization is cancelled by the financial institution. The financial institution cannot cancel the authorization by advice to the Government agency.

CHANGING RECEIVING FINANCIAL INSTITUTIONS

The payee's Direct Deposit will continue to be received by the selected financial institution until the Government agency is notified by the payee that the payee wishes to change the financial institution receiving the Direct Deposit. To effect this change, the payee will complete a new SF 1199A at the newly selected financial institution. It is recommended that the payee maintain accounts at both financial institutions until the transition is complete, i.e. after the new financial institution receives the payee's Direct Deposit payment.

FALSE STATEMENTS OR FRAUDULENT CLAIMS

Federal law provides a fine of not more than $10,000 or imprisonment for not more than five (5) years or both for presenting a false statement or making a fraudulent claim.

INSTRUCTIONS FOR USE OF FORM OWCP-915

- This form is to be used to seek reimbursement for out of pocket medical expenses pertaining to the treatment of an accepted condition. Form OWCP-915 can be used to seek reimbursement for expenses in regard to medical treatment, prescription medication and medical supplies.
- Please submit a separate reimbursement claim for each provider where an out of pocket expense was incurred.
- Please print clearly and legibly. Reference your OWCP file number on all documentation. Maintain a copy of the completed OWCP-915 and supporting documentation for your records.

DOCUMENTATION REQUIRED FOR MEDICAL REIMBURSEMENT

Prescription Medication

1. Completed OWCP-915

2. A paper pharmacy billingform, which must be attached to the OWCP-915 and must include the following information:
   a. Name, address and telephone number of pharmacy
   b. Pharmacy provider number
   c. Prescription number
   d. Name of claimant
   e. Date of purchase
   f. Eleven Digit National Drug Code (NDC#)
   g. New prescription or refill number
   h. Quantity of medication (e.g. # of pills or ml/cc)
   i. Amount paid by employee per medication

3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Medical Expense other than prescription medication

1. Completed OWCP-915

2. Physicians and other health care providers (i.e. physical therapists) must complete Form OWCP-1500. Hospitals and other facilities, such as ambulatory surgical centers, skilled nursing facilities, etc. must submit their bills on Form OWCP-04. Every form must be completed in its entirety in the same manner as bills submitted by the provider directly to OWCP. The amount paid by the claimant must be indicated. The OWCP-1500 or OWCP-04 must be attached to this form. It is the responsibility of the person submitting a claim for reimbursement to obtain a completed OWCP-1500 or OWCP-04 from the provider rendering service. *Without a fully completed OWCP-1500 or OWCP-04, the OWCP is not able to process a reimbursement.*

3. Proof of payment (can include cash receipt, cancelled check or credit card slip)

Travel

Do not use Form OWCP-915 to submit a claim for travel reimbursement. Claims for travel reimbursement should be submitted on Form OWCP-957.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

OWCP-915 Page 2 (Rev. 12-07)

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask you for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq., 30 USC 901 et seq., 38 USC 613, 42 USC 7384d, E.O. 9397 and E.O. 13179. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

ACCOMMODATION STATEMENT

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or your claims examiner to ask about this assistance.

Medical Travel Refund Request

Reset Print

U.S. Department of Labor
Office of Workers' Compensation Programs

NOTE: This report is authorized by the Federal Employees' Compensation Act (5 USC 8103(a)), the Black Lung Benefits Act (30 USC 901; 20 CFR 725.406 and 725.701) and the Energy Employees Occupational Illness Compensation Program Act of 2000, (42 USC 7384 and 20 CFR 30.701). While you are not required to respond, this information is required to obtain reimbursement for travel expenses. The method of collecting information compiles with the Freedom of Information Act, the Privacy Act of 1974 and OMB Circ. 130. This form should be used for medically related travel covered by the Federal Employees' Compensation Act, the Black Lung Benefits Act and the Energy Employees Occupational Illness Compensation Program Act of 2000.

OMB No. 1240-0037
Expires: 06/30/2021

1. Claimant's Name (Last, First, Mi.):

2. Case/Claim Number:

3. Payee's Name if different from claimant's name (last, first, mi.): (See Instruction No. 3 for further requirements if payee is not the claimant)

4. Claimant's/Payee's Address (Street/RFD, City, State, Zip Code. See Instruction No. 4 for address requirements if claim is filed under the Division of Federal Employees' Compensation):

Special Instructions:
1. See reverse side of form for complete instructions and attachment of receipts.
2. Physician's signature or facsimile is **REQUIRED by BLACK LUNG** for verification of each service date and type.

5a. Date of Travel:
b. ☐ One-way ☐ Round Trip
c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
e. Medical Facility Name and Address
f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other (Specify)
g. Private Auto Only Miles traveled
DOL USE ONLY TOS/Procedure Code $ Total $
FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

6a. Date of Travel:
b. ☐ One-way ☐ Round Trip
c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
e. Medical Facility Name and Address
f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other (Specify)
g. Private Auto Only Miles traveled
DOL USE ONLY TOS/Procedure Code $ Total $
FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

7a. Date of Travel:
b. ☐ One-way ☐ Round Trip
c. Travel From: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
d. Travel To: ☐ Hospital ☐ Office/clinic ☐ Lab ☐ Home
e. Medical Facility Name and Address
f. Total expense/cost: ☐ Taxi $ ☐ Bus/Train ☐ Tolls/Pkg ☐ Lodging ☐ Meals ☐ Other (Specify)
g. Private Auto Only Miles traveled
DOL USE ONLY TOS/Procedure Code $ Total $
FOR BLACK LUNG USE ONLY
h. To be completed by Physician: (Mark one box only) Care Rendered
☐ Treatment for Black Lung
☐ Not Black Lung Related
☐ Determine, Test for Black Lung
Diagnosis
(Signature of Physician)
(Date Care Rendered)

8. **Payee's Certification:** I certify that the information provided is true and accurate to the best of my knowledge and belief. I am aware that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud, to obtain reimbursement as provided by the OWCP, or who knowingly accepts reimbursement to which that person is not entitled is subject to civil or administrative remedies as well as criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment, or both. In addition, a state or federal criminal conviction for OWCP fraud will result in termination of all current and future OWCP benefits.

Claimant's/Payee's Signature: Date:

If you have a disability and are in need of communication assistance (such as alternate formats or sign language interpretation), accommodations and/or modifications, please contact OWCP. See form Instructions for REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES.

Form OWCP-957
Revised February 2017

Instructions (Form OWCP-957)

1. Enter claimant's full name: last name, first name, middle initial.

2. Enter claimant's claim/case file number.

3. Enter payee's full name (if person other than the claimant is to be reimbursed): last name, first name, middle initial.
A payee other than the claimant must have special authorization.

Please explain the following:

a. Relationship to the claimant _____

b. The reason you are requesting reimbursement

_____

4. Enter the address of the person to be reimbursed. The address is to include: Street/RFD, City, State, Zip Code

Note: If your claim is filed under the Federal Employees' Compensation, please enter the following as an address: the House Number and Street Name, City/Town, State, and Zip Code.

For the FECA program to effectuate proper claims management, a FECA claimant is expected to provide the home address where he or she resides. A Post Office (PO) Box or attorney/representative address does not suffice for this purpose.

5. 6, and 7. Complete a separate block for each medical facility visited on the same day. For travel on different days, complete one block for each date.

a. Enter date of travel.

b. Mark one box only.

c. Mark one box only.

d. Mark one box only.

e. Enter the name and address of the medical facility.

f. Mark each box for which you are claiming reimbursement and list the amount of money spent for each item.

g. Enter the total number of miles traveled by private automobile.

h. The physician or designee is to complete this item (for Black Lung use only).

8. The person claiming reimbursement must sign here.

Attach all original receipts for expenses listed in 5f, 6f, and 7f. The claimant's full name and Social Security Number should appear on each receipt.

FOR BLACK LUNG USE ONLY

Note: _ Only travel expenses for the miner are reimbursable

_ Special approval from the district office is needed for lodging or for travel exceeding 100 miles one way or 200 miles roundtrip.

_ To obtain your district office telephone number, call toll free 1-800-638-7072.

_ Travel to pick up medicine, equipment or supplies is not reimbursable.

FOR ENERGY EMPLOYEES ONLY

Note: Special approval from the district office is needed for overnight or air travel, or for travel exceeding 100 miles one way or 200 miles roundtrip. To obtain your district office telephone number, call toll free 1-866-272-2682.

NOTE: Persons are not required to respond to this collection of Information unless it displays a currently valid OMB control number.

REQUESTS FOR ACCOMMODATIONS OR AUXILIARY AIDS AND SERVICES

If you have a disability, federal law gives you the right to receive help from the OWCP in the form of communication assistance, accommodation(s) and/or modification(s) to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to accommodate your disability. Please contact our office or your OWCP claims examiner to ask about this assistance.

Return this completed form to the appropriate program at the following address to prevent a delay in the processing of your bills.

For Federal Employees' Compensation Act (FECA) Program:	For Black Lung Program:	For Energy Program:
OWCP/FECA P.O. Box 8300 London, KY 40742-8300 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.	OWCP/DCMWC P.O. Box 8302 London, KY 40742-8302 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.	OWCP/DEEOIC P.O. Box 8304 London, KY 40742-8304 If you have any questions regarding the completion of the form, please call Toll Free: 1-844-493-1966.

PUBLIC BURDEN

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary (5 U.S.C. 8101 et seq; 30 USC 901 et seq; 42 USC 7384 et seq,) to obtain or retain a benefit. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room S-3524, Washington, DC 20210, and reference the OMB Control Number 1240-0037. Note: Please do not return the completed form to this Office.

PRIVACY ACT STATEMENT

The Privacy Act of 1974, as amended (5 U.S.C. 552a) authorizes OWCP to ask for information needed in the administration of the FECA, Black Lung and EEOICPA programs. Authority to collect information is in 5 USC 8101 et seq., the Black Lung Benefits Act (BLBA), 30 USC 901 et seq., and the Energy Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. 7384 *et seq., and* P.L. 103-196. The information we obtain with this form is used to identify you and to determine your eligibility for reimbursement. It is also used to decide if the services and supplies you received are covered by these programs and to ensure that proper payment is made. There are no penalties for failure to supply information; however, failure to furnish information regarding the medical service(s) received or the amount charged will prevent payment of the claim. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to Federal programs, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records. See Department of Labor systems DOL/GOVT-1, DOL/ESA-6 and DOL/ESA-49 published in the Federal Register, Vol. 67, page 16816, Mon. April 8, 2002, or as updated and republished.

SAMPLE REMAND ORDER

Date

Claimant Name File Number:
Address

Dear Claimant:

Enclosed please find the Remand Order concerning your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act.

Please note that the remand order is directed to the EEOICP
district office. Unless you are contacted by that office for additional information, you are not required to take any action
at this time. I regret any inconvenience caused to you by this remand.

Your file is being returned to:

U.S. Department of Labor, DEEOIC
XXXXX District Office
Address
City, State Zip

Future correspondence, inquiries, or telephone calls may be directed to the district office. Thank you for your cooperation.

Sincerely,

[Name]
[Title]
Final Adjudication Branch

EMPLOYEE: **[Employee's Name]**

CLAIMANT: **[Claimant's Name]**

FILE NUMBER: **[Last 4 digits of file #]**

DOCKET NUMBER: **[Docket Number]**

DECISION DATE: **[Decision Date]**

REMAND ORDER

This order of the Final Adjudication Branch (FAB) concerns your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended (EEOICPA or the Act), 42 U.S.C. § 7384 *et seq*. Your case is remanded to the EEOICP district office for consideration of the new medical evidence received that established a cancer diagnosis.

On February 9, 2005, you filed a claim for survivor benefits under the Act, based upon the claim that the employee contracted skin cancer, seizures and heart problems while employed at the Iowa Ordnance Plant. You submitted no medical evidence to establish that the employee was diagnosed with cancer.

On May 16, 2006, the district office issued a recommended decision concluding that there was insufficient evidence to establish an occupational illness under Part B of the Act and that there was insufficient evidence to establish a covered illness under Part E of the Act. Therefore, it was recommended that your claim for survivor benefits under the Act be denied. On May 30, 2006, you filed objections to the recommended decision and requested a hearing.

On August 18, 2006, a hearing was conducted on your objections. At, and subsequent to, the hearing, you submitted additional medical evidence. The medical records, specifically a pathology report of February 12, 2001, support a finding that the employee was diagnosed with basal cell carcinoma, i.e. skin cancer. This new evidence is sufficient to warrant further development of the claim.

Pursuant to 20 C.F.R. § 30.317: "At any time before issuance of its final decision, the FAB may return the claim to the district office for further development and/or issuance of a new recommended decision without issuing a final decision, whether or not requested to do so by the claimant." Therefore, the May 16, 2006 recommended decision is vacated and the case is being returned to the EEOICP district office for further development and issuance of a new recommended decision.

Washington, DC

[Name]
[Title]
Final Adjudication Branch

CERTIFICATE OF SERVICE

I hereby certify that on _____, a copy of the Remand Order was sent by regular mail to the following:

Claimant Name
Claimant Address

[Name]
[Title]
Final Adjudication Branch

NOTICE OF DENIAL OF REQUEST FOR RECONSIDERATION (NO NEW EVIDENCE OR ARGUMENT SUBMITTED)

EMPLOYEE: **[Employee's Name]**

CLAIMANT: **[Claimant's Name]**

FILE NUMBER: **[Last 4 digits of file #]**

DOCKET NUMBER: **[Docket Number]**

DECISION DATE: **[Decision Date]**

This is in response to your letter of January 29, 2011 requesting reconsideration of the January This is in response to your letter of January 29, 2011 requesting reconsideration of the January 12, 2011 Final Decision of the Final Adjudication Branch (FAB). For the reasons set forth below, your request for reconsideration is denied.

The January 12, 2011 Final Decision found that your lung cancer was "not at least as likely as not" related to your employment at the Pinellas Plant. It was on this basis that your Part B claim was denied under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Further, the final decision was based on the evidence of file, which included the dose reconstruction report, your letters of objection, the hearing transcript and comments you submitted regarding the hearing transcript.

As you have not submitted any new argument or evidence which justifies reconsideration of the January 12, 2011 final decision, I must deny your request. Accordingly, the decision of the FAB denying your Part B claim is final on the date of issuance of this denial of your request for reconsideration. 20 C.F.R. § 30.319(c)(2).

Washington, D.C.

[Name]
[Title]
Final Adjudication Branch

Sample Denial of Reconsideration Request (New Evidence and/or New Argument Submitted)

EMPLOYEE: **[Employee's Name]**

CLAIMANT: **[Claimant's Name]**

FILE NUMBER: **[Last 4 digits of file #]**

DOCKET NUMBER: **[Docket Number]**

DECISION DATE: **[Decision Date]**

NOTICE OF DENIAL OF REQUEST FOR RECONSIDERATION

This is a response to your request for reconsideration of the July 1, 2011 final decision of the Final Adjudication Branch (FAB) under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) which denied your Part E claim for sleep apnea consequential to sarcoidosis. The FAB received your request and determined that it was timely filed. 20 C.F.R. § 30.319 (2011). On August 15, 2011, the FAB acknowledged receipt of your request for reconsideration. However, the evidence of record shows that, to date, you have not submitted any additional evidence.

In your request for reconsideration, you stated, "The opinion of Dr. Smith and the Contract Medical Consultant (CMC) conflicted, which would require that the matter be sent to a third physician for a referee opinion, and it was an error not to do so." The Federal (EEOICPA) Procedure Manual Chapter 2-0800.13 provides guidance when making a determination as to when a claim is to be referred for a referee opinion:

> In most instances, careful weighing of the medical evidence should allow for resolution of the issues without having to resort to a referee or "impartial" specialist. However, where the weight of medical evidence is divided equally between the opinion of the treating doctor and that of the second opinion physician, a referee opinion must be obtained...a conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record by considering all factors, to include each physician's specialty and qualifications, completeness and comprehensiveness of evaluations and rationale, and consistency of opinions.

The FAB weighed the medical evidence and determined that the conflicting medical opinions were not of equal weight. In such cases, a referee specialist examination is not necessary. I have reviewed the evidence of record, including the CMC report and the medical evidence you have submitted and the opinion of Dr. Smith. I have determined that the report of the CMC is of greater weight and probative value because Dr. Smith failed to provide a complete and

comprehensive medical report. The FAB noted that the district office requested such a report; however none was provided. Accordingly, the FAB gave consideration to the relative value of the opposing opinions, including considering the rationale and consistency of the respective opinions, and determined the CMC's report should be granted more weight.

Additionally, in your request for reconsideration you stated, "The treating physician who examined and treated the claimant was not given proper weight over a CMC who never saw the claimant." According to the EEOICPA Procedure Manual, in evaluating the merits of medical reports, greater value is assigned to a well-rationalized opinion which is based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. The FAB notes that Dr. Smith stated in his report that he "believed your sleep apnea was indirectly related to your lung disease." Dr. Smith continued, "I do not have any concrete evidence to prove this, but it is my opinion." As such, Dr. Smith's opinion is not based on complete factual and medical information, but is instead subjective. In contrast, the opinion of the CMC was found to be well-rationalized, supported by the medical evidence in this case and cites recent scientific and medical literature in support of his conclusion. Further, the EEOICPA Procedure Manual outlines that the opinion of an expert in the relevant medical field is to be granted greater value. Dr. Smith is a general practitioner specializing in geriatric medicine. The CMC is an expert in occupational medicine.

Your request for reconsideration goes on to object to the handling of your claim by the Hearing Representative (HR). You state that the HR "applied the wrong standard of proof by a preponderance of evidence instead of the at least as likely as not standard in the Conclusions of Law." The 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. To establish eligibility for a consequential condition under Part E, you must prove by preponderance of the evidence that the diagnosed illness, in this case sleep apnea, occurred as a result of an accepted illness. This is established by a fully-rationalized medical report by a physician which shows the relationship between the claimed consequential condition and the accepted illness. The "at least as likely as not" standard cited in your request only pertains to causation determinations for primary illnesses, which is not at issue in your claim for a consequential illness.

Finally, the request for reconsideration renewed your previous objections to the June 9, 2010 recommended decision of the Denver district office. These objections were previously considered by the FAB and were addressed in the July 1, 2011 final decision.

The EEOICPA is administered according to the Act itself, 42 U.S.C. § 7384, et seq., the associated Code of Federal Regulations, 20 C.F.R. Part 30, Bulletins, Circulars and the Federal EEOICPA Procedure Manual. The FAB has thoroughly reviewed your case file and finds that your claim has been properly adjudicated according to the Act and its associated regulations, policies and procedures.

The Federal (EEOICPA) Procedure Manual Chapter 2-1800 provides that a timely request for reconsideration may be denied if it does not contain sufficient probative evidence or substantiated argument that directly contradicts a material finding of fact or conclusion of law set forth in the final decision. You have not submitted a new argument or evidence that directly

contradicts the conclusions reached in the July 1, 2011 final decision. As such, your request for consideration is denied. The denial of your Part E claim for sleep apnea is final on the date of issuance of this denial of your request for reconsideration. 20 C.F.R. § 30.319(c).
Denver, Colorado

[Name]
[Title]
Final Adjudication Branch

SAMPLE COVER LETTER, ALTERNATIVE FILING - DENIAL

Dear Claimant Name:

Enclosed please find the Notice of Final Decision which denies your claim for compensation and benefits under the Energy Employees' Occupational Illness Compensation Program Act (EEOICPA). If you disagree with this decision, you may request reconsideration. Such a request must be in writing and must be made within 30 days of the date of issuance of this decision. It must clearly state the grounds upon which reconsideration is being requested. In order to ensure that you receive an independent evaluation of the evidence, your request for reconsideration will be reviewed by a different Final Adjudication Branch hearing representative than that who issued the final decision. Your request for reconsideration should be sent to:

U.S. Department of Labor
DEEOIC
Final Adjudication Branch
Attn: FAB OPS
P. O. Box XXX
CITY, STATE ZIP CODE

If your claim was denied because you have not established covered employment or a covered illness and you have new evidence of either covered employment or a covered illness, you may request a reopening of your claim. If your claim was denied because a cancer was not causally related to work-related exposure to radiation and you can identify either a change in the probability of causation guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort, you may also request a reopening of your claim.

These requests to reopen your claim must be in writing and be sent, along with your supporting information, to the following address:

U.S. Department of Labor
DEEOIC, DISTRICT DIRECTOR
P.O. BOX XXX
CITY, STATE ZIP CODE

While you do not meet the statutory definition of an eligible survivor as set out under Part E of the EEOICPA, you may seek an alternative filing review pursuant to 42 U.S.C. § 7385s-4(d). You may request such a review by writing to:

U.S. Department of Labor
DEEOIC, DISTRICT DIRECTOR
ADDRESS

Alternative filing reviews can also be conducted by the district office upon request. In these reviews, the district office will assess a facility where alleged employment and exposure took

place and render a determination as to potential causation. Should you wish to receive this type of review; the district office will provide you with a determination. Please note, however, that such a determination does not change your eligibility for benefits or establish causation under the Act, and is not subject to further agency or judicial review.

Please be advised that the final decision on your claim may be posted on the agency's website if it contains significant findings of fact or conclusions of law that might be of interest to the public. If it is posted, your final decision will not contain your file number, nor will it identify you or your family members by name.

Except as provided above, all future correspondence, inquiries or telephone calls should be directed to the district office. Thank you for your cooperation.

Sincerely,

[Name]
[Title]

Enc: Notice of Final Decision

Sample Director's Order to Reopen

<Date>

Joe C. Claimant
123 Main Street
City, State, Zip

Dear Mr. Claimant:

I am writing in reference to your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or the Act).

On May 6, 2005, the Final Adjudication Branch (FAB) issued a Final Decision denying your claim for colon cancer under Part B of the EEOICPA, citing the lack of medical evidence to establish that a physician diagnosed you with colon cancer. The FAB issued a subsequent Final Decision on June 10, 2006, which finalized the Part E denial of your claim because the case file did not contain evidence of your diagnosis with colon cancer.

The EEOICPA allows for review by the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) of decisions issued by the FAB. It is solely within the Director's discretion to review and reopen such claims as necessary. The Director has delegated the authority to review and issue determinations for certain claims to the District Director having jurisdictional authority over the case.

A recent review of your case reveals that medical evidence received by the Cleveland District Office on May 26, 2007 confirms your diagnosis of colon cancer and this new evidence is sufficient to warrant reopening your claims under both Part B and Part E. Accordingly, the attached Director's Order vacates the May 6, 2005 and June 10, 2006 Final Decisions denying your claims for benefits for the condition of colon cancer under Part B and Part E, respectively. The attached Director's Order explains in more detail the reasons for this decision. The district office is directed to evaluate the new medical evidence in support of your claims, and issue a new Recommended Decision to address your eligibility under both Part B and Part E of the Act.

Your case file is being returned to the *[district office]* of DEEOIC. All future correspondence concerning your claim should be directed to:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If you have any questions about the Director's Order, you may contact the *[district office]* at *[district office telephone number]*.

Sincerely,

[Name]
[Title]
DEEOIC

EMPLOYEE: **Joe C. Claimant**

CLAIMANT: **Joe C. Claimant**

CASE ID: **1234**

DOCKET NUMBER(S): **00000-2003**
00000000-2006

DIRECTOR'S ORDER

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA or the Act) Regulations at 20 C.F.R. § 30.320 state that a Final Decision, or any other decision issued by the Final Adjudication Branch (FAB), may be reopened at any time on motion of the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC). It further states that the case may be reopened without regard to whether new evidence or information is presented or obtained, and that the decision whether or not to reopen a case is solely within the discretion of the Director of the DEEOIC.

For the reasons set forth below, the May 6, 2005 and June 10, 2006 Final Decisions denying your claims for benefits for the condition of colon cancer under Part B and Part E, respectively, are vacated. The case is returned to the Cleveland District Office to proceed as outlined below.

BACKGROUND

The evidence of record shows that on May 7, 2004, you filed claims for benefits under both Part B and Part E of the EEOICPA. You claimed that you developed colon cancer as a result of your employment at a Department of Energy (DOE) facility.

Form EE-3, Employment History, includes information describing your work as a production worker at the Iowa Army Ammunition Plant (IAAP) in Burlington, Iowa, from May 3, 1965 to May 25, 1971. The DOE was able to verify the claimed dates of employment at the IAAP.

With regard to the claimed condition of colon cancer, you did not submit medical evidence to establish the diagnosis. As such, the district office issued four letters, dating from July of 2004 to December of 2004, requesting that you provide evidence to establish your diagnosis with colon cancer, and that the condition resulted from your occupational exposure to a toxic substance. However, you provided no further evidence.

Accordingly, on January 28, 2005, the district office issued a Recommended Decision to deny your claim for colon cancer under Part B of the EEOICPA; finding insufficient evidence to establish that you were diagnosed with colon cancer. The FAB finalized the recommendation in a Final Decision of May 6, 2005.

Subsequently, on May 1, 2006, the district office also issued a Recommended Decision to deny your claim for colon cancer under Part E; again citing insufficient evidence that you were diagnosed with the claimed illness. After an independent assessment and review, on June 10, 2006, the FAB issued a Final Decision finalizing the findings of the district office.

In a submission received by the district office on May 26, 2007, you provided a pathology report and additional medical records to confirm your diagnosis with colon cancer. Accordingly, the district office referred your case file to the Office of the Director for review and consideration of reopening claims under both Part B and Part E of the Act.

DISCUSSION

After careful assessment of your case record, I find it necessary to vacate the May 6, 2005 and June 10, 2006 Final Decisions denying your claims for benefits for the condition of colon cancer under Part B and Part E, respectively. Sufficient evidence exists to establish your diagnosis with colon cancer. As such, additional development is required to determine your eligibility to benefits under both Part B and Part E of the EEOICPA.

On May 26, 2007, you submitted new medical evidence in support of your claims for colon cancer. This new evidence includes a pathology report dated January 16, 2002, confirming your diagnosis with colon cancer. Additionally, various medical reports and progress notes, ranging from 2002 to the present, establish your diagnosis and treatment for this illness. This new evidence invalidates the basis of the May 6, 2005 and June 10, 2006 Final Decisions denying your Part B and Part E claims. As such, it is necessary to vacate these prior Final Decisions so that the district office may proceed with a new examination of your eligibility under Part B and Part E for colon cancer.

CONCLUSION

The May 6, 2005 and June 10, 2006 Final Decisions, respectively, denying your claim for colon cancer under Part B and Part E are vacated. The district office is directed to evaluate the new medical evidence in support of your claims and issue a new Recommended Decision to encompass your eligibility to benefits for the condition of colon cancer under both Part B and Part E of the Act.

Should you disagree with the decision, you will be afforded the opportunity to file an objection and request an oral hearing or a review of the written record.

Washington, D.C.

[Name]
[Title]
DEEOIC

CERTIFICATE OF SERVICE

I hereby certify that on a copy of the Director's Order was sent by regular mail to the following:

Joe C. Claimant
123 Main Street
City, State, Zip

[Name]
[Title]
DEEOIC

Sample Denial of Request for Reopening

<Date>

Jane B. Claimant
PO Box 12345
City, State Zip

Dear Ms. Claimant:

I am writing in reference to your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

On December 7, 2005, the Final Adjudication Branch (FAB) issued a Final Decision to deny your claim for breast cancer under Part B, because the probability of causation failed to exceed the 50% threshold for compensability. A subsequent Final Decision of October 24, 2006 denied your claim for breast cancer under Part E, finding insufficient evidence to establish that this condition was related to exposure to toxic substances.

The Regulations provide that a claimant may file a written request that the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) reopen his/her claim. The decision whether or not to reopen a claim under this section is solely within the discretion of the Director.

On December 9, 2008, you requested reopening of your claim for benefits under Parts B and E of the EEOICPA. I have reviewed the objections and the evidence on file and I find that your case is not in posture for reopening at this time. The attached Denial of Reopening Request provides further explanation of why there is insufficient basis to warrant reopening.

Your case file is being returned to the *[district office]* of DEEOIC. All future correspondence concerning your claim should be directed to:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If you have any questions about this Denial of Reopening Request, you may contact the *[district office]* at *[district office telephone number].*

Sincerely,

Director,
Division of Energy Employees
Occupational Illness Compensation

EMPLOYEE:	**Jane B. Claimant**
CLAIMANT:	**Jane B. Claimant**
CASE ID:	**1234**
DOCKET NUMBER(S):	**XXXXX-2005** **XXXXXXXX-2006**

DENIAL OF REOPENING REQUEST

The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) Regulations provide that a claimant may file a written request that the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) reopen his/her claim. The Regulations state that in order to support the request to reopen, a claimant must submit evidence of either covered employment or exposure to a toxic substance, or identify either a change in the probability of causation guidelines, a change in the dose reconstruction methods or an addition of a class of employees to the Special Exposure Cohort (SEC). The decision whether or not to reopen a claim under this section is solely within the discretion of the Director.

For the reasons set forth below, the December 9, 2008 reopening request is denied. Accordingly, the December 7, 2005 Part B and the October 24, 2006 Part E Final Decisions of the Final Adjudication Branch (FAB) remain in effect. The case is returned to the Jacksonville District Office.

BACKGROUND

The evidence of record shows that on January 5, 2005, you filed a claim for benefits under the EEOICPA. You claimed that you developed breast cancer as a result of your employment at a covered Department of Energy (DOE) facility.

Form EE-3, Employment History, provides information that describes your employment at the Pinellas Plant, located in Largo, FL, from 1975 until 1997. The DOE was able to establish your employment with General Electric, a known DOE contractor at the Pinellas Plant, from May 3, 1975 to June 10, 1997. With regard to the claimed condition, a pathology report of December 3, 2001 established your diagnosis with breast cancer.

In development of your claims for benefits, the assigned Claims Examiner (CE) referred your case to the National Institute for Occupational Safety and Health (NIOSH) to

prepare a radiation dose reconstruction. The DEEOIC used the information supplied in the dose reconstruction report to determine whether your breast cancer is "at least as likely as not" related to radiation exposure during your employment at the Pinellas Plant. For a claim to be compensable under Part B, the probability of causation (PoC) must be 50% or greater. In this case, the dose reconstruction estimates resulted in an 18.26% probability.

Accordingly, on August 22, 2005, the CE recommended denial of your claim for benefits under Part B, finding that your breast cancer was not "at least as likely as not" caused by occupational exposure to radiation. After its independent assessment, the FAB Hearing Representative finalized the denial of your claim in a Final Decision of December 7, 2005.

With regard to your claim under Part E, the CE conducted a search of the Site Exposure Matrices (SEM). The SEM acts as a repository of information related to toxic substances potentially present at covered DOE sites and has information regarding site investigations and Haz-Map (Occupational Exposure to Hazardous Agents) to assist in evaluating causation. Based on the results of the SEM search and a review of all other evidence presented in the case, the CE was unable to find a link between toxic exposure and breast cancer.

In addition to the SEM search, the CE requested that you provide additional information in support of your claim under Part E. Specifically, by letter dated June 30, 2006, the CE requested evidence to support a link between your claimed condition and exposure to a toxic substance. However, you did not provide any additional evidence for consideration.

As such, on August 15, 2006, the CE issued a Recommended Decision to deny your claim for breast cancer under Part E; finding insufficient evidence to establish that the claimed condition was "at least as likely as not" caused, contributed to, or aggravated as a result of exposure to toxic substances during your employment. By Final Decision dated October 24, 2006, a FAB CE finalized the recommendation denying your claim for benefits under Part E of the EEOICPA.

You requested a reopening of your claims under both Part B and Part E of the Act by fax received in the district office on December 9, 2008. Due to the nature of the request, the CE sent your case to the Office of the Director for reopening review.

DISCUSSION

After a careful assessment of your case record, I have concluded there is insufficient evidence to warrant reopening your claim. Your request for reopening cites several technical objections challenging NIOSH's dose reconstruction methodology.

Furthermore, you object to the Part E decision by presenting a list of toxic substances, along with excerpts of scientific journals referencing human and non-human epidemiological studies.

To determine the probability of whether you sustained cancer in the performance of duty, the CE referred your case to NIOSH for radiation dose reconstruction. NIOSH reported annual dose estimates from the date of initial radiation exposure during covered employment, to the date you first were diagnosed with cancer. A summary and explanation of information and methods applied to produce these dose estimates, including your involvement through an interview and review of the dose report, are documented in the "NIOSH Report of Dose Reconstruction under EEOICPA." On July 26, 2005, you signed the OCAS-1, indicating that you reviewed the NIOSH Draft Report of Dose Reconstruction and that you agreed that it identified all of the relevant information provided to NIOSH. The district office received the final NIOSH Report of Dose Reconstruction on August 2, 2005.

In your letter requesting reopening, you raise a number of points of contention with regard to your Part B claim. These objections to the Part B decision denying your claim are challenges to the dose reconstruction methodology. Methodology used by NIOSH in arriving at reasonable estimates of radiation doses received by an employee is binding on the DEEOIC. However, for thoroughness, a DEEOIC Health Physicist conducted a May 20, 2009 reassessment of your case file along with a re-examination of the NIOSH dose reconstruction methodology. After his assessment, he reported that the assessment of your occupational radiation dose was factually accurate. He also noted that the dose reconstruction derived from an accurate application of dose reconstruction science and NIOSH policy. Therefore, the Health Physicist found no basis for a rework of the dose reconstruction, and as such, I do not have reason to support a reopening of your claim.

In addition to the Health Physicist review, a DEEOIC Toxicologist reviewed the objections with regard to the denial of your claim under Part E. In your request for reopening, you presented references pertaining to chemical substances linked to breast cancer, but did not provide any treatment records or other medical evidence that showed you developed breast cancer as a result of a exposure to an occupational toxin. The DEEOIC Toxicologist reviewed the most recent published literature of occupational medicine regarding toxic chemical exposure in the workplace and the potential development of adverse health effects. She opined that review of the occupational desk references used by occupational health physicians and epidemiologists, which were peer reviewed by scientists, and the review of individual published studies that have investigated breast cancer, did not show a causal link between occupational exposures described in your letter and the development of breast cancer. Given the opinion of the DEEOIC Toxicologist and the lack of any medical evidence showing a link between

breast cancer and an occupational toxic substance exposure, I have no basis to reopen the Part E portion of your claim.
In summary, I find that the application of the NIOSH dose reconstruction methodology was appropriate, and there is no basis to warrant reopening your claim under Part B of the Act. Additionally, I find no new evidence to establish a link between toxic substance exposure and the claimed illness that necessitates reopening your claim under Part E.

CONCLUSION

Based upon the foregoing discussion, I find there is insufficient basis to warrant reopening the December 7, 2005 Part B and the October 24, 2006 Part E Final Decisions of the FAB. As such, I have to deny your December 9, 2008 request for reopening. However, if you should obtain new and probative evidence that establishes a link between toxic substance exposure and your claimed conditions of breast cancer, the DEEOIC will reconsider its position.

Washington, D.C.

Director
Division of Energy Employees
Occupational Illness Compensation

CERTIFICATE OF SERVICE

I hereby certify that on a copy of the Denial of Reopening Request was sent by regular mail to the following:

Jane B. Claimant
PO Box 12345
City, State 67890

Director
Division of Energy Employees
Occupational Illness Compensation

Sample Ancillary Medical Services Development Letter

Date:

Claimant: (or Auth Rep/Provider)
Street Address
City, State, Zip

Case ID:
Accepted Condition(s):

Dear *[Enter Claimant or Auth Rep]*:

I am writing to you concerning your benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). We have received a request for authorization for the *[Enter type of ancillary medical service requested]*. In order to properly evaluate and respond to this request, we need additional information from you.

Please provide our office with the following information:

(*Request only that information that is necessary to process the claim. Feel free to modify the following, if necessary.)*

- *Prescription from your treating physician (should include diagnosis code(s) for the condition for which the item(s) is being prescribed).*
- *Letter of Medical Necessity or other medical documentation (describe the general information a LMN is to provide.*
- *Claimant information such as name, case file number, date of birth, and telephone number.*
- *Provider or vendor information such as name, provider address, Bill Pay Agent provider number, Tax ID number, national provider identification number, telephone number, and fax number.*
- *Treating physician contact information such as name, address, telephone number, and fax number.*
- *DME information such as diagnosis code, HCPCS/CPT, modifier, quantity, purchase price, rental price, total cost, begin date, end date, and duration of use.*

You have 15 calendar days to provide the additional information. Your lack of response or submission of insufficient evidence will result in a denial of the request.

In the interest of expediting the approval of your request for *[Enter type of Ancillary Medical Service]*, please fax the requested information to the DEEOIC Bill Processing Agent at (800) 882-6147, within 30 days, or contact me if you have questions regarding this request.

Thank you for your assistance.

Sincerely,

[Name]
[Telephone and Fax Numbers]

cc: *[Enter as appropriate]*

Sample Development Letter (DME/Oxygen Therapy Equipment/Oxygen Medical Supplies)

Date:

Claimant: (or Auth Rep/Provider)
Street Address
City, State, Zip

Case ID:
Accepted Condition(s):

Dear *[Enter Claimant or Auth Rep]*:

I am writing to you concerning your benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). We have received a request for authorization for the *[rental/purchase]* of a *[Enter type of DME, Oxygen Therapy Equipment and/or Oxygen Medical Supplies requested]*. In order to properly evaluate and respond to this request, we need additional information from you.

Please provide our office with the following information:

(*Request only that information that is necessary to process the claim. Feel free to modify the following, if necessary.)*

- *Prescription from your treating physician (should include diagnosis code(s) for the condition for which the item(s) is being prescribed).*
- *Letter of Medical Necessity or other medical documentation (describe the general information a LMN is to provide.*
- *Claimant information such as name, case file number, date of birth, and telephone number.*
- *Provider or vendor information such as name, provider address, Bill Pay Agent provider number, Tax ID number, national provider identification number, telephone number, and fax number.*
- *Treating physician contact information such as name, address, telephone number, and fax number.*
- *DME information such as diagnosis code, HCPCS/CPT, modifier, quantity, purchase price, rental price, total cost, begin date, end date, and duration of use.*
- Diagnostic testing that supports the physician's reasons for prescribing oxygen therapy DME or oxygen medical supplies, and identifies clear, objective pulmonary deficits including results from an arterial blood gas (ABG) and/or resting/exercise spirometry test, and/or nocturnal oximetry studies. The results are to identify the conditions under which the test(s)/studies were performed; (i.e.; during exercise, at rest, or during sleep).

- The test(s) are to be performed by a qualified medical professional, and originate from a qualified source such as a laboratory, diagnostic testing facility, hospital, physician's office or clinic.

Note that add-ons and/or upgrades to Oxygen Therapy Equipment and/or Oxygen Medical Supplies will be considered for approval if evidence substantiates a medical need for the enhancement. However, add-ons and/or upgrades to Oxygen Therapy Equipment and/or Oxygen Medical Supplies are not covered when they are intended primarily for the claimant's convenience and do not significantly enhance functionality.

You have 15 calendar days to provide the additional information. Your lack of response or submission of insufficient evidence will result in a denial of the request.

In the interest of expediting the approval of your request for *[Enter type of DME, Oxygen Therapy Equipment and/or Oxygen Medical Supplies]*, please fax the requested information to the DEEOIC Bill Processing Agent at (800) 882-6147, within 30 days, or contact me if you have questions regarding this request.

Thank you for your assistance.

Sincerely,

[Name]
[Telephone and Fax Numbers]

cc: *[Enter as appropriate]*

OXYGEN DELIVERY SYSTEMS

GASEOUS OXYGEN SYSTEM – This consists of an oxygen tank with a regulator/flowmeter. This is a compressed gas system. A regulator/flowmeter is attached to the tank via an oxygen wrench. The flow rate is controlled by adjusting the knob on the regulator/flowmeter. Oxygen tanks, no matter how large or small, are all portable.

OXYGEN CONCENTRATOR – An oxygen concentrator is a device which takes ambient or room air and divides the air into oxygen and nitrogen. The nitrogen is discarded and the oxygen is stored, concentrated, and delivered to the patient at 90-95% purity. A stationary concentrator is most typically utilized inside the patient's home. A stationary system runs on electricity. A stationary system has a regulator/flowmeter built into the device. A stationary system typically has a single delivery port and, depending upon the model, can deliver up to 8 liters per minute (LPM) of oxygen to the patient. A portable oxygen concentrator is most typically utilized outside the patient's home. A portable system runs on a battery that must be recharged periodically. The battery recharger runs on electricity. Typical battery life for a portable oxygen concentrator is approximately 4 hours.

LIQUID OXYGEN SYSTEM – Liquid oxygen systems consist of a stationary unit or reservoir which stores a large volume of liquid oxygen and a portable unit which can be refilled from the stationary unit. Neither the stationary or portable units require electricity.

MECHANICAL VENTILATOR – Mechanical ventilation may be defined as a life-support system designed to replace or support normal ventilator lung function. Mechanical ventilation serves only to provide assistance for breathing and does not cure a disease process. Mechanical ventilators require electricity and a skilled professional (M.D., D.O., PA, NP, RN, or RRT) to monitor the patient and the ventilator settings.

Sample Home Modification Letter

[*Date*]

[*Claimant Name or AR Name*]
[*Street Address*]
[*City, State, Zip*]

Employee: [*Insert Employee Name*]
Case ID: XXXXX

Dear [*Insert Employee or AR Name*]:

This letter is in reference to your claim for medical benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) recently received an authorization request for home modifications related to your accepted medical condition(s).

Along with your request we also received a copy of your letter of medical necessity, prescribing [*Insert brief description of modifications prescribed by letter of medical* necessity]. Additionally, we received the two, detailed contractor estimates, describing the scope and cost of the proposed modifications.

After a careful review of your request, we have determined that the evidence submitted is sufficient to authorize your request for home modification. The request is **approved** subject to the following conditions:

- The DEEOIC is approving modifications based upon the proposal submitted by: [*Insert Name and Address of Contractor and Date of Proposal, for the approved bid.*]
- The total approved cost for all work, including materials, labor, profit and overhead is the amount of[*Insert Approved Dollar* Amount] as stated in the proposal.
- Upon completion of the approved modifications, you must submit a signed letter to DEEOIC advising that all of the approved work has been completed, and that the work has been completed in a satisfactory manner. Along with your letter you must submit a completed OWCP Form 915 (Claim For Medical Reimbursement), a final invoice for the charges billed, and proof of payment to the contractor.
- If you want DEEOIC to pay the contractor directly, it will be necessary for the contractor to enroll in our medical bill processing system in order to receive payment. Contractors seeking additional enrollment information can call our toll-free number (866-272-2682) for answers to billing questions. Once the approved work has been completed, it will be necessary for you to write us advising that all work has been completed in a satisfactory

manner, and that you are requesting DEEOIC to make payment directly to the contractor, for the pre-approved amount.

- Once DEEOIC has approved a written proposal for medically necessary modifications, you have the option of contracting for additional modifications, or for materials and appliances that represent an upgrade from the medically necessary standard prescribed. You may do so with the understanding that DEEOIC will only reimburse you for the cost of medically necessary modifications approved in writing. Reimbursement for the approved amount will be made to you upon completion of all work, and upon receipt of the following:
    - A letter from you stating that all work, as detailed in the approved modification proposal, has been completed to your satisfaction.
    - A final invoice from the contractor itemizing the cost of the completed work.
    - Proof of payment to the contractor for an amount no less than the amount approved for reimbursement by DEEOIC.
- The DEEOIC neither endorses nor sponsors any entity providing services to beneficiaries of our program.

If you have any questions or concerns regarding this authorization please call me at [*Insert Telephone Number*].

Sincerely,

[*Name*]
[Title]

Copy To: Authorized Representative

Copy To: Contractor

CLAIM FOR HOME HEALTH CARE, NURSING HOME, OR ASSISTED LIVING BENEFITS UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Instructions	
To claim for home health care, nursing home or assisted living benefits, please indicate below which benefits you are claiming, provide the requested contact information for your treating physician, sign and date the bottom of this form and mail it to: DOL DEEOIC Central Mail Room Correspondence, P.O. Box 8306, London KY 40742-8306. DO NOT WRITE IN SHADED AREAS.	OMB Control No: 1240-0002 Expiration Date: 03/31/2022

Employee's Information	
Name (Last, First, Middle Initial)	**Social Security Number:** **XXX-XX- _ _ _ _**
Address (Street, Apt. #, P.O. Box)	**DEEOIC Case ID#:**
(City, State, Zip Code)	**Telephone Number(s)** Home: ( ) - Other: ( ) -

Type of Medical Benefit Claimed (Check appropriate box)

I hereby request Home Health Care, Nursing Home, or Assisted Living benefits that are directly related to my DEEOIC accepted condition(s) and ordered by my treating physician. I acknowledge it is my responsibility to ensure that all requested medical documentation is submitted in support of my claim for these benefits.

☐ **Home Health Care** ☐ **Assisted Living** ☐ **Nursing Home**

Treating Physician of Record	
Physician Name (Last, First, Middle Initial)	**Telephone Number(s):** Office: ( ) -
Address (Name of Facility, Street, Suite #, P.O. Box)	Other: ( ) -
(City, State, Zip Code)	**Note:** Your physician must be either an M.D. or D.O.

Employee Declaration

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain benefits provided under EEOICPA, or who knowingly accepts benefits to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment, or both. Any change to the information provided on this form, once it is submitted, must be reported immediately to the district office responsible for the administration of the claim. I hereby make a claim for benefits under EEOICPA and affirm that the information I have provided on this form is true. **I authorize any physician or hospital (or any other person, institution, corporation or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs.**

Employee Signature _____ Date _____

Page 1

Form EE-17A
January 2015

Privacy Act Statement
In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 USC 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information received will be used to determine eligibility for, and the amount of, benefits payable under EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be disclosed to physicians and other health care providers for use in providing treatment, performing evaluations for the Office of Workers' Compensation Programs, and for other purposes related to the medical management of the claim. (4) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue debt collection actions required or permitted by the Debt Collection Act. (5) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.
Public Burden Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are required to respond to this collection to obtain EEOICPA benefits (20 CFR 30.403). Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-17A. **DO NOT SUBMIT THE COMPLETED FORM TO THIS ADDRESS.**

PHYSICIAN'S CERTIFICATION OF MEDICAL NECESSITY UNDER THE ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT

U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation

Instructions	
Please provide the identifying information requested below, indicate the date of your face-to-face physical examination of your patient, check either the box requesting an in-home assessment or the other box indicating you are attaching a Letter of Medical Necessity, sign and date the bottom of this form. For additional instructions, see page 2. **DO NOT WRITE IN SHADED AREAS.**	OMB Control No: 1240-0002 Expiration Date: 03/31/2022

Patient Information	
Name(Last, First, Middle Initial)	**Date of Birth:**_____ **DEEOIC Case I.D.** _____ **SSN: XXX-XX-**_____ (Last Four Only)
Address(Street, Apt. #, P.O. Box)	**Telephone Number(s)** Home: ( ) -
(City, State, Zip Code)	Other: ( ) -

Treating Physician Information		
Physician Name (Last, First, Middle Initial)	**Telephone Number(s):** Office: ( ) -	
Address (Name of Facility, Street, Suite #, P.O. Box)	Other: ( ) -	
(City, State, Zip Code)	**Circle One:** M.D. or D.O.	**National Provider Identifier:**

DEEOIC Accepted Conditions

Date of Physician's Examination, and Request for Assessment or Letter of Medical Necessity (check appropriate box)	
Date of Face-to-Face Physical Examination:	☐ **In-home Assessment Requested** Before prescribing home health care, nursing home or assisted living services for my patient, I am requesting an in-home assessment to assist me in determining the need for services related to the DEEOIC accepted condition(s) listed above.
	☐ **Letter of Medical Necessity Attached** I have attached a Letter of Medical Necessity that contains both a plan of care and the rationale for my conclusion that the prescribed home health care, nursing home or assisted living services are medically necessary for treatment of the DEEOIC accepted condition(s) listed above.

Physician Declaration

By signing this Form EE-17B, I acknowledge that: the above-named patient is currently under my care for the DEEOIC accepted condition(s) listed above; I have personally examined this patient on the date indicated above; I have read the DEEOIC Home Health Care Letter to Physicians; I understand that DEEOIC only pays for care that is medically necessary for treatment of DEEOIC accepted conditions; and I understand that DEEOIC cannot pay for care for any condition that may be a consequence of DEEOIC accepted condition(s) until specifically claimed for and accepted by DEEOIC. I have attached copies of the relevant medical documentation and objective testing supporting my attached Letter of Medical Necessity (if I have provided one).

_____ _____

Physician Signature Date

Additional Instructions to Physician

Form EE-17B is used to obtain a Letter of Medical Necessity (LMN) from the treating physician that describes the claimant's Home Health Care (HHC) needs as they relate to one or more of the DEEOIC accepted conditions identified on this form. The LMN must state that you have personally met with and examined your patient within the past 60 days, and have made a determination as to the type of care, and the frequency and duration of such in-home care, as it relates to the accepted condition(s).

If you feel that you need more information from your patient before you can prepare the LMN, you may first wish to schedule a visit with your patient to discuss his/her HHC needs. If you feel that an in-home assessment by a provider of HHC services would be of value, please check the appropriate box on page 1, sign the Physician Certification at the bottom of the form and return it to the DEEOIC Central Mail Room address below. Our claims staff will notify the HHC provider, designated by your patient, that an in-home assessment of HHC needs has been authorized by DEEOIC. Once the assessment has been completed, our district office will forward a report to your office, and you can proceed with preparing your LMN. Once you have the necessary information to prepare a LMN, here is the specific information we are seeking:

Physical Examination: DEEOIC requires a physician to have personally visited with and conducted a physical examination of the patient, within the past 60 days. Your LMN should provide a written narrative describing your physical findings at the time of examination, and the specific functional limitations resulting exclusively from the accepted work-related illness.

Type and Duration of Care: The LMN must clearly specify the type(s) of HHC required, and for each type of care must specify the number of hours per day, and number of days per week for that particular type of service. The letter must also provide a description of the specific medical services to be performed by each type of caregiver. Examples of the various types of HHC available are as follows:

Skilled Nursing Care (RN/LPN)
Home Health Aid/Personal Care Attendant
Respiration Therapist
Occupational/Physical Therapist

Please be sure to sign the Form EE-17B and mail it to the claims examiner at: DOL DEEOIC Central Mail Room Correspondence, P.O. Box 8306, London KY 40742-8306.

Privacy Act Statement

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Public Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to the information collections on this form unless it displays a valid OMB control number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering the data needed, and completing and reviewing the collection of information. You are not required to respond to this collection, but failure to respond may result in an unfavorable decision. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Workers' Compensation Programs, Room S3524, 200 Constitution Avenue N.W., Washington, D.C. 20210, and reference OMB Control No. 1240-0002 and Form EE-17B. **DO NOT SUBMIT THE COMPLETED FORM TO THIS ADDRESS.**

Sample Letter to Physician

U.S. Department of Labor

Office of Workers' Compensation Programs
Division of Energy Employees Occupational Illness Compensation
DOL DEEOIC Central Mail Room
P.O. Box 8306
London, KY 40742-8306

Date:

Patient Name:
D.O.B.
DEEOIC Case ID:

Dear Dr. _____:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) administers claims for medical benefits to certain workers exposed to radiation and other toxic exposures, who were employed at covered worksites involved in the production of nuclear weapons. These benefits, which can include home health care, are limited to the specific medical condition or conditions identified on the enclosed Physician's Certification (Form EE-17B) as DEEOIC accepted conditions.

We are writing to you because your patient has requested that DEEOIC authorize home health care (HHC) benefits, for one or more of his/her accepted conditions, and has identified you as his/her treating physician, and we rely upon the medical advice of the patient's treating physician when evaluating these claims. As the treating physician, you are responsible for ensuring that the employee's plan of care aligns with the requisite HHC services necessary to therapeutically treat his/her accepted condition(s).

We ask that you prepare a Letter of Medical Necessity (LMN), describing your patient's HHC needs, as they relate to one or more of his/her accepted conditions. The LMN should indicate that you have personally met with and examined your patient within the past 60 days, identifying the date of the visit. Your letter should specify the level of in-home care required: skilled nursing care and/or services of an assistive health care individual. With respect to skilled nursing care (RN/LPN), please identify and describe what specific medical services the patient requires, the frequency or interval at which these services are to be performed, and the number of hours required to perform the prescribed function each time it is performed. With respect to assistive health care services (HHA, PCA, etc.), please identify the specific physical limitations caused by the accepted conditions that necessitate assistance in accomplishing activities of daily living (i.e., feeding, dressing, bathing etc.), and indicate the number of hours each day that are required for care.

Additional requirements regarding the LMN are provided in the enclosed "Additional Instructions to Physician." If you feel that an in-home assessment by a HHC provider would be appropriate, you may select this option on Form EE-17B and return the form to us. A Medical Benefits Examiner (MBE) will request an in-home assessment from the HHC provider identified

by your patient. Once the HHC provider completes the assessment, we will forward it to you for review and preparation of your LMN.

If it is your intention to prescribe home or residential health care, you will need to identify the medical /home health care provider that has been selected by you and the claimant. The DEEOIC requires that the medical/home health care provider be enrolled in our medical bill processing system. The DEEOIC neither endorses nor sponsors any home health care provider, or any other entity providing medical services. Please include the following information with your order for care:

- Provider Name,
- Address,
- Phone Number
- National Provider Identifier (NPI) (if available), and
- DEEOIC Medical Bill Processing System Number (if you have it).
  DEEOIC cannot authorize a provider that is not actively enrolled in our medical bill processing system.

Be aware that third-party providers of HHC services are not, in any way, affiliated with the Department of Labor. DEEOIC does not endorse, sponsor, or select any provider of medical benefits. That choice is left to the individual requesting medical care. We want to make clear that any plan of care, prepared by a third-party provider, is solely their recommendation regarding the health care needs of your patient. The final decision as to your patient's needs rests with you, in consultation with your patient.

Home health care authorization requests not supported by the requested medical evidence may be delayed or denied. Submission of documentation signed by a physician who has not physically examined the patient will be of reduced probative value in assessing requests for home health care services.

If you have questions regarding this process, you may contact the Medical Benefits Examiner assigned to your patient's case at the number provided below.

Thank you for your time and attention to this matter.

Sincerely,

[Name]
[Title]

DEEOIC Home and Residential Health Care Authorized Billing Codes

This information is intended to serve only as a general reference resource. Reimbursement is based on the OWCP fee schedule.

T1001: Nursing Assessment/Initial Evaluation: This service does not require prior authorization from DEEOIC Medical Benefits Examiner. Providers must submit the treating physician's prescription and/or Letter of Medical Necessity along with the nurse's assessment report with the bill upon billing for services rendered.

T1017: Targeted Case Management (15 minutes = 1 Unit): This service requires prior authorization from the DEEOIC Medical Benefits Examiner for a Registered Nurse to perform targeted case management. This is limited to the clinical impact of a covered employee's accepted work-related condition on his/her current medical status. The skill level of a Registered Nurse is required for this targeted case management activity. The Medical Benefits Examiner's authorization will specify the number of hours authorized for a case management visit. Each unit of a T1017 code is equal to 15 minutes; therefore, if a nurse case manager is at the covered employee's home for an assessment for one hour, the proper number of units to bill for this T1017 code is 4 units.

T1019: Personal Care Attendant (PCA) (15 Minutes = 1 Unit): This service requires prior authorization from the Medical Benefits Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist covered employee with activities of daily living (i.e. bathing, feeding, dressing, etc.) Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

Each unit of a T1019 code is equal to 15 minutes; therefore, if an attendant provides services for one hour, the proper number of units to bill for this T1019 code is 4 units. Under no circumstances should this code be authorized for more than 7 hours and 45 minutes (31 units) of care per day.

T1020: Personal Care Services (PCA) Per Diem (8 hrs.): This service requires prior authorization from the DEEOIC Medical Benefits Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist covered employees with activities of daily living (i.e. bathing, feeding, dressing, etc.) Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

12-hour care: For personal care services approved for 12 hour care, the bill must be submitted with one unit of a T1020 code, which covers the 8-hour period of provided services, and 16 units T1019 which cover the 4-hour period of provided services.

T1030: Nursing Care, in-home, by Registered Nurse (RN), Per Diem (8 Hours): This service requires prior authorization from the DEEIOC Medical Benefits Examiner for a Registered Nurse to perform in home health care (per 8 hour shift). An RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an RN for an 8 hour shift(s).

24-hour care: If this billing code is approved for 24 hour care, the bill must be submitted with 3 units of a T1030 code which covers the 24 hour period of provided services, regardless of the number of RNs assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1030 code.

T1031: Nursing Care, in-home, by Licensed Practical Nurse (LPN) Per Diem (8 Hours): This service requires prior authorization from the DEEOIC Medical Benefits Examiner for a Licensed Practical Nurse to perform in-home health care (per 8 hour shift). An LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an LPN for an 8 hour shift(s).

24-hour care: If this billing code is approved for 24 hour care, the bill must be submitted with 3 units of a T1031 code which covers the 24 hour period of provided services, regardless of the number of LPNs assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1031 code.

S5126: Attendant: Home Health Aide (HHA), Certified Nurse Assistant (CNA), Per Diem (8 Hours): This service requires prior authorization from the DEEIOC Medical Benefits Examiner. A HHA/CNA can only be authorized for care if there is sufficient medical rationale from a physician documenting the medical necessity of the service for the accepted work-related condition. If a HHA/CNA is authorized and a RN/LPN is utilized, bills should be submitted with the S5126 code.

24-hour care: If this billing code is approved for 24 hour care and the care is provided, the bill must be submitted for 3 units which cover the 24 hour period of provided services, regardless of the number of HHA/CNAs assigned. For example, if two HHA/CNAs are utilized for two 12 hour shifts, the service provided still covers the authorized three 8 hour shifts and the bill should reflect 3 units of the authorized S5126 code.

S9122: Home Health Aide (HHA) or Certified Nurse Assistant (CNA) Hourly Code (less than 8 hour care): This service requires prior authorization from the DEEOIC Medical Benefits Examiner for a HHA or CNA to perform in home health care (per hour code only). A HHA or CNA can be approved if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a HHA or CNA. Under no circumstances should an hourly code be authorized for more than 7 hours (units) of care per day.

S9123: Nursing Care in-home Registered Nurse (RN) Hourly Code (less than 8 hour care): This service requires prior authorization from the DEEOIC Medical Benefits Examiner for a RN to perform in home care (per hour code only). A RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a RN. Under no circumstances should an hourly code be authorized for more than 7 hours (units) of care per day.

S9124: Nursing Care in-home License Practical Nurse (LPN) Hourly Rate (less than 8 hour care): This service requires prior authorization from the Medical Benefits Examiner for a LPN to perform in home care (per hour code only). A LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a LPN. Under no circumstances should an hourly code be authorized for more than 7 hours (units) of care per day.

S9126: Hospice Care, in the home, Per Diem (8 Hour Shifts): Hospice care is generally requested and authorized when a covered employee is determined to be terminally ill. Hospice services include services such as nursing care, social services, and counseling services. This service requires prior authorization from the DEEOIC Medical Benefits Examiner.

24-hour care: If this billing code is approved for 24 hour care, the bill must be submitted with 3 units of a S9126 code which covers the 24 hour period of provided services.

Note: Under no circumstances should a per diem code be used for less than 8 hours of care.

INSTRUCTIONS FOR COMPLETING OFFSET WORKSHEET

Employee:

Claimant:

Claim Number:

1. Gross Settlement/Final Judgment Amount $_____

   a. Amount of Line 1 that is for damages to real/personal property (if any) $_____

   b. Amount of Line 1 that is for medical treatment before filing date (if any) $_____

   c. Subtract Lines 1a and 1b from amount on Line 1 and enter balance here $_____

2. Were the amounts entered at Step 1 only paid to or on behalf of one party (see Instructions, Step 2)? Y / N

   a. If no, go to either Step 3 or Step 4

   b. If yes, go to Step 5

3. Allocation Between Parties Provided by Judge or Jury:

   a. Amount of Line 1c awarded to employee for injuries due to covered exposure to toxic substance $_____

   b. Amount of Line 1c awarded to other party(s). Go to Step 5 $_____

4. CE Allocation Between Parties (all other cases):

   a. Standard allocation for living employee is 75% of Line 1c. Enter result here and go to Step 4c $_____

   b. Standard allocation for deceased employee is 50% of Line 1c. Enter result here and go to Step 4c $_____

   c. Good cause shown for different allocation? Y / N

   c. If yes, allocation for living/deceased employee is ____% of Line 1c. Enter dollar amount here $_____

5. Allowable Deductions From Payment:

   a. Costs of Suit (see Instruction Step 5) $_____

   Divide costs by gross payment to determine costs percentage (Line 5a/Line 1)....._____%

   b. Multiply Line 1c, 3a, 4a, 4b or 4d (one only) by the costs percentage. Enter here $_____

   c. Attorney Fees $_____

Divide attorney fees by gross payment to determine attorney fees percentage (Line 5c/Line 1) _____%

d. Multiply Line 1c, 3a, 4a, 4b or 4d (one only) by the LESSER of attorney fees Percentage or 40%. Enter here $_____

e. Enter amount of Line 1 that was paid to satisfy workers' compensation lien of a state authority or insurer (if any) $_____

6. Net Amount of Payment to be used for Offset:

a. Subtract Line 5b from Line 1c, 3a, 4a, 4b or 4d, as appropriate. Enter balance here $_____

b. Subtract Line 5d from Line 6a. Enter balance here $_____

c. Subtract amount on Line 5e (if any) from Line 6b to arrive at amount of offset And enter result here $_____

7. Offset of Part B/E Benefits, Surplus Payment:

a. Amount of unpaid lump-sum payment $_____

b. If Line 7a is larger than Line 6c, subtract Line 6c from Line 7a and enter balance due claimant here $_____

c. If Line 7a is smaller than Line 6c, subtract Line 7a from Line 6c and enter amount of surplus to be recovered from future lump-sum payments and/or medical benefits $_____

READ BEFORE THE WORKSHEET IS COMPLETED: Lump-sum payments and/or medical benefits to be awarded for an accepted condition are only "offset" or reduced to reflect the amount of any settlement or final judgment payment for injuries due to exposure to the same toxic substance for which EEOICPA payments are payable. If the payment was for injuries due solely to exposure to some other toxic substance, no offset of EEOICPA benefits is required. For example, a Part B award for lung cancer due to exposure to radiation is NOT offset to reflect a settlement or final judgment payment in a suit that only alleges exposure to asbestos fibers. Also, if the tort complaint alleges exposure that is clearly outside the time frame and/or location of exposure awarded under EEOICPA, offset is not required. As long as there is one exposure that would be compensable, offset is required even if the tort suit or EEOICPA claim has several other different exposures. In order to determine whether offset will be necessary, the CE must examine the complaint to see what alleged exposure is identified as causing the alleged injuries.

The CE does not have to fill out the Worksheet if the employee or his/her survivor(s) has had their workers' compensation benefits, or a RECA section 4 or 5 award, or a prior award of EEOICPA Part B/E benefits offset to reflect the full amount of a settlement or final judgment payment. However, if the reduction of those prior benefits was not enough to fully offset the payment, leaving a surplus payment still requiring an offset, enter the dollar amount of the surplus payment on Line 6c and complete the remainder of the Worksheet. The CE does not have to complete the entire Worksheet if he or she is only offsetting a claimant's current Part B/E lump-sum award or future medical benefits to reflect a surplus payment.

Step 1 – Putting a Value on a Settlement or Final Judgment.

Settlements or final judgments can include both an initial cash payment and future payments. The "value" of future payments is their present value, not the sum of the future payments (which will always be more than the present value of the future payments). If the future payments are made through an annuity, the CE may accept the purchase price of the annuity as the present value of the future payments. Do not attempt to put a value on a future payment that is contingent upon an event that has not yet taken place, such as the diagnosis of another medical condition. This particular type of future payment cannot be valued and is not to be included in the amount listed on Line 1 of the Worksheet. However, if the event in question has occurred by the time a later award under Part E becomes payable, any payment for that event must be added to the amount entered on Line 1, and the Worksheet must be completed again. Any payment for the aggravation, by medical malpractice, of illnesses caused by the same exposure for which EEOICPA benefits are payable is an amount that must be reported to OWCP and included in the amount listed on Line 1.

In some rare cases, a complaint alleging injuries due to exposure to a toxic substance may contain causes of action for unrelated damages to either personal property or real property of the plaintiff(s). If this occurs, and the payment listed on Line 1 includes an amount for damages to personal or real property, enter this amount on Line 1a. If there is a question about whether or not the complaint contains a cause of action of this sort, contact the National Office.

Since EEOICPA benefits are not offset to reflect the amount of any payment for medical treatment provided BEFORE the date an employee files a claim, enter the amount of the payment listed on Line 1 that is explicitly designated as being for this medical treatment on Line 1b, even if the payment was made directly to the provider. Also, if a malpractice payment is included in the amount on Line 1, and it only constitutes a reimbursement for medical treatment provided before the employee filed a claim, include the malpractice payment in the amount listed on Line 1b and complete the remainder of the Worksheet. If a malpractice payment constitutes anything other than a reimbursement for medical treatment provided to the employee before he/she filed a claim for EEOICPA benefits, do not complete the Worksheet and refer the case to the National Office.

Some law suits, such as those related to exposure to asbestos, may involve multiple defendants making multiple payments over time. EEOICPA benefits currently payable will be reduced to reflect the total of only those settlement or final judgment payments received. Payments received at a later date may be offset from any future EEOICPA award of lump-sum benefits or payment of medical benefits, at which time another Worksheet must be completed, listing on Line 1 the total of the payments received since the completion of the prior Worksheet (also add any prior unabsorbed surplus from any earlier offset of benefits to the amount in Line 6c).

Step 2 – Single Recoveries vs. Joint Recoveries.

A payment on a final judgment or settlement is a joint recovery only if it was paid to multiple parties. Joint recoveries are "allocated" or split up between multiple parties at either Step 3 or 4 of the Worksheet. If only one party received the amounts on Lines 1a, 1b and 1c of the Worksheet, AND THAT PARTY WAS THE EMPLOYEE OR ANOTHER PERSON

WITHOUT THEIR OWN CAUSE OF ACTION IN THE COMPLAINT, fill in the remainder of the Worksheet. It is rare that a payment will be made to a person who does not have their own cause of action in the complaint. However, if an unmarried employee files suit and then dies, a court may appoint another person to take charge of the suit. While this person will not have their own cause of action, he will be the proxy for the deceased employee.

If someone other than these two specific parties received the entire payment, and the employee was alive at the time it was paid, no offset is needed and the Worksheet does not need to be completed. For example, if an employee and his or her spouse were both plaintiffs with causes of action in a case they brought together and they both signed releases to settle their case, but only the spouse received a payment and the employee was alive at that time, no offset is required

Step 3 – Judge/Jury Allocation of Joint Recoveries.

If a judge or jury specifies how to allocate a joint recovery between multiple parties, the CE MUST use that allocation to fill in the blanks in Step 3, as appropriate. In these situations, the CE must obtain a copy of either the judge's order or the jury's verdict making the allocation.Step 4 – All Other Allocations for Living/Deceased Employees.

In all other situations involving a joint recovery, the CE will automatically allocate 75% of the amount on Line 1c to the employee and the remaining 25% to the other parties to the litigation if the employee was alive at the time the payment was made, then enters this amount on Line 4a of the Worksheet. If the employee died before a payment was made, the CE automatically allocates 50% of the amount on Line 1c for the employee's occupational illness/covered illness, and enters this amount on Line 4b.

If the claimant wants to allocate less than the standard percentages to the recovery of the employee (which will reduce the amount by which the EEOICPA award must be offset), the claimant must submit evidence and legal argument to the CE that shows that a lower percentage is appropriate. This evidence MUST show that:

A. State law in the relevant state provides a cause of action for loss of consortium (tort claim based on deprivation of a spousal or parental relationship due to injuries) or wrongful death for the family member to whom the recovery is attributed, and

B. A cause of action for loss of consortium or wrongful death was actually asserted by that family member, either in the same action or in separate actions.

To make these required showings, the claimant must submit a copy of the complaint filed on behalf of the spouse and/or children, and citations to appropriate state case law or statutes. If the CE determines that the evidence as noted above support allocating a lower percentage to the employee, the CE circles "Y" at Line 4c and enters the lower percentage for the employee in the appropriate blank in Line 4d. Using this percentage, the CE calculates the new allocation for the employee and enters this amount on Line 4d. Any situations where this matter is unclear should be referred to the National Office for guidance.

In the event there are multiple payments over time constituting joint recoveries by an employee and other plaintiffs, and the employee dies after receiving at least one payment (but before all of the payments are made), the CE calculates the amount of the offset of an EEOICPA award by using two Worksheets. Using two Worksheets enables the CE to allocate the appropriate percentage of the joint recoveries to the employee. The CE completes one Worksheet for payments received prior to the employee's death (entering that amount on Line 1), and another Worksheet for payments received after the employee's death.

Step 5 – Allowable Deductions from a Payment.

Costs that may be listed on Line 5a of the Worksheet are reasonable out-of-pocket costs and expenses involved in bringing a lawsuit, but do not include fees paid to co-counsel or normal office expenses like secretary or paralegal services or in-house record copying costs. Before the CE may approve the deduction of any costs, the costs MUST be itemized so the CE may evaluate the nature of each individual cost to ensure that it is allowable. Costs that are allowable could include filing fees, travel expenses, record copy services, witness fees, court reporter costs for transcripts of hearings and depositions, postage, and long distance telephone calls. Once the allowable costs have been identified and the sum of those costs are listed on Line 5a, the CE must divide these costs by the amount of the gross payment listed on Line 1 of the Worksheet to determine the percentage of the payment that is represented by the allowable costs, rounded up to the next highest tenth. For example, 26.121% is rounded up to 26.2%. Once this rounded percentage is calculated, the CE must multiply it by the amount listed on Line 1c (if the only party paid was the employee or another person without their own cause of action), or the amount listed on Line 3a, 4a, 4b or 4d (if multiple parties were paid) to calculate the amount of costs to deduct. The CE then enters the result on Line 5b.

Attorney fees submitted for consideration should be entered on Line 5c of the Worksheet. Using the same basic calculation method used for costs, the CE should divide Line 5c by Line 1 to determine the percentage of the gross payment that is represented by the attorney fees, rounded up to the next highest tenth. For example, 26.121% is rounded up to 26.2%. Enter the rounded percentage in the space provided after Line 5c. In general, any fee that exceeds 40% will be considered unreasonable. To determine the amount of allowable attorney fees to be deducted, the CE must multiply the amount listed on Line 1c (if the only party paid was the employee or another person without their own cause of action), or the amount listed on Line 3a, 4a, 4b or 4d (if multiple parties were paid), by the LOWER of the attorney fees percentage that was entered in the space after Line 5c or 40%, and enter the result on Line 5d. If the attorney fee percentage exceeds 40%, the CE should inform the claimant and allow an opportunity to establish that an attorney fee in excess of 40% is reasonable.

The circumstances which should be taken into account in determining the reasonableness of both attorney fees and costs of suit include prevailing local fees, cases of similar complexity and the amount of the gross settlement or final judgment at issue. CE determinations in these areas are made for the sole purpose of administering § 7385 of EEOICPA and do not have any effect on a fee agreement between an attorney and client or any other matter not involving the application of the Act.

Sometimes after an attorney receives a settlement or final judgment payment, but before the attorney distributes that payment to his or her clients, the attorney has to pay out a portion of the payment to satisfy the lien of a state workers' compensation system or an insurer for amounts paid by the system or insurer for the employee's medical condition. When this has occurred, the CE enters the amount of the payment that was made to satisfy the lien on Line 5e of the Worksheet.

Step 6 – Calculating the Amount of the Offset.

To calculate the amount by which EEOICPA benefits must be offset, the CE subtracts Line 5b from Line 1c, 3a, 4a, 4b or 4d, as appropriate, and enters the result on Line 6a. The CE then subtracts Line 5d from Line 6a, and enters the result on Line 6b. Finally, the CE subtracts the amount on Line 5e (if any) from Line 6b, and enters the result on Line 6c. This last amount is the amount by which the claimant's Part B or E award must be offset.

Step 7 – Amount of Part B/E Benefits Due or Surplus Payment.

At Step 7 of the Worksheet, the CE determines either the net amount of EEOICPA benefits due the claimant, or the amount of the surplus payment remaining that must still be absorbed from either future Part E lump-sum payments, or future medical benefits under either Part B or Part E.

DO NOT COORDINATE
Multiple illnesses arising out of same incident accepted under SWC, only *one* of those accepted as covered illness under Part E of EEOICPA – *do not coordinate any Part E benefits*
SWC paid only medical benefits, no monetary benefits – *do not coordinate any Part E benefits*
SWC paid only vocational rehabilitation benefits, no monetary benefits – *do not coordinate any Part E benefits*
Illness accepted under Part B, accepting same illness under Part E for causation only (no monetary) for the condition accepted under Part B *only – do not coordinate Part E medical benefits (but coordinate impairment and wage-loss benefits).*

Instructions for Completing Coordination of SWC Benefits Worksheet

Covered Part E Employee:

Claimant:

Claim Number:

1. Gross dollar amount of SWC received for the covered illness or illnesses accepted by DEEOIC $_____

2. Does amount listed on Line 1 include medical and/or vocational rehabilitation benefits? YES/NO

   a. If "YES", complete Step 3 of the Worksheet

   b. If "NO", skip Step 3 and go directly to Step 4

3. Deductions from amount of SWC received:

   a. SWC paid as medical benefits $_____

   b. SWC paid as vocational rehabilitation $_____

   c. Add Lines 3a and 3b $_____

   d. Net SWC (Subtract Line 3c from Line 1) $_____

4. Deductions for costs of suit and attorney fees:

   a. Total costs of suit $_____

   b. Determine costs percentage (Line 4a/Line 1) _____%

   c. Deductible costs of suit (Line 4b x either Line 1 or Line 3d) $_____

   d. Attorney fees paid $_____

   e. Determine fees percentage (Line 4d/Line 1) _____%

   f. Deductible attorney fees (Line 1 or Line 3d x the LESSER of Line 4e or 40%) $_____

   g. Allowable deductions (Line 4c + Line 4f) $_____

5. Amount of SWC requiring coordination (Subtract Line 4g from either Line 1 or Line 3d) $_____

6. Current Part E entitlement $_____

7. Coordinate current Part E benefits (Subtract Line 5 from Line 6) $_____

8. Is the amount entered on Line 7 a positive amount? YES/NO

   a. If "YES", this is the amount of the Part E award.

   b. If "NO", this is the amount of the Part E surplus that must be absorbed from future Part E benefits.

Determining the amount of SWC received. Enter the gross dollar amount of SWC the claimant received as of the date of the recommended decision on Line 1, less any amounts previously coordinated with prior Part E payments. SWC received by someone other than the claimant is not used to coordinate the claimant's Part E benefits and must not be included in the amount entered on Line 1. For example, SWC received by a worker who is now deceased is not used to coordinate Part E benefits payable to that worker's survivor(s). If the amount on Line 1 includes SWC that was received for a medical condition other than the covered illness(es) accepted by DEEOIC in the claim, DO NOT COMPLETE THE WORKSHEET.

If the amount entered on Line 1 does not include medical and/or vocational rehabilitation benefits, the CE circles "NO" at Step 2 and skips Step 3. However, if the amount on Line 1 does include medical and/or vocational rehabilitation benefits, the CE circles "YES" at Step 2 and performs the calculations listed at Step 3. On Line 3a, the CE enters the amount of medical benefits paid to both the employee and any providers. On Line3b, the CE enters the total amount of vocational rehabilitation expenses paid to both the employee and any providers. These amounts are added at Line 3c, and this total is subtracted from the amount listed on Line 1, leaving the "net" SWC listed on Line 3d.

Costs of suit that may be listed on Line 4a of the Worksheet are reasonable out-of-pocket costs and expenses involved in bringing a SWC lawsuit, but do not include any fees paid to co-counsel or normal office expenses like secretarial or paralegal services or in-house record copying costs. To be deductible from the amount of SWC received by the claimant, the costs MUST be itemized so each individual cost may be evaluated by the CE to ensure that it is allowable and authentic. Costs that are routinely allowable are filing fees, travel expenses, record copy services, witness fees, postage, court reporter costs for transcripts of hearings and depositions, and long distance telephone calls. Once the costs percentage has been calculated (round this figure to the nearest HIGHER one-tenth percentage point) and entered on Line 4b, the CE multiplies that percentage by the amount listed on Line 1, or the amount listed on Line 3d if "YES" was circled at Step 2, and enters this amount on Line 4c. Attorney fees supported by bills or other appropriate documentation are entered on Line 4d of the Worksheet. In general, attorney fees that exceed 40% of the SWC amount entered on Line 1 will be considered unreasonable. If the fees percentage (round this figure to the nearest HIGHER one-tenth percentage point also) entered on Line 4e is greater than 40%, the CE must inform the claimant of this matter and provide him or her an opportunity to show (to the CE's satisfaction) that the attorney fees paid were reasonable. If the claimant is unable to do so, the CE uses 40% to calculate the amount entered on Line 4f.

To determine the amount of SWC requiring coordination, the CE subtracts the amount entered on Line 4g from the SWC entered on Line 1, or the "net" SWC entered on Line 3d if Step 3 of the Worksheet was used, and enters the result on Line 5. The amount entered on Line 5 is the amount of SWC to be used to coordinate the claimant's current Part E benefits.

Coordinating the Part E benefits. To perform the required coordination of Part E benefits, the CE enters the amount of Part E benefits that are currently payable to the claimant on Line 6 of the Worksheet, and subtracts the amount of SWC entered on Line 5 of the Worksheet from the amount entered on Line 6. The result of this coordination is entered on Line 7. If Line 5 is LESS than Line 6, the amount on Line 7 is the compensation payable to the claimant under Part

E of EEOICPA, reduced to reflect the benefits previously received under a SWC program. This is also the amount of Part E compensation that must be referenced in the recommended decision. If Line 5 is MORE than Line 6, the amount on Line 7 will be a negative number that represents the amount of the "surplus" of SWC that must be absorbed from any future Part E benefits payable to the claimant.

Payment Transaction Form for Expedited Processing (EPPTF)

US DOL - OWCP - DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

PAYMENT TRANSACTION FORM for EXPEDITED PROCESSING

EMPLOYEE SSN: ____ - ____ - ____ **PAYEE SSN:** ____ - ____ - ____

PAYEE NAME: _____ _____ _____
Last *First* *M.I.*

PAYMENT AMOUNT: $ _____ **PAYMENT TYPE: PART B** ☐ **PART E** ☐

PAYMENT ADDRESS *For Checks ONLY* ***(Do Not Repeat Payee Name on Lines Below)***

Is this a PAYMENT ONLY address? YES ☐ NO ☐

LINE 1 _____

LINE 2 _____

LINE 3 _____ _____ _____
CITY STATE ZIP

EFT ACCOUNT INFORMATION

Bank Account #: _____ Type: **CHECKING** ☐ **SAVINGS** ☐

Routing (ABA/RTN) #: ☐☐☐☐☐☐☐☐☐ **ACH** ☐ **FED WIRE** ☐

CERTIFICATION

APPROVALS	PRINT NAME	ECS User ID	SIGNATURE	DATE
1. SPS Data Entry				
2. SPS Certification				

SCHEDULE #: _____ ECS COMPLETE: ☐ ECS LOG ID: _____

Version 4.0;02.2016

Payment Transaction Form for 3rd Party Expedited Payments (EPPTF)

US DOL - OWCP - DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

PAYMENT TRANSACTION FORM for EXPEDITED PROCESSING

"FOR PAYMENTS TO THIRD-PARTY ACCOUNTS AND PAYEE ALIAS NAMES" *

EMPLOYEE SSN: ____ - ____ - ____ **PAYEE SSN:** ____ - ____ - ____

PAYEE NAME: _____ _____ _____
Last *First* *M.I.*

***ACCT HOLDER NAME:** _____ _____ _____
Last *First* *M.I.*

PAYMENT AMOUNT: $ _____ **PAYMENT TYPE: PART B** ☐ **PART E** ☐

PAYMENT ADDRESS *For Checks ONLY* ***(Do Not Repeat Payee Name on Lines Below)***

Is this a PAYMENT ONLY address? YES ☐ NO ☐

LINE 1 _____

LINE 2 _____

LINE 3 _____ _____ _____
CITY STATE ZIP

EFT ACCOUNT INFORMATION

Bank Account #: _____ Type: **CHECKING** ☐ **SAVINGS** ☐

Routing (ABA/RTN) #: ☐☐☐☐☐☐☐☐☐ **ACH** ☐ **FED WIRE** ☐

CERTIFICATION

APPROVALS	PRINT NAME	ECS User ID	SIGNATURE	DATE
1. SPS Data Entry				
2. SPS Certification				

SCHEDULE #: _____ ECS COMPLETE: ☐ ECS LOG ID: _____

Version 4.0;02.2016

Payment Transaction Form for Exception Processing

US DOL - OWCP - DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION

PAYMENT TRANSACTION FORM for EXCEPTION PROCESSING

TO BE USED FOR NON-ECS PAYMENTS ONLY

EMPLOYEE SSN: ___ - ___ - ___ **PAYEE SSN:** ___ - ___ - ___

PAYEE NAME: _____ _____ _____
Last *First* *M.I.*

PAYMENT AMOUNT: $ _____ **PAYMENT TYPE: PART B** ☐ **PART E** ☐

PAYMENT ADDRESS *For Checks ONLY* ***(Do Not Repeat Payee Name on Lines Below)***

Is this a PAYMENT ONLY address? YES ☐ NO ☐

LINE 1 _____

LINE 2 _____

LINE 3 _____ _____ _____
CITY STATE ZIP

EFT ACCOUNT INFORMATION

Bank Account #: _____ Type: **CHECKING** ☐ **SAVINGS** ☐

Routing (ABA/RTN) #: ☐☐☐☐☐☐☐☐☐ **ACH** ☐ **FED WIRE** ☐

CERTIFICATION

APPROVALS	PRINT NAME	ECS User ID	SIGNATURE	DATE
1. Set Up/CE				
2. Certification/SrCE				
3. Verification/FO				
4. Authorization/DD				
5. SPS Data Entry				
6. SPS Certification				

SCHEDULE #:_____ ECS COMPLETE: ☐ ECS LOG ID: _____

Version 4.0;02.2016

ECS Payment Cancellation Form

ECS PAYMENT CANCELLATION

Case I.D.: _____

PAYEE NAME: _____ **Payee SSN:** _____

FILE NUMBER: _____ **Part B or E:** _____

Payment Date: _____ **Payment Amt:** _____

Check, as Applicable:

Action 1:

If Initiated by Claimant . . .

- ☐ Letter/Call Received from Claimant
- ☐ Status Reviewed in PACER
- ☐ Return of Payment To DEEOIC Verified

If Initiated by Dept of Treasury . . .

- ☐ Treasury Cancellation Report Received by DEEOIC
- ☐ Status Reviewed in PACER/TCIS And Return of Payment to DEEOIC Verified

Printed Name - NO Fiscal Officer	Signature - NO Fiscal Officer	Date

Action 2: ☐ Reviewed by Unit Chief, BPRP

Printed Name - Unit Chief	Signature - Unit Chief	Date

Action 3: ☐ Reviewed by Director or Deputy Director, EEOICP

Action 4: ☐ Payment Cancellation Initiated in ECS (Director or Deputy Director)

Printed Name - Director or Deputy	Signature - Director or Deputy	Date

Action 5: ☐ Reviewed by District Director, DO

Action 6: Repayment to this claimant authorized? ☐ YES ☐ NO

Action 7: ☐ Payment Cancellation Authorized in ECS (District Director)

Printed Name - District Director	Signature - District Director	Date

SAMPLE MEMORANDUM TO FILE FOR ADMINISTRATIVE WRITE-OFF OF DEBT EQUAL TO OR LESS THAN $2500

MEMORANDUM

DATE:

TO: {**Name**]**,** Unit Chief, PRPU

FROM: {**Name**]**,** Policy Analyst

SUBJECT: Employee:
Claimant:
DEEOIC CASE ID:
ADMINISTRATIVE WRITE-OFF OF DEBT EQUAL TO OR LESS THAN $2,500

The Federal Claims Collection Standards (FCCS), 4 CFR Section 103.4, state that a claim may be compromised if the cost of collection would not justify enforcing the collection of the full claim. Section 104.3I states, that collection action may be terminated when it is likely that the cost of further collection action will exceed the amount likely to be recovered. In a decision issued on September 29, 1986, the Comptroller General elaborated on 4 CFR by concluding that these standards extend to the collection of debts from federal employees, and that agencies may establish "minimum debt amounts" and realistic "points of diminishing returns" in their debt collection activities. The term "minimum debt amounts" refers to the designation of categorical thresholds beneath which collection action need not be initiated because the amount of the debts in that class are so small in relation to the costs of attempting collection efforts. "Diminishing returns" refers to an agency's designation of thresholds beneath which the agency will discontinue collection efforts already initiated when it appears that the costs of additional collection actions would exceed the amounts likely to be recovered. The Comptroller General instructed further that agencies may, on a case-by-case basis, take the anticipated costs of required administrative hearings into consideration when determining whether to compromise or terminate collection action.

The National Office has considered the case and has noted that the following applied: [**Describe how debt occurred.**]

RECOMMENDATION: Based upon the above, I find that the following action is appropriate: [**Explain why it's feasible to terminate debt collection activities.**]

Sample Initial Overpayment Notification Letter - Without Fault

Employee:

EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear [**Claimant Name**]:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) has made a preliminary finding that you have been overpaid benefits in the amount of [**$**]. The overpayment occurred because:

[Describe reason]

DEEOIC has also made a preliminary finding that you are without fault in creating the overpayment. If you disagree with the fact or the amount of the overpayment, you have a right to submit new evidence.

When a claimant is without fault in creating an overpayment, the law states that DEEOIC may not recover the overpayment if the recovery would defeat the purpose of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), or the recovery would be against equity and good conscience.

To defeat the purpose of the EEOICPA, it must be found that the claimant requires substantially all current income to meet current ordinary and necessary living expenses and the claimant assets do not exceed a specified amount as determined by DEEOIC from data furnished by the Bureau of Labor Statistics.

It would be against equity and good conscience to recover an overpayment when:

1. A claimant would suffer severe financial hardship in trying to repay the debt; or

2. A claimant, acting on incorrect information from DEEOIC, gives up a verifiably valuable right or changes his or her position for the worse, such as leaving a job which he or she cannot regain; or

3. A claimant, acting on incorrect information from DEEOIC, spends or commits funds in ways which he or she otherwise would not have done, and suffers a financial loss as a result.

ACTIONS YOU MAY TAKE

If you believe that you should receive a waiver instead of repaying the overpayment, you may take any one of the following actions within 30 days of the date of this letter:

1. Request a telephone conference with the DEEOIC National Office; or

2. Request that the DEEOIC National Office issue a final decision based on the written evidence of record.

The DEEOIC staff will address the following issues during the telephone conference or in writing:

a. How the overpayment occurred and the amount;

b. Discuss the criteria for a waiver on collecting the overpayment.

INFORMATION NEEDED TO WAIVE RECOVERY OF THE OVERPAYMENT

If you are seeking a waiver of recovery (whether you choose a phone conference or not) you should send the following to DEEOIC:

1. A detailed explanation of your reasons for seeking waiver;

2. A fully-completed Overpayment Recovery Questionnaire (Form OWCP-20) (copy enclosed); and

3. Supporting documents, to include copies of income tax returns, bank account statements, bills and canceled checks, pay slips, and other records to support income and expenses shown on Form OWCP-20. Do not send originals as they will not be returned.

This information will help us decide whether or not you meet the criteria to waive recovery of the overpayment. If waiver is not granted, the information will be used to decide how to collect the overpayment. We will not try to collect the overpayment until we reach a final decision on your request for waiver.

Also please note that under 20 CFR 30.518, we will deny waiver if you fail to furnish the information requested on the enclosed Form OWCP-20 (or other information we need to address a request for waiver) within 30 days. We will not consider any further request for waiver until the requested information is furnished. Once an overpayment final decision letter is issued, a waiver of recovery of the overpayment is no longer an option.

CONTACTING DEEOIC

If you wish to have a telephone conference, please so state on the attached Response to Initial Overpayment Notice, and send it to the DOL DEEOIC Central Mail Room address noted below the National Office within 30 days. You must also submit a detailed explanation of your reasons for seeking waiver, a fully-completed and signed Form OWCP-20, and supporting documents along with your request. We will then contact you to arrange a convenient time for the conference, allowing enough time for you to prepare. If we do not receive a reply from you within 30 days of the date of this letter, we will issue a final decision based on the information currently on file. Please note that without the required financial information, a waiver of recovery of the overpayment cannot be granted.

If you wish to have a decision made based on the written evidence only, please so state on the attached form and send it to the DOL DEEOIC Central Mail Room within 30 days. (We may still contact you to arrange a telephone conference if the written evidence is not sufficient to make a decision.)

A request for either a conference or a decision on the written evidence, along with any supporting evidence or arguments, should be sent to the following address:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If you agree with the findings of this decision, and you wish to make payment at this time, please send a check to the address shown below. Make the check payable to the "U.S. Department of Labor, OWCP", notate the case ID, and indicate that it is for an overpayment.

US DEPARTMENT OF LABOR
DEEOIC
PO Box 77247
Washington, DC 20013-7247

If we do not receive a reply from you within 30 days of the date of this letter, a final decision will be issued based on the evidence of record.

If you have any questions about this letter, you may contact me at { } or 202-693-0081.

Sincerely,

{**Name**}
DEEOIC

Enclosures: Overpayment Recovery Questionnaire (Form OWCP-20)
Response to Initial Overpayment Notice

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

RESPONSE TO INITIAL OVERPAYMENT NOTICE

EMPLOYEE:
EEOICPA CASE ID:
CLAIMANT:
EEOICPA CLAIM ID:

____ I request a **telephone conference** with the National Office on the issue of possible waiver of recovery of this overpayment. My supporting financial documents are enclosed.

____ I request that the National Office make a **decision based on the written evidence** on the issue of possible waiver of recovery of this overpayment. My supporting financial documents are enclosed.

Signature: _____ Date: _____

SAMPLE INITIAL OVERPAYMENT NOTIFICATION LETTER - AT FAULT

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear [**Claimant Name**]:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) has made a preliminary finding that you have been overpaid benefits in the amount of [**$**]. The overpayment occurred because:

[Describe reason]

DEEOIC has also made a preliminary finding that you were at fault in this matter for the following reason(s):

[Describe reason]

This letter is not a final decision. You have the right to submit evidence or arguments which you believe will affect these preliminary findings if:

1. You disagree that the overpayment occurred;

2. You disagree with the amount of the overpayment;

3. You believe that the overpayment occurred through no fault of your own; or

4. You believe that the overpayment occurred through no fault of your own and that DEEOIC should waive recovery of the overpayment.

ACTIONS YOU MAY TAKE

You may take any one of the following actions within 30 days of the date of this letter:

1. Request a telephone conference with the DEEOIC National Office; or

2. Request that the DEEOIC National Office issue a final decision based on the written evidence of record.

The following issues will be addressed during the telephone conference or in writing:

a. How the overpayment occurred and the amount;

b. Discuss the criteria for a waiver on collecting the overpayment.

INFORMATION NEEDED TO WAIVE RECOVERY OF THE OVERPAYMENT

A waiver of recovery of an overpayment can only be granted when the claimant is without fault in causing it. When the claimant is without fault, the law states that DEEOIC may not recover the overpayment if the recovery would defeat the purpose of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA), or the recovery would be against equity and good conscience.

To defeat the purpose of the EEOICPA, it must be found that the claimant requires substantially all current income to meet current ordinary and necessary living expenses and the claimant's assets do not exceed a specified amount as determined by DEEOIC from data furnished by the Bureau of Labor Statistics.

It would be against equity and good conscience to recover an overpayment when:

1. A claimant would suffer severe financial hardship in trying to repay the debt;

2. A claimant, acting on incorrect information from DEEOIC, gives up a valuable right, such as leaving a job which he or she cannot regain; or

3. A claimant, acting on incorrect information from DEEOIC, spends or commits funds in ways which he or she otherwise would not have done, and suffers a financial loss as a result.

DEEOIC may overturn the preliminary finding of at fault based on new evidence or arguments you submit. This action may make it possible for DEEOIC to waive recovery of the overpayment. Therefore, you should complete the enclosed Overpayment Recovery Questionnaire (Form OWCP-20) and submit it to this office at the DOL DEEOIC Central Mail Room address. You should attach supporting documents to Form OWCP-20, including copies of income tax returns, bank account statements, bills and canceled checks, pay slips, and any other records which support the income and expenses listed. Do not send originals as they will not be returned.

If the preliminary finding is overturned, this information will help us determine whether or not you meet the criteria to waive recovery of the overpayment. If the preliminary finding is upheld or waiver is not granted, the information will be used to decide how to collect the overpayment.

Please note that if we make a final decision that you were at fault in creating an overpayment, we cannot waive recovery of the overpayment. However, we will not try to collect the overpayment until we reach a final decision on your request for waiver.

Also, please note that under 20 CFR 30.518, we will deny a waiver if you fail to furnish the information requested on the enclosed Form OWCP-20 (or other information we need to address a request for waiver) within 30 days. We will not consider any further request for waiver until the requested information is furnished. Once an overpayment final decision letter is issued, a waiver of recovery of the overpayment is no longer an option.

CONTACTING DEEOIC

If you wish to have a telephone conference, please so state on the attached Response to Initial Overpayment Notice, and send it to the DOL DEEOIC Central Mail Room address noted below within 30 days. You must also submit a detailed explanation of your reasons for requesting a waiver, a fully-completed and signed Form OWCP-20, and supporting documents. We will then contact you to arrange a convenient time for the conference, allowing enough time for you to prepare. If we do not receive a reply from you within 30 days of the date of this letter, we will issue a final decision based on the information currently on file. Please note that without the required financial information, a waiver of recovery of the overpayment cannot be granted.

If you wish to have a decision made based on the written evidence only, please so state on the attached form and send it to this office at the DOL DEEOIC Central Mail Room address within 30 days. (We may still contact you to arrange a telephone conference if the written evidence is not complete enough to make a decision.)

A request for either a conference or a decision on the written evidence, along with any supporting evidence or arguments, should be sent to the following address:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

If you do not disagree with findings of this decision, and wish to make payment at this time, please send a check or money order to the address shown below. Make it payable to the "U.S. Department of Labor, OWCP", notate the case ID, and indicate that it is for an overpayment.

U.S. Department of Labor
DEEOIC
PO Box 77247
Washington, DC 20013-7247

If we do not receive a reply from you within 30 days of the date of this letter, we will issue a final decision based on the evidence of record.

If you have any questions about this letter, you may contact me at { } or 202-693-0081.

Sincerely,

{**Name**}
DEEOIC

Enclosure: Form OWCP-20
Response to Initial Overpayment Notice

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

RESPONSE TO INITIAL OVERPAYMENT NOTICE

EMPLOYEE:
EEOICPA CASE ID:
CLAIMANT:
EEOICPA CLAIM ID:

____ I request a **telephone conference** with the DEEOIC National Office on the issues of fault and possible waiver of recovery of this overpayment. My supporting financial documents are enclosed.

____ I request that the DEEOIC National Office make a **decision based on the written evidence** on the issues of fault and possible waiver of recovery of this overpayment. My supporting financial documents are enclosed.

Signature: _____ Date: _____

SAMPLE LETTER TO NON-CLAIMANT REGARDING FEDERAL DEBT

Employee:
EEOICPA Case ID:

Name
Address

Dear :

This letter concerns the claim filed by {**Claimant's name**}, under Part {**B and/or E**} of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

A compensation payment in the amount of {**$ **} was paid to {**Claimant's name**} on {**date**} by way of direct deposit into a joint bank account held by {**Claimant's name**} and you at the {**name of bank**}. Subsequent to the payment, the district office became aware that {**Claimant's name**} died on {**date of death**}, which is prior to the date of payment. Under the EEOICPA, a person is only eligible for benefits if that person is alive at time of payment. Since {**Claimant's name**} died prior to the payment, the compensation should have been returned.

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) contacted the {**name of bank**} requesting that the {**$ **} be returned to the U.S. Treasury. However, the bank stated that you had withdrawn the money and closed the account.

You must return the full amount of the compensation. To resolve this matter, please send a check or money order made payable to the U.S. Dept. of Labor, OWCP/DEEOIC. Please notate the EEOICPA case ID on the check and indicate that it is a return of benefits. Send the payment to:

U.S. Dept. of Labor
DEEOIC
P.O. Box 77247
Washington, DC 20013

If we do not receive payment within 30 days, this will be considered a delinquent debt. You should be aware that the DEEOIC will refer delinquent debts to the U.S. Department of the Treasury for collection. The Department of Treasury may recover this debt by administrative wage garnishment, offset from any federal payments that may be due you, and/or referral to private collection agencies. An administrative cost will be assessed to help defray the expense of this referral. Furthermore, information about the status and delinquency of your debt will be subject to credit reporting.

Interest began accruing as of the date of this letter at the current U.S. Treasury note rate of { **%**} annually. If you wish to repay the entire amount of the debt at this time, and thus avoid the payment of interest, please submit your full payment immediately.

Thank you for your prompt attention to this matter. If you have any questions about this letter, please feel free to contact this office at {**Analyst's phone number**}.

Sincerely,

{Name}
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE PRE-CONFERENCE CALL CHECKLIST

Name of person to be called: _____
Telephone Number: _____
(Area code, number)

Person to be called is: _____Claimant ___Attorney/Representative

Agenda items:	Item Completed	Comments
1. Explain purpose of pre-conference call	_____	_____
2. Explain purpose of conference and topics to be discussed; i.e., fault determination and/or waiver	_____	_____
3. Describe info person will need at conference	_____	_____
4. Confirm person's ability to obtain info	_____	_____
5. Explain "at fault" finding, if applicable	_____	_____
6. Explain criteria for "waiver"	_____	_____
7. Explain "interest" charges	_____	_____
8. Indicate conference is limited to overpayment issues	_____	_____
9. Confirm person's understanding of conference	_____	_____
10. Ask if person has questions	_____	_____

11. Conference scheduled for:

Date_____ Time_____

12. Other items (specify)

_____

_____

13. Pre-conference call made by _____Date_____

MEMORANDUM OF CONFERENCE

DATE:

NAME OF EMPLOYEE:

NAME OF CLAIMANT:

CASE ID:

CONFERENCE DATE:

PARTICIPANTS: { **Name** } , Claimant
{ **Name** } , Policy Analyst, DEEOIC

PREPARED BY: {**Analyst's name**}

This memorandum summarizes the telephone conference held to discuss the {**$** } overpayment in the claim filed by {**Claimant's name**} under Part {**B and/or E}** of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

PURPOSE OF TELEPHONE CONFERENCE:

In response to an overpayment notice, {**Claimant's name**} requested a telephone conference to discuss the findings pertaining to the overpayment in {**his / her**} claim, including a request for waiver of recovery of the overpayment.

BACKGROUND:

{Describe the background of the claim and how the overpayment was determined.}

When an overpayment occurs in a claim, the DEEOIC is required to take the appropriate action to recover the overpaid benefits. The DEEOIC sent {**Claimant's name**} a notice informing {**him / her**} of the overpayment. The notice also informed {**him / her**} of the preliminary finding that {**he / she**} was {**insert fault finding**} in causing the overpayment. {**If at fault, insert why this finding was made.**}

In response to the notice, {**Claimant's name**} requested a telephone conference and requested a waiver of recovery. **{Claimant's name**} submitted an Overpayment Recovery Questionnaire and {**insert documentation submitted**}.

PRE-CONFERENCE CALL:

On {**date**}**,** {**Analyst's name**} telephoned {**Claimant's name**} to schedule a telephone conference. {**Claimant's name**} was informed that the purpose of the conference was to give {**him / her**} the opportunity to discuss the criteria for granting a waiver of recovery of the overpayment. The telephone conference was scheduled for {**date**}**.**

OVERPAYMENT TELEPHONE CONFERENCE:

The telephone conference was held on {**date**} with {**Analyst's name**}, who advised {**Claimant's name**} that the purpose of the conference was to give {**him / her**} the opportunity to provide information to support the request for a waiver of recovery of the overpayment.

{Insert in detail what claimant stated during the conference}

{**Analyst's name**} explained the criteria for granting a waiver of recovery of the overpayment. A waiver can be granted if a claimant is not at fault in causing the overpayment, and that it would be a financial hardship and defeat the purpose of the EEOICPA, or it would be against equity and good conscience if required to repay the money.

{If waiver request is based on financial hardship, list type and amount of income, expenses, and assets.}

{**Claimant's name**} stated that the monthly income, expenses, and assets include the following:

Monthly Income:
{Identify each income source} $

Monthly Expenses:
{Identify each monthly expense} $

Countable Assets:
(Identify each countable asset and value) $

-OR-

{If waiver request is based on against equity and good conscience, describe the basis for that request and documentation submitted to support it.}

{**Analyst's name**} informed {**Claimant's name**} that if a waiver is granted based on "against equity and good conscious," financial information is not taken into consideration. Therefore, {**his / her**} complete financial information was not being requested at this time.

CONCLUSION:

{**Analyst's name**} informed {**Claimant's name**} that {**he / she**} would prepare and send a memorandum summarizing the telephone conference. If {**he / she**} had any comments regarding the memorandum, {**he / she**} should send the comments in writing to {**Analyst's name**}. The information in the case file will be reviewed, and a final decision regarding the overpayment will be sent to {**him / her**}. {**Claimant's name**} stated that {**he / she**} did not have any further statements, and the telephone conference was concluded.

SAMPLE COVER LETTER TO MEMORANDUM OF CONFERENCE

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear {**Claimant Name**}**:**

This letter is in reference to the telephone conference held on {**date**}**.** You requested the conference to discuss the overpayment in your claim under Part {**B and/or E**} of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

A memorandum summarizing the telephone conference is attached for your review. The memorandum does not include any findings in this matter. If you do not disagree with anything in the memorandum, you do not have to send a response. If you find that the memorandum does not accurately report what you stated during the conference, please provide me with your reasons for disagreeing in writing within fifteen (15) days of the date of this letter.

{Insert a request for additional documentation, if needed. Additional documentation is to be submitted within 30 days.}

Send your response to the following address:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

All information regarding the overpayment will be reviewed, and an overpayment final decision will be sent to you. If you have any questions regarding this matter, you may contact me at {**phone number**}**.**

Sincerely,

{**Name**}
DEEOIC

Attachment

SAMPLE OVERPAYMENT FINAL DECISION – PRELIMINARY AT FAULT DETERMINATION CORRECT

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear {**Claimant Name**}**:**

This is the final decision in reference to the overpayment of benefits in the amount of {**$** } in your {**Part B and/or E**} claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

{**Provide explanation of how overpayment occurred.**}

{Provide explanation of how the overpayment final decision was determined.}

Based on the review of the evidence of record, DEEOIC finds that you did not provide sufficient evidence to reverse the preliminary overpayment determination. Accordingly, the final determination in this case is that you were at fault in causing the overpayment, and that you must return the {**$** }.

In addition, as of the date of this decision, interest on this debt began accruing at the current U.S. Department of Treasury note rate of { **%**} annually. If you wish to repay the overpayment at this time and avoid the payment of interest, please send your full payment immediately. You may also request to enter into a repayment agreement to make monthly installment payments. If we do not receive your payment or request to enter into a repayment agreement within 30 days of the date of this letter, this will be a delinquent debt.

It is important to note that delinquent debts will be referred to the Department of the Treasury for recovery. This referral is authorized under the Debt Collection Act, which also authorizes the assessment of interest, administrative costs, and penalties on delinquent debts. Various measures may be utilized to collect the debt, including administrative wage garnishment, offset of payments from federal programs such as income tax refunds, and referral of debts to private collection agencies and credit bureaus. The information that will be provided to a credit bureau includes your name, address, social security number, the amount, status, and history of the debt, and the program under which the debt arose (Energy Employees Occupational Illness Compensation Program).

Certain rights are provided to you with respect to the referral of your debt to the Department of Treasury or credit bureaus. If you think that the determination regarding the debt is in error, you may request further information as noted below, and send your request to: DOL DEEOIC Central Mail Room, PO Box 8306, London, KY 40742-8306.

- You may request copies of your records about this debt.

- You may request a review of our determination about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

To pay the overpayment in full, you should send your payment in the amount of {**$** } within 30 days. Make your check or money order payable to "U.S. Dept. of Labor, OWCP/DEEOIC." Please notate the case ID on the check or money order and indicate that it is for an overpayment refund. Send the payment to: US Department of Labor, DEEOIC, PO Box 77247, Washington, DC 20013.

If you cannot repay the full amount at this time and would like to enter into a written repayment agreement, you should contact this office to make arrangements for installment payments. The Overpayment Recovery Questionnaire and supporting financial documentation will be used in setting up the repayment agreement.

If you have any questions about this letter or wish to set up an installment repayment plan, you may contact me at {**phone number**} or 202-693-0081.

Sincerely,

{**Name**}
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE OVERPAYMENT FINAL DECISION – WITHOUT FAULT - WAIVER DENIED

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant's Name
Address

Dear {**Claimant Name**}:

This is the final decision in reference to the overpayment of benefits in the amount of {**$** } in your {**Part B and/or E**} claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). After a thorough review of the financial information submitted, it has been determined that you do not meet the criteria for a waiver of the overpayment recovery.

{Provide explanation of how overpayment occurred.}

{Provide explanation of how the overpayment final decision was determined. If applicable, include a statement if the preliminary at fault finding was reversed.}

In response to an overpayment notice sent to you on {**date**}, you completed an Overpayment Recovery Questionnaire (OWCP-20) and requested a waiver of recovery of the overpayment. To support your request, you submitted the required financial information pertaining to your income, expenses, and assets. This determination is based on the financial documentation that you provided.

The EEOICPA Federal Procedure Manual at Chapter 35.10.a states that an overpayment waiver may be granted if recovery would defeat the purpose of the EEOICPA. This means that it must be found that the claimant requires substantially all current income to meet current ordinary and necessary living expenses. To meet this criterion, the monthly income must not exceed monthly expenses by more than $200. In addition, the claimant's countable assets must not exceed an amount as determined by data obtained from the Bureau of Labor Statistics (BLS). The countable asset limit is $5,500 for an individual and $9,200 for an individual and spouse, plus $1,100 for each dependent.

The information you provided shows that your household consists of you, {**include spouse and number of children, if any**}. The monthly household income is approximately {**$** }. The monthly expenses that you submitted are approximately {**$** }, and include {**list type of expenses**}. Based on this information, {**state whether monthly income exceeds monthly expenses by more than $200 or it does not exceed monthly expenses by more than $200.**}

With regard to your assets, your home and up to two motor vehicles are excluded from your countable assets. The information you submitted show that your countable assets include the following:

{**List assets and value**} $

Total Countable Assets $

The asset amount allowed for your household is {**$** }. The known value of your countable assets is {**$** }. {**State whether assets are under or over the countable asset limit to qualify for a waiver.**}

{State why claimant does not meet waiver criteria}

The EEOICPA Federal Procedure Manual at Chapter 3-0800.10.b states that an overpayment waiver may also be granted if recovery of the overpayment would violate equity and good conscience. The following is the criteria to qualify for a waiver under this clause:

1. A claimant would suffer severe financial hardship in trying to repay the debt;

2. A claimant, acting on incorrect information from DEEOIC, gives up a verifiably valuable right or changes his or her position for the worse, such as leaving a job which he or she cannot regain; or

3. A claimant, acting on incorrect information from DEEOIC, spends or commits funds in ways which he or she otherwise would not have done, and suffers a financial loss as a result.

I advised you of this clause and explained the criteria for a waiver. However, you did not provide any information to indicate that you would meet the waiver criteria.

The DEEOIC Policy Unit has reviewed the documentation submitted in support of your request for a waiver of recovery of the overpayment. The final determination with regard to the overpayment in your claim is that you do not meet the criteria for a waiver to be granted. Accordingly, you must return the overpaid compensation of {**$** }.

In addition, as of the date of this decision, interest on this debt began accruing at the current U.S. Department of Treasury note rate of { **%**} annually. If you wish to repay the overpayment at this time and avoid the payment of interest, please send your full payment immediately. You may also request to enter into a repayment agreement to make monthly installment payments. If we do not receive your payment or request to enter into a repayment agreement within 30 days of the date of this letter, this will be a delinquent debt.

It is important to note that delinquent debts will be referred to the U.S. Department of Treasury for recovery. This referral is authorized under the Debt Collection Act, which also authorizes the assessment of interest, administrative costs, and penalties on delinquent debts. Various measures may be utilized to collect the debt, including administrative wage garnishment, offset of payments from federal programs such as income tax refunds, and referral of debts to private collection agencies and credit bureaus. The information that will be provided to a credit bureau includes your name, address, social security number, the amount, status, history of the debt, and the program under which the debt arose (Energy Employees Occupational Illness Compensation Program).

Certain rights are provided to you with respect to the referral of your debt to the Department of Treasury or credit bureaus. If you think that the determination regarding the debt is in error, you may request further information as noted below, and send your request to: DOL DEEOIC Central Mail Room, PO Box 8306, London, KY 40742-8306.

- You may request copies of your records about this debt.
- You may request a review of our determination about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

To pay the overpayment in full, send your payment in the amount of {**$** } within 30 days of the date of this letter. Make your check or money order payable to "U.S. Dept. of Labor, OWCP/DEEOIC". Please notate the case ID number on the check or money order and indicate that it is for an overpayment refund. Send the payment to: US Department of Labor, DEEOIC, PO Box 77247, Washington, DC 20013.

If you cannot repay the full amount at this time and would like to enter into a written repayment agreement, you should contact this office to make arrangements for installment payments. The Overpayment Recovery Questionnaire and supporting financial documentation will be used in setting up the repayment agreement.

If you have any questions about this letter or wish to set up an installment repayment plan, please contact me at {**phone number**} or 202-693-0081.

Sincerely,

{Name}
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE OVERPAYMENT FINAL DECISION – WAIVER GRANTED BASED ON DEFEAT PURPOSE OF EEOICPA

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear {**Claimant Name**}**:**

This is the final decision in reference to the overpayment of benefits in the amount of {**$** } in your {**Part B and/or E**} claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). A full waiver recovery of the overpayment in your claim is hereby granted.

{Provide explanation of how overpayment occurred.}

On {**date**}, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) sent you a letter informing you of the overpayment, with a finding that you were without fault in creating the overpayment. The letter also informed you that when a without fault finding is made, the overpaid claimant is still required to repay that money, but may request a waiver under certain financial circumstances. You requested a waiver of recovery of the overpayment.

The EEOICPA Federal Procedure Manual at Chapter 35.10.a states that an overpayment waiver may be granted if recovery would defeat the purpose of the EEOICPA. This means that it must be found that the claimant requires substantially all current income to meet current ordinary and necessary living expenses. To meet this criterion, the monthly income must not exceed monthly expenses by more than $200. In addition, the claimant's countable assets must not exceed an amount as determined by data obtained from the Bureau of Labor Statistics (BLS). The countable asset limit is $5,500 for an individual and $9,200 for an individual and spouse, plus $1,100 for each dependent.

To support your waiver request, you submitted the required financial information.

{Describe documents submitted and financial information}

The information you provided shows that your household consists of you, {**include spouse and number of children, if any**}**.** The monthly household income is approximately {**$** }. The monthly expenses are approximately {**$** }. Based on this information, your expenses are within the limits of being reasonable and necessary, and your monthly income does not exceed your monthly expenses by more than $200. Your countable assets of {**$** } do not exceed the resource limit of {**$** } based on the limit for your household. As such, your financial documents show that you meet the criteria for a waiver of recovery of the overpayment based on "recovery would defeat the purpose of the EEOICPA."

Accordingly, the DEEOIC grants a waiver of recovery of the {**$ **} overpayment in the Part {**B and/or E**} claim filed by {**Claimant's name**}. This matter is closed and no further action will be taken. If you have any questions about this letter, you may contact this office at {**Analyst's phone number**} or 202-693-0081.

Sincerely,

{**Name**}
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

SAMPLE OVERPAYMENT FINAL DECISION - WAIVER GRANTED (FULL OR PARTIAL) BASED ON VIOLATE EQUITY AND GOOD CONSCIENCE

Employee:
EEOICPA Case ID:
EEOICPA Claim ID:

Claimant Name
Address

Dear {**Claimant Name**}**:**

This is the final decision in reference to the overpayment of benefits in the amount of {**$ **} in your {**Part B and/or E**} claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act). A {**full or partial**} waiver recovery of the overpayment in your claim is hereby granted.

{**Provide explanation of how overpayment occurred.**}

On {**date**}, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) sent you a letter informing you of the overpayment, with a finding that you were without fault in creating the overpayment. The letter also informed you that when a without fault finding is made, the overpaid claimant is still required to repay that money, but may request a waiver under certain financial circumstances. You requested a waiver of recovery of the overpayment.

The EEOICPA Federal Procedure Manual at Chapter 35.10.b states that an overpayment waiver may be granted if recovery would violate equity and good conscience. This means that (1) recovery will cause the claimant to suffer severe financial hardship and meets the required criteria, or (2) the claimant has relinquished a valuable right or changed position for the worse.

To support your waiver request, you stated that {**insert claimant's reason for requesting a waiver**}, and submitted the required documentation.

{Describe documents submitted that meet the criteria for the waiver}

The DEEOIC has reviewed the documents and statements provided, and finds that you meet the criteria for a waiver. Accordingly, the DEEOIC grants a {**full or partial**} waiver of recovery of the overpayment in the amount of {**$ **} in the Part {**B and/or E**} claim filed by {**Claimant's name**}.

{If full waiver is granted insert the following closing paragraph}

This matter is closed and no further action will be taken. If you have any questions about this letter, you may contact this office at {**Analyst's phone number**} or 202-693-0081.

Sincerely,

{Name}
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

– or –

{If partial waiver granted, explain further collection actions to be taken and rights as noted below, and include Notice for check payment.}

You must return the remaining overpaid compensation of {**$** }. As of the date of this decision, interest on this debt began accruing at the current U.S. Treasury note rate of { **%**} annually. If you wish to repay the overpayment at this time and avoid the payment of interest, please send your full payment immediately. If you cannot pay the full amount at this time, you may also request to enter into a repayment agreement to make monthly installment payments.

This debt will become delinquent if your payment is not received or you do not request to enter into a repayment agreement within 30 days of the date of this letter. It is important to note that delinquent debts will be referred to the U.S. Department of Treasury for recovery. This referral is authorized under the Debt Collection Act, which also authorizes the assessment of interest, administrative costs, and penalties on delinquent debts. Treasury may utilize various measures to collect the debt, including administrative wage garnishment, offset of payments from federal programs such as income tax refunds, and referral of debts to private collection agencies and the credit bureaus. The information that will be provided to a credit bureau includes your name, address, social security number, the amount, status, history of the debt, and the program under which the debt arose (Energy Employees Occupational Illness Compensation Program).

Certain rights are provided to you with respect to the referral of your debt to Treasury or to credit bureaus. If you think that the determination regarding the debt is in error, you may request further information as noted below. Send your request to this office at:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

- You may request copies of your records about this debt.

- You may request a review of our determination about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not

accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

To pay the overpayment in full, send your payment in the amount of {**$** } within 30 days of the date of this letter. Make your check or money order payable to "U.S. Dept. of Labor, OWCP/DEEOIC", notate the case ID, and indicate that it is for an overpayment. Send the payment to:

US DEPARTMENT OF LABOR
DEEOIC
P.O. Box 77247
Washington, DC 20013

If you wish to set up a repayment agreement or have any questions about this letter, please contact this office at {**Analyst's phone number**} or 202-693-0081.

Sincerely,

{**Name**}
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE SECOND DEMAND LETTER

Employee:
Claimant:
Case ID:

Claimant Name
Address

Dear [**Claimant Name**]:

This is the second demand letter for payment in reference to the overpayment of compensation in your Part {**B and/or E**} claim filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

On [**date**], the Division of Energy Employees Occupational Illness Compensation (DEEOIC) sent you an overpayment final decision informing you of an overpayment of compensation in the amount of [**$**] in your Part {**B and/or E**} claim. The decision provided a detailed explanation of the overpayment, informed you that you must repay it, and that interest began accruing on the debt at the rate of { **%**} annually. You did not respond to the notice. Since you have not returned the overpaid compensation or made arrangements to do so, the debt is now delinquent.

When an overpayment debt remains delinquent, it must be referred to the United States Department of the Treasury for collection. This referral is authorized under the Debt Collection Act, which also authorizes the assessment of interest, administrative costs, and penalties on delinquent debts. The Department of the Treasury may recover an overpayment by garnishing the debtor's salary; administratively offsetting any federal payments that may be due to the debtor; or referring the debt to a collection agency. Administrative costs and penalties will be added to the debt. In addition, information about the status and delinquency of the debt is reportable to credit bureaus. The information that will be provided to a credit bureau includes your name, address, social security number, the amount, status, and history of the debt, and the program under which the debt arose (Energy Employees Occupational Illness Compensation Program).

Certain rights are provided to you with respect to the referral of your debt to the Department of Treasury or credit bureaus. If you think that the determination regarding the debt is in error, you may request further information as noted below, and send your request to: DEEOIC, DOL Central Mail Room, PO Box 8306, London, KY 40742-8306.

- You may request copies of your records about this debt.

- You may request a review of our determination about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in writing, state your reason(s) for challenging our determinations, and sign your statement. If

you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

To resolve this matter and avoid further collection activities and additional fees, please send your payment within 30 days to the address below. Make your check or money order in the amount of [**$**] payable to "U.S. Dept. of Labor, OWCP/DEEOIC." Please notate the case ID number on the form of payment and indicate that it is for an overpayment refund. Send the payment to:

US DEPARTMENT OF LABOR
DEEOIC
P.O. Box 77247
Washington, DC 20013

If you cannot pay the full amount of the overpayment at this time, you may request that we set up an installment repayment plan. If have any questions about this letter or wish to set up a repayment plan, you may contact me at {**PA phone number**} or 202-693-0081.

Sincerely,

{**Name**}
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE THIRD AND FINAL DEMAND LETTER

Employee:
Claimant:
Case ID:

Claimant Name
Address

Dear [**Claimant Name**]:

This is the third and final demand letter for payment in reference to the overpayment of compensation in your Part {**B and/or E**} claim filed under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

On [**date**], the Division of Energy Employees Occupational Illness Compensation (DEEOIC) sent you an overpayment final decision informing you of an overpayment of compensation in the amount of [**$**] in your Part {**B and/or E**} claim. The decision provided a detailed explanation of the overpayment, informed you that you must repay it, and that interest began accruing on the debt at the rate of [**%**] annually. Since you did not respond to the notice, the DEEOIC sent you a second demand letter on [**date**]. You have not returned the overpaid compensation or made arrangements to do so. Therefore, this is a delinquent debt.

When an overpayment debt remains delinquent, it must be referred to the United States Department of the Treasury for collection. This referral is authorized under the Debt Collection Act, which also authorizes the assessment of interest, administrative costs, and penalties on delinquent debts. The Department of the Treasury may recover an overpayment by garnishing the debtor's salary; administratively offsetting any federal payments that may be due to the debtor; or referring the debt to a collection agency. Administrative costs and penalties will be added to the debt. In addition, information about the status and delinquency of the debt is reportable to credit bureaus. The information that will be provided to a credit bureau includes your name, address, social security number, the amount, status, and history of the debt, and the program under which the debt arose (Energy Employees Occupational Illness Compensation Program).

Certain rights are provided to you with respect to the referral of your debt to the Department of Treasury or credit bureaus. If you think that the determination regarding the debt is in error, you may request further information as noted below, and send your request to:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

- You may request copies of your records about this debt.

- You may request a review of our determination about the amount of your debt, its past-due status, and its legal enforceability. To exercise this right, you must state your request in

writing, state your reason(s) for challenging our determinations, and sign your statement. If you believe that any information of record concerning your debt is not accurate, timely, relevant, or complete, you must provide information or documentation to support your belief.

To resolve this matter and avoid further collection activities and additional fees, please send your payment within 30 days to the address below. Make your check or money order in the amount of [**$**] payable to "U.S. Dept. of Labor, OWCP/DEEOIC." Please notate the case ID number on the form of payment and indicate that it is for an overpayment refund. Send the payment to:

US DEPARTMENT OF LABOR
DEEOIC
P.O. Box 77247
Washington, DC 20013

If you cannot pay the full amount of the overpayment at this time, you may request that we set up an installment repayment plan. If you have any questions about this letter or wish to set up a repayment plan, you may contact me at [**PA phone number**] or 202-693-0081. This is the final notice before the debt is referred to the Department of the Treasury.

Sincerely,

{**Name**}
DEEOIC

Notice to Customers Making Payment by Check

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment.

***Privacy Act* – A Privacy Act Statement required by 5 U.S.C. § 552a(e)(3) stating our authority for soliciting and collecting the information from your check, and explaining the purposes and routine uses which will be made of your check information, is available on internet site at: https://www.pccotc.gov/pccotc/index.htm , or call toll free at 1-866-945-7920 to obtain a copy by mail. Furnishing the check information is voluntary, but a decision not to do so may require you to make payment by some other method.**

SAMPLE LETTER – NO FURTHER REVIEW

Employee:
Case ID:
Claim ID:

Claimant Name
Address

Dear [**Claimant Name**]:

I am writing in response to your letter requesting further review of the overpayment in your claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act).

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) issued a final overpayment decision on [**date**] pertaining to the overpayment of benefits in the amount of [**$**] in your Part [**B and/or E**] claim. The overpayment decision described the circumstances that led up to the incorrect payment of benefits, and the further adjudicatory steps that DEEOIC took once its attention was brought to this overpayment.

The [**date**] decision served as the first demand letter advising you that you must return the overpaid benefits. The decision also advised you that the overpayment is now a debt that you owe, and that DEEOIC is required to refer delinquent debts to the U.S. Department of the Treasury for collection. It further informed you of the rights that you have with respect to the referral of your debt to Treasury for collection. The type of review available to you is limited to a review of: (1) the amount of your debt; (2) its past-due status; and (3) its legal enforceability. You do not have a right to ask for a review of the underlying final overpayment decision itself, which is the final determination of DEEOIC on this matter under the EEOICPA.

If you have any questions pertaining to this letter you may contact this office at [**PA phone number**} or 202-693-0081.

Sincerely,

Name
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

SAMPLE REPAYMENT AGREEMENT COVER LETTER

Employee:
Case ID:
Claim ID:

Claimant Name
Address

Dear {**Claimant Name**}**:**

Enclosed is a Repayment Agreement pertaining to the overpayment of benefits in your Energy Employees Occupational Illness Compensation Program Act (EEOICPA or Act) claim.

On [**date**], the Division of Energy Employees Occupational Illness Compensation sent you a final decision regarding an overpayment in your {**Part B and/or E**} claim in the amount of [**$**]. Thereafter, you requested that an installment plan be set up to repay the overpaid benefits, and a monthly repayment plan of [**$**] was agreed upon**.**

Please review the Repayment Agreement, sign and date it, and mail it to the following address:

US Department of Labor – DEEOIC
[Central Mailroom Address]
[City, State Zip Code]

A copy of the Repayment Agreement is provided for your records. When you send the installment payments, please provide the Case ID on all checks or money orders, and notate that it is an overpayment refund. Mail all payments to:

U.S. Department Of Labor
DEEOIC
PO Box 77247
Washington, DC 20013

If you have any questions, please contact this office at [**PA phone number**] or 202-693-0081.

Sincerely,

Name
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

SAMPLE REPAYMENT AGREEMENT

Employee:
Claimant:
Case ID:

REPAYMENT AGREEMENT

On [**date**], the Division of Energy Employees Occupational Illness Compensation sent {**Claimant name**} a final decision regarding an overpayment in {**his or her**} {**Part B and/or E**} claim for benefits in the amount of [**$**]. **{Claimant name}** requested that an installment repayment plan be set up for monthly payments in the amount of [**$**]. The installment payments will begin [**date**], and will be due on the 1st of each month until paid in full, including accrued interest.

A check or money order is to be made payable to the "U.S. Dept. of Labor, OWCP/DEEOIC"**.** The Case ID is to be notated on all payments. Mail the payments to:

U.S. Department Of Labor
DEEOIC
PO Box 77247
Washington, DC 20013

I agree to repay the overpayment at stated in this Repayment Agreement.

Claimant: _____ Date: _____
[Claimant Name]

Approved By: _____ Date: _____
,Unit Supervisor
Policy, Regulations and Procedures
DEEOIC

SAMPLE REPAYMENT STATUS LETTER

Employee:
Claimant:
Case ID:

Claimant Name
Address

Dear :

This letter is to provide you with the status of the overpayment in your claim for benefits under the Energy Employees Occupational Illness Compensation Program Act.

On [**date**], the Division of Energy Employees Occupational Illness Compensation sent you a final decision regarding an overpayment in your {**Part B and/or E**} claim in the amount of [**$**]. Thereafter, you signed a Repayment Agreement to repay the overpayment in monthly installments of [**$**].

You began sending payments on [**date**]. The total repaid to date is [**$**]. Interest began accruing at the rate of [**%**] annually on [**date**]**.** The interest is calculated on the balance of the debt remaining at the end of the calendar year. The payments, accrued interest, and overpayment balance for each year are as follows:

Year	Beginning Balance	Payments	Balance	Interest	Accrued & Interest	Year-End Principal
	$	$		$	$	$
	$	$		$	$	$

If you have any questions pertaining to the overpayment, you may contact me at [**PA phone number**] or 202-693-0081.

Sincerely,

{Name}
DEEOIC

Enclosure

WAIVER OF CHARGES WORKSHEET

Employee:
Claimant
Case ID:

1. Current principal balance $_____

2. Accrued charges
a.) accrued Administrative charges $_____
b.) accrued penalty $_____
c.) accrued interest $_____
Total (Item 2a + Item 2b + Item 2c) $_____

3. Interest rate (express as percent; i.e. 5% not .05)
Monthly interest rate (annual rate/12) _____%

4. Monthly payment $_____

5. Monthly interest (Item 1 x Item 3) $_____
If Item 5>= Item 4, then charges are waived. Stop here
If Item 5< Item 4, go on to Item 6

6. Period to repay full amount of debt (months)
a) Period to repay accrued charges _____ mos.
Item 2/Item 4- (Item 1 x Item 3)
b) Period to repay principal _____ mos.
Total (Item 6a + Item 6b) _____ mos.

7. Debtor's life expectancy (see page 2 of this exhibit; multiply that figure by 12 to convert years to months).

IF ITEM 7 IS LESS THAN ITEM 6, then all charges must be waived.

IF ITEM 7 IS GREATER THAN OR EQUAL TO ITEM 6, then charges cannot be waived.

Consider whether the accrued charges and/or principal must be compromised by completing the Compromise of Principal Worksheet.

Calculations performed by: _____ Date: _____

Certified by: _____ Date: _____

EXPECTENCY OF LIFE BY AGE
United States Life Tables - 2011

Age	All races and origins				
	Total		Male		Female
0.	78.7		76.3		81.1
1.	78.2		75.8		80.5
5.	74.3		71.9		76.6
10.	69.3		66.9		71.6
15.	64.4		62.0		66.7
20.	59.5		57.2		61.7
25.	54.8		52.5		56.9
30.	50.0		47.9		52.0
35.	45.3		43.2		47.2
40.	40.6		38.6		42.4
45.	36.0		34.0		37.8
50.	31.5		29.7		33.2
55.	27.2		25.5		28.8
60.	23.1		21.6		24.5
65.	19.2		17.8		20.3
70.	15.5		14.3		16.5
75.	12.1		11.1		12.9
80.	9.1		8.2		9.6
85.	6.5		5.9		6.9
90.	4.6		4.1		4.8
95.	3.2		2.9		3.3
100.	2.3		2.1		2.3

SOURCE: U.S. Dept. of Health and Human Services
Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System
Volume 64, Number 11, Table A - September 22, 2015

COMPROMISE OF PRINCIPAL WORKSHEET

Employee:
Claimant
Case ID:

1. Current principal balance $_____

2. Accrued charges
a.) accrued Administrative charges $_____
b.) accrued penalty $_____
c.) accrued interest $_____
Total (Item 2a + Item 2b + Item 2c) $_____

3. Interest rate (express as percent; i.e. 5% not .05)
a.) Annual Interest rate _____%
b.) Monthly interest rate (annual rate/12) _____%

4. Monthly payment $_____

5. To determine if this is a candidate for compromise apply the following rule:

Divide the current principal balance (plus any accrued charges) by the monthly payment; and multiply the result by the annual interest rate.

_____ + _____ / _____ x _____ = _____
Item 1 Item 2 Item 4 Item 3a

If the result is less than 5.5, no compromise is necessary. If the result is 5.5 or greater complete the balance of the worksheet to determine the amount, if any, to be compromised.

6. First month interest (Item 1 x Item 3b/100) $_____

7. Period within which debt must be repaid (months)
(Item 1/Item 4 x 1.35) _____

If Item 6 is >/= to Item 4, then all accrued charges are compromised; skip Item 8 through 10, and go to Item 11 to determine the amount of principal to be compromised. Otherwise, continue with Item 8.

8. Period to repay full amount of debt (months)
a.) Period to repay accrued charges _____ mos.
(Item 2/Item 4) – (Item 1 x Item 3)
b.) Period to repay principal _____ mos.
Total (Item 8a + Item 8b) _____ mos.

If Item 8b is </= to Item 7, no principal need be compromised. Skip to Item 12.
If Item 8b is > Item 7, the amount of the principal must be compromised. Continue to the next item.

9. Maximum amount of accrued charges to be compromised.
(Item 8 – Item 7/Item 8a) x Item 2 _____

If no number is generated here, then there are no accrued charges to be compromised. Proceed to the next item.

10. Apportionment of compromise
a.) Item 9 or Item 2, whichever is less
b.) Admin Charges (Item 2a or Item 10a, whichever is less)
c.) Balance (Item 10a – Item 10b)
d.) Penalty (Item 2b or Item 10c, whichever is less)
e.) Balance (Item 10c – Item 10d)
f.) Interest (Item 2c or Item 10e, whichever is less)

11. Amount of principal after compromise $_____
If this amount is more than the original principal, then there is no compromise of principal.

12. New debt balances. (If Item 10 was skipped then consider item 10a thru 10e as zero)
a.) Accrued admin charges (Item 2a – Item 9b)
b.) Accrued penalty (Item 2b – Item 10d)
c.) Accrued interest (item 2c – Item 10f)
d.) Principal Balance (Item 11; or, if Item 11 was skipped, use Item 1)

Calculations performed by: _____ Date:_____

Certified by: _____ Date:_____

SAMPLE COMPROMISE MEMORANDUM

MEMORANDUM

DATE:

TO: [**Name**], Unit Chief
Policy, Regulations and Procedures
DEEOIC

FROM: {**Name**}, Policy Analyst

SUBJECT: Employee Name:
Claimant Name:
Case ID:
Compromise of Overpayment

On [**date**], the Division of Energy Employees Occupational Illness Compensation (DEEOIC) sent {**Claimant name**} a final decision regarding an overpayment in {**his or her**} {**Part B and/or E**} claim for compensation in the amount of {**$** }. The overpayment was created when {**describe overpayment circumstances**}.

The {**Claimant name**} requested that the DEEOIC accept a compromise of payment to be paid in a partial settlement to resolve this matter. {**Describe the compromise circumstances; i.e., the amount of the overpayment the claimant will refund, whether the claimant will pay it in a lump sum or installment payments, and the amount to be compromised.**} There is no indication of fraud in this case.

The claimant submitted an OWCP-20 with the required financial documentation to support the compromise request. {**Briefly describe the claimant's financial circumstances supporting the need for a compromise**}**.**

Since it appears unlikely that the debt can be recouped in a reasonable period of time, either voluntarily or through legal proceedings, given the claimant's age, health, and financial circumstances, I recommend that this proposal for settlement be accepted, and that DEEOIC issue a Compromise Order.

SAMPLE COMPROMISE ORDER

Employee:
Claimant:
Case ID:

COMPROMISE ORDER

1. This Compromise Order pertains to an overpayment of benefits in the {**Part B and/or E**} claim filed by [**Claimant name**} under the Energy Employee's Occupational Illness Compensation Program (EEOICPA or Act). The amount of the overpayment is [**$** }.

{Adjust wording of paragraph 2 to fit circumstances.}

2. On [**date**], the Division of Energy Employees Occupational Illness Compensation {DEEOIC) sent the claimant an overpayment notice with a preliminary finding that the claimant was {**at fault/without fault**} in the matter of the overpayment. The claimant was notified of the grounds for consideration of waiver of recovery of the overpayment, and {**his or her**} rights in the matter. The claimant applied for waiver of recovery. On {**date**}, the DEEOIC sent the claimant a final determination that {**he or she**} did not meet the criteria for a waiver of recovery of the overpayment.

It has been determined that the claimant does not have the present or prospective ability to pay the full amount of the debt within a reasonable period of time. It has been further determined that there is no indication of fraud, the filing of a false claim, or misrepresentation on the part of the claimant or on the part of any other party having an interest in the claim. Furthermore, the principal amount of the overpayment does not exceed $100,000.

3. Based on the information outlined above, it is hereby determined that a compromise of the debt shall be accepted, and settlement of the claim for recovery of the overpayment shall be accepted in the amount of {**$** }, which does not exceed $100,000 exclusive of interest and penalties. The claimant will pay the remaining amount of the debt in the following manner and time:

{**Describe payment terms**}

4. The overpayment shall not be considered settled until full payment of [**$**] has been received by DEEOIC within the time and in the manner specified above. The failure to make such payment shall result in the reinstatement of the full amount of the overpayment, less any amounts paid prior to default.

_____ _____

Name Date
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

SAMPLE LETTER SUSPENDING COLLECTION ACTIONS

Employee:
Claimant:
Case ID:

Claimant Name
Address

Dear [**Claimant name**}:

This is in reference to the overpayment of benefits in your {**Part B and/or E**} claim under the Energy Employee's Occupational Illness Compensation Program Act (EEOICPA or ACT) in the amount of {**$** }.

I have reviewed the evidence of record pertaining to the overpayment in your claim, and the financial documentation that you have provided. I have determined that collection action on your debt will be suspended indefinitely, and that no further action will be taken by this office, unless we are notified that your circumstances have changed.

I have taken this action because it has been found that your financial circumstances are such that recovery would cause hardship. In the event that we receive evidence of substantial income or assets that would support resuming collection of this debt, we reserve the right to take further action to recover the money due.

If you have any questions pertaining to the overpayment, you may contact this office at [**PA phone number**] or 202-693-0081.

Sincerely,

Name
Unit Supervisor for Policy,
Regulations and Procedures
DEEOIC

- Version 1.0 consolidates the PM into one document, changing the outline formatting and numbering sequence of chapters. Version 1.0 contains no substantive changes to existing program procedure. **EEOICPA Transmittal No. 17-06** describes the specific revisions which constitute v1.0.

- Version 1.1 updates guidance provided in Chapter 15 - Establishing Toxic Substance Exposure and Causation, and provides expanded guidance on assessing claim compensability. **EEOICPA Transmittal No. 17-07** describes the specific revisions which constitute v1.1.

- Version 2.0 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 18-01** describes the specific revisions which constitute v2.0.

- Version 2.1 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 18-02** describes the specific revisions which constitute v2.1.

- Version 2.2 includes Appedix 3 – Index of Archived Bulletins and Circulars. **EEOICPA Transmittal No. 18-03** describes the specific revision which constitutes v2.2.

- Version 2.3 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 18-04** describes the specific revisions which constitute v2.3.

- Version 3.0 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 19-01** describes the specific revisions which constitute v3.0.

- Version 3.1 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 19-02** describes the specific revisions which constitute v3.1.

- Version 4.0 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 20-01** describes the specific revisions which constitute v4.0

- Version 4.1 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 20-02** describes the specific revisions which constitute v4.1.

- Version 4.2 updates guidance provided in multiple chapters throughout the PM. **EEOICPA Transmittal No. 20-03** describes the specific revisions which constitute v4.2.

- Version 4.3 updates guidance provided in multiple chapters throughout the PM. Following are the content edits which make up the Federal (EEOICPA) PM, v4.3:

  - **Chapter 2 – The EEOICPA**

    - Ch. 2.6 has been updated to reflect the current distribution method for initial case assignments. The language in v4.2 previously read:

6. Jurisdiction. This paragraph describes the jurisdiction of the four DEEOIC DOs. The DO that handles a claim is determined by where the employee last worked as a covered employee. A DO acquires jurisdiction if the last covered facility is/was located within the geographical area it serves.

a. Survivor Claims. This rule applies to claims from survivors as well as those brought by the employee.

b. Uranium Workers. All claims for uranium workers (or their survivors) who may have been awarded benefits under Section 4 or 5 of RECA are within the jurisdiction of the Denver DO.

It has been updated in v4.3 to:

6. Jurisdiction. Employee and survivor claims filed with the DEEOIC are assigned to a CE within one of the four district offices on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

- Exhibit 2-1, Jurisdictional Map, that was previously included in v4.2, has been removed from v4.3, as this exhibit was outdated. As such, the remaining exhibits of Chapter 2 has been renumbered accordingly.

- **Chapter 6 – Processing Mail**

  - Ch. 6.7i has been updated to remove all references to the Regional Director and to communicate a uniform procedure for reporting PII violations. The language in v4.2 previously read:

i. Improper Release of Protected PII. If protected PII is improperly release to an incorrect individual, or documentation sent to the correct individual contains protected PII of another individual that was not redacted, DEEOIC staff must:

(1) Contact the individual via telephone and registered mail to request the return of the document. The DEEOIC staff member provides a self-addressed, stamped envelope for the return of the material directly to the DEEOIC;

(2) Immediately notify Appropriate Management (DD, FAB Manager or FAB Branch Chief) who in turn notifies the Regional Director or NO, who complies with established departmental reporting requirements, documenting the type of PII disclosure, the circumstances surrounding the disclosure, how it was discovered, the appropriate actions taken to recover the document in question, and the disposition of the recovery effort; and

(3) Track each PII recapture request within the Regional or FAB Office.

(a) If the recapture of the PII documentation is successful, the incident becomes closed with the incident record filed and maintained in OWCP.

(b) If the third party in possession of the improperly released documentation refuses to return it, the DEEOIC staff member reports the situation through the appropriate management, through the Regional Director (except FAB), to the NO, who will provide guidance.

It has been updated in v4.3 to:

i. Improper Release of Protected PII. If protected PII is improperly released to an incorrect individual, or documentation sent to the correct individual contains protected PII of another individual that was not redacted, DEEOIC staff must notify their supervisor who will follow the standard department protocols for reporting PII violations.

- Exhibit 6-1, OIS Subjects and Categories, that was previously included in v4.2, has been removed from v4.3, as this Exhibit was outdated. As such, the remaining exhibits of Chapter 6 have been renumbered accordingly.

- **Chapter 7 – Case Creation**

  - Ch. 7.4 has been updated to remove references to claims assignments based on jurisdictional locations. The language in v4.2 previously read:

4. Assignment of Claims to a DO. The assignment of a claim to a particular DO occurs based on the state where the employee's most recent location of covered employment occurred, as listed on Form EE-3. Each DO is responsible for claims originating from a state for which it has jurisdictional responsibility. Information regarding DO jurisdictional boundaries is located on the DEEOIC main webpage. If the claimant does not submit a Form EE-3 with his claim, the CCC uses the claimant's state of residence to make a DO assignment. Each DO is to provide the CCC with an up to date case create digit assignment list so that upon creation, the CCC directs the claim to appropriate CE. When CE digit assignments change, the DD or a designee is to email the updated list to zzOWCP-DEEOIC-Centralized Case Create Group.

It has been updated in v4.3 to:

4. Assignment of Claims to a DO. The assignment of a claim to a particular DO occurs on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

  - Ch. 7.7a has been updated to remove reference to the Resource Center (RC) verifying employment using ORISE, as this function is now performed by the assigned district office Claims Examiner (CE). The language in v4.2 previously read:

a. Consideration of Employment. In addition to considering the claimed medical condition(s), claimed employment is also considered. Part B of the EEOICPA covers employees of the DOE, its contractors and subcontractors, beryllium

vendors, AWEs and eligible survivors. Part E offers benefits to DOE contractors, subcontractors and their eligible survivors.

For claims filed at the RC, the RC verifies employment through the Oak Ridge Institute for Science and Education (ORISE) and/or clarifies the nature of claimed employment.

It has been updated in v4.3 to:

a. Consideration of Employment. In addition to considering the claimed medical condition(s), claimed employment is also considered. Part B of the EEOICPA covers employees of the DOE, its contractors and subcontractors, beryllium vendors, AWEs and eligible survivors. Part E offers benefits to DOE contractors, subcontractors and their eligible survivors.

Upon receipt of a claim filed at the RC, the District Office CE will perform all necessary actions to verify claimed employment, including review of the Oak Ridge Institute for Science and Education (ORISE) database information.

- **Chapter 9 – Transfers and Loans**
  - Ch. 9.3c has been updated to remove language related to case transfers based on the last place of covered employment. The language in v4.2 previously read:

c. DOs may transfer case files to other jurisdictions permanently, based upon the employee's last verified covered employment. Alternatively, management decisions may lead to changes in case allocations amongst the district or FAB offices.

It has been updated in v4.3 to:

c. DOs may transfer case files to other jurisdictions permanently, based on management decisions regarding case allocations amongst the district or FAB offices.

- **Chapter 10 – Resource Centers**
  - Chapter 10 has been replaced in its entirety to update the functions of the Resource Center and their role in occupational history development.
  - Exhibit 10-1, Occupational History Interview, has been updated.
  - Exhibit 10-2, RECA Occupational History Interview, that was previously included in v4.2, has been removed from v4.3, as this Exhibit was outdated.
  - Accordingly, what was Exhibit 10-3, Interview Confirmation Letter, in v4.2, has been updated and renumbered as Exhibit 10-2 in v4.3.

- **Chapter 11 – Initial Development**

  - Ch. 11.9 has been added to include a description of the Correspondence Creation and Tracking System (CCAT) and an overview of the forms and letters contained therein. The new section contained in v4.3 reads:

9. Correspondence Creation and Tracking System (CCAT.) CCAT is an internal form and correspondence generator within ECS that is used to generate certain standardized forms and correspondence letters. The system populates various fields with information already contained within ECS, such as names and addresses, while allowing the user to input other claim-specific information. In addition, CCAT also contains samples of these forms and letters.

a. Below, in alphabetical order, are the forms and letters currently available in CCAT:

(1) Alternative Filing Acknowledgement Letter

(2) AR Acknowledgement Letter

(3) Change of Address Acknowledgement Letter

(4) Claim Acknowledgement Letter

(5) DEEOIC Case Transfer Sheet

(6) DME Authorization Letter

(7) EE-8 and EN-8 Smoking History Questionnaire

(8) EE-9 and EN-9 Race/Ethnicity Questionnaire

(9) EE-10 and EN-10 Claim for Additional Wage-Loss and/or Impairment Benefits under the EEOICPA

(10) EE-11A and EN-11A Form (Impairment)

(11) EE-16 and EN-16 Form

(12) Hearing Request Acknowledgement Letter

(13) Hearing Transcript Letter

(14) HHC Authorization Letter

(15) Home Hospice Authorization Letter

(16) Letter to DOJ for RECA Award Confirmation

(17) Lump Sum Payment Acknowledgement Letter

(18) Medical Travel Reimbursement Authorization Letter

(19) Not Claiming Impairment and/or Wage-Loss Letter

(20) Physician Letter

(21) Rehabilitative Service Authorization Letter

(22) Residential Care Facility Authorization Letter

(23) Review of Written Record Acknowledgement Letter

(24) Untimely Hearing Request Letter

- In conjunction with the above change, the following exhibits that were previously included in v4.2 and are now available through CCAT, have been removed from v4.3, and the remaining exhibits of the affected chapters have been renumbered accordingly:

  - Exhibit 7-1: Sample Acknowledgement Letter
  - Exhibit 12-3: Notification to Representative
  - Exhibit 19-1: Letter to DOJ for RECA Award Confirmation
  - Exhibit 19-2: Alternate Letter to DOJ for RECA Award Confirmation
  - Exhibit 20-2: Sample Alternative Filing Letter
  - Exhibit 21-2: Not Claiming Impairment Letter
  - Exhibit 22-2: Not Claiming Wage-Loss Letter
  - Exhibit 25-1: Sample Acknowledgment Letter, Review of Witten Record
  - Exhibit 25-2**:** Sample Acknowledgement Letter, Hearing
  - Exhibit 29-3**:** Sample Ancillary Medical Services Authorization Letter
  - Exhibit 29-4**:** Sample Authorization Letter
  - Exhibit 29-7**:** Sample Travel Authorization Letter

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

  - Chapter 14.6 has been updated to reflect additional guidance for calculating workday requirements in instances where evidence supports an onsite presence at a designated Special Exposure Cohort (SEC) facility for 24 hours. The language in v4.2 previously read:

6. <u>Workday Requirement</u>. Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC worksites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are

some cases where the employee worked for less than a year, and additional guidance is required to calculate the 250 workdays.

a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.

b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workdays any infrequent periods of non-presence or non-work, like sick leave, strikes, layoffs or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC worksite for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.

c. The period of 250 workdays starts with the worker's first day of employment at the SEC worksite. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC worksites.

d. Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension, dues, union local records, etc.), the following table may be used for conversion.

250 days =	*50 five-day weeks, or*
	42 six-day weeks, or
	12 months (five-day weeks), or
	10 months (six-day weeks), or
	2,000 hours

One month = 21 days (if evidence indicates six-day weeks, 25 days)

e. Where records of an employee's earnings are available, such as a W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows. Divide the annual wages earned at the SEC worksite by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual

employment. As such, this method should only be used when all primary employment data is lacking.

f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the NO Policy Unit may be required.

It has been updated in v4.3 to:

6. *Workday Requirement. Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC worksites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are some cases where the employee worked for less than a year, and additional guidance is required to calculate the 250 workdays.*

a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.

(1) If evidence exists establishing an employee's onsite presence at a designated SEC facility for 24 hours, including time spent working or living at the facility, the employee will be credited for 3 work shifts (i.e. 3 workdays) towards the 250-work day requirement. In such instances, the 250-work day requirement will be satisfied if the evidence establishes the employee's onsite residential presence at a designated SEC facility for 83 days, which a CE may consider as the equivalent of 250 workdays.

b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workdays any infrequent periods of non-presence or non-work, like holidays, sick leave, strikes, layoffs, or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC worksite for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.

c. The period of 250 workdays starts with the worker's first day of employment at the SEC worksite. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC worksites.

d. Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension,

dues, union local records, etc.), the following table may be used for conversion.

250 days =	*50 five-day weeks, or*
	42 six-day weeks, or
	12 months (five-day weeks), or
	10 months (six-day weeks), or
	2,000 hours
	24 hours per day of residential onsite presence for 83 days
One month =	*21 days (if evidence indicates six-day weeks, 25 days)*

e. Where records of an employee's earnings are available, such as W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows: Divide the annual wages earned at the SEC worksite by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual employment. As such, this method should only be used when all primary employment data is lacking.

f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the NO Policy Unit may be required.

- Exhibit 14-1, List of SEC Designated Classes, has been updated to include the following EEOICPA Circulars:
  - Circular 20-01: West Valley Demonstration Project SEC (01/01/69 – 12/31/73)
  - Circular 20-02: Y-12 Plant SEC (01/01/77 – 07/31/79)
- Exhibit 14-2, SEC Class Screening Worksheet, which was previously included in v4.2, has been removed from v4.3. As such, the remaining exhibits of Chapter 14 have been renumbered accordingly.

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**
  - Exhibit 15-4: Exposure and Causation Presumptions with Development Guidance for Certain Conditions, has been updated.

- Exhibit 15-4.1b, regarding Angiosarcoma, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to polyvinyl chloride for at least 250 aggregate work days. This can be determined by an IH assessment.

  It has been updated in v4.3 to:

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

- Exhibit 15-4.4b, regarding Asbestosis, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.
  It has been updated in v4.3 to:

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

- Exhibit 15-4.6c, regarding Bladder Cancer, has been amended. The language in v4.2 previously read:

  c. Causation: For employees with demonstrated regular, routine exposure at significant levels (as opined by an Industrial Hygienist) to one of these substances for a full, consecutive working year, causation is presumed.

  It has been updated in v4.3 to:

  c. Causation: For those employees who were employed consecutively for a full working year in a position that would have involved significant exposure to one of the toxins identified in (b)(1-5) (as opined by an Industrial Hygienist), causation is presumed.

- Exhibit 15-4.7b(1), regarding Chronic Obstructive Pulmonary Disease, has been amended. The language in v4.2 previously read:

  (1) *The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1986.*

It has been updated in v4.3 to:

(1) The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1995.

- Exhibit 15-4.9b, regarding Kidney Cancer, has been amended. The language in v4.2 previously read:

  ii. Exposure: An employee who was employed for 5 or more consecutive years prior to 1990 and had significant exposure to trichloroethylene (TCE). This can be determined by an IH assessment or without the review of an IH if the employee meets all of the following employment criteria (exposure presumption):

  It has been updated in v4.3 to:

  b. Exposure: An employee must have been employed for 5 or more consecutive years prior to 1990 in a position that would have had significant trichloroethylene (TCE) exposure. This can be determined by an IH assessment or without the review of an IH if the employee meets all of the following employment criteria (exposure presumption):

- Exhibit 15-4.10b, regarding Laryngeal Cancer, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

  It has been updated in v4.3 to:

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

- Exhibit 15-4.11b, regarding Leukemia, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to benzene for at least 250 aggregate work days. This can be determined by an IH assessment.

  It has been updated in v4.3 to:

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

- Exhibit 15-4.12b, regarding Lung Cancer, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

  It has been updated in v4.3 to:

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

- Exhibit 15-4.15b, regarding Non-Hodgkin's Lymphoma, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure with lindane (1,2,3,4,5,6-Hexachlorocyclohexane) for at least 56 days.

  or

  The employee was employed in a job that would have brought the employee into contact with significant exposure with pentachlorophenol for at least 2 years.

  It has been updated in v4.3 to:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure with lindane (1,2,3,4,5,6-Hexachlorocyclohexane) for at least 56 days.

  or

  The employee was employed for an aggregate of 2 years in a position that would have had significant pentachlorophenol exposure.

- Exhibit 15-4.16b, regarding Ovarian Cancer, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250

aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment

It has been updated in v4.3 to:

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

- Exhibit 15-4.18b, regarding Pleural Plaques, has been amended. The language in v4.2 previously read:

  b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

  It has been updated in v4.3 to:

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

- **Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions**
  - Ch. 18.19 has been edited to comply with the removal of Exhibit 18-1. The language in v4.2 previously read:

19. Other Conditions. Like asbestosis and the lung ailment COPD, there are a host of other non-cancerous conditions potentially covered under Part E that are not covered under Part B. With the wide variety of conditions claimed under Part E, this chapter cannot address diagnostic requirements of all possible conditions. However, the matrices in Exhibit 18-1 have been created to provide information relating to the assessment of the following conditions: kidney disease; occupational asthma; toxic neuropathy; and chronic toxic encephalopathy. Ultimately, the CE uses his or her best judgment in reviewing and evaluating the probative value of the medical evidence.

It has been updated in v4.3 to:

19. Other Conditions. With the wide variety of conditions claimed under Part E, this chapter cannot address all common diagnostic or clinical characteristics for every particular diagnosis. Ultimately, the CE uses his or her best judgment in weighing the probative value of available medical evidence to ascertain a diagnosis. The establishment of a diagnosis requires that a qualified physician apply sound medical reasoning to interpret available clinical or diagnostic evidence to identify a disease or

disorder. In those instances where the CE cannot establish that the weight of medical evidence supports a diagnosis, the CE is to seek clarification from the claimant's treating physician. If the CE is unable to obtain clarification from the treating physician or in instances where the claimant is not currently under the care of a physician, the CE may seek clarification of a medical diagnosis from a CMC.

- Exhibit 18-1: Matrix for Confirming Sufficient Evidence of Non-Cancerous Covered Illness, has been deleted based on input from the Advisory Board on Toxic Substances and Worker Health.

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

  - Ch. 19.3a and Ch. 19.3b, pertaining to RECA claims being solely adjudicated by the Denver District Office, have been removed.

- **Chapter 20 – Establishing Survivorship**

  - Chapter 20.12b has been amended to clarify that a survivor electing to receive Part E monetary benefits which an employee would have been eligible to receive will have to have those monetary benefits coordinated if the employee received benefits as part of a State Workers' Compensation (SWC) claim. The language in v4.2 previously read:

b. Death Due to Non-Covered Illness, Part E. If a covered Part E employee dies after filing a claim but before the claimed payment is received, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received, had he/she not died prior to payment, rather than survivor benefits. It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment benefits for the election option to be available to the survivor(s). As long as the employee filed a Part E claim, claims for wage-loss and impairment benefits are presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any subsequent amount of monetary benefits claimed by the survivor.

It has been updated in v4.3 to:

b. Death Due to Non-Covered Illness, Part E. If a covered Part E employee dies after filing a claim, but before the monetary benefits are paid, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received had he/she not died prior to payment. This would be in lieu of the survivor lump-sum compensation payable under Part E.

It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment benefits for the election option to be available to the

survivor(s). As long as the employee filed a Part E claim, claims for wage-loss and impairment benefits are presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any remaining balance of Part E lump-sum compensation available to a survivor under Part E should they make an election. Once a survivor makes an election to receive a payment that the covered Part E employee would have received, the survivor is treated the same as the employee in determining whether the payment is subject to state workers' compensation (SWC) coordination. For example, if the employee received SWC benefits for asbestosis and the survivor elected to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the amount payable to the survivor with the amount of those SWC benefits. (See PM Chapter 32, Coordinating State Workers' Compensation Benefits).

- **Chapter 22 – Wage-Loss Determinations**
  - Exhibit 22-4, SSA Contact Numbers, which was previously included in v4.2, has been removed from v4.3, as it is duplicative with Exhibit 13-1. As such, the remaining exhibits of Chapter 22 have been renumbered accordingly.

- **Chapter 24 – Recommended Decisions**
  - Ch. 24.7a has been edited for clarity. The language in v4.2 previously read:

    a. Written Decision. The written decision is comprised of an Introduction, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.

    (1) Introduction. This portion of a RD succinctly summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E.

    It has been updated in v4.3 to:

    a. Written Decision. The written decision is comprised of an introductory statement, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.

    (1) Introductory Statement. This is a statement written following the title "Recommended Decision" that summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E.

  - Exhibit 24-1 has been modified to align with the text of Ch. 24.7; specifically, the header "Notice of Recommended Decision" has been changed to "Recommended Decision.

- Exhibit 24-2 has been modified to align with the text of Ch. 24.7; specifically, the header "Notice of Recommended Decision" has been changed to "Recommended Decision.

- Exhibit 24-3, Notice of Recommended Decision, has been updated to include new language to clarify reporting requirements for recommended acceptances.

- **Chapter 26 – FAB Decisions**

  - The final paragraph of Ch. 26.3a has been updated to clarify the requirement that two EN-20s are to be included with each final decision acceptance. The language in v4.2 previously read:

An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 26-2); and/or (2) an Acceptance of Payment form (EN-20), which is required before payment can be issued.

It has been updated in v4.3 to:

An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 26-2); and/or (2) two Acceptance of Payment forms (EN-20), one of which must be properly completed and returned before payment can be issued.

  - Ch. 26.5c has been edited to remove outdated reference to Co-Located Unit. The language in v4.2 previously read:

c. Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained by the Co-Located Unit within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.

It has been updated in v4.3 to:

c. Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.

- Exhibit 26-2, Medical Benefits Letter, has been updated to include language regarding the U.S. Department of Treasury's direct deposit program, and the inclusion of SF 1199A, Direct Deposit Sign-Up Form.

- **Chapter 28 – Medical Bill Process**

  - Ch. 28.13 has been amended to reflect existing practices related to the OWCP fee schedule review process. The language in v4.2 previously read:

13. Fee Schedule Appeal Process. As part of the medical bill review process, program regulations provide for the appeal of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service.) In order to maintain consistency, record responses, and track fee schedule appeals, the following procedures have been developed to further delineate this process.

a. When the BPA receives a fee appeal request letter, the BPA stores an electronic copy of the appeal letter in the XTCM Image Retrieval system, linked to the remittance voucher if submitted by the provider, and sends an email to the MBPU for review.

b. For each fee schedule appeal letter received, the MBPU creates a record, and maintains it in a tracking system (spreadsheet or database) created for this purpose.

c. The MBPU POC reviews the fee appeal request to determine if the provider has met any of the conditions below which justify a reevaluation of the amount paid. These three conditions, as found in 20 C.F.R. 30.712, are:

(1) The service or procedure was incorrectly identified by the original code; or,

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or,

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

d. Within 15 days of receiving the request for reconsideration, the MBPU prepares a response to the medical provider outlining DEEOIC's decision to either:

(1) Approve an additional payment amount: In this instance, the MBPU generates a draft letter for DD signature, informing the provider of the approval for additional payment. Where an

additional amount is found to be payable based on unusual provider qualifications, the DD determines whether future bills for the same or similar service from that provider should be exempt from the fee schedule. The MBPU also prepares a memorandum for the case file stating the findings and the basis for the approval of the additional amount, or;

(2) Deny any additional payment: In this instance the MBPU prepares a draft letter-decision for DD signature, advising that additional payment is denied, based upon the provider's inability to establish one of the conditions listed above in Item c (1)(2)(3). Where additional payment is denied, the letter decision must contain a notice of the provider's right to further review, similar to the following:

> *If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and must be addressed to the Regional Director, District _____, Office of Workers' Compensation Programs, U.S. Department of Labor, [Insert appropriate Regional Office address and Zip Code.]*

e. The draft approval or denial letters are prepared by the MBPU, for the signature of the DD whose office has control of the claim file(s) being addressed in the decision(s). The MBPU sends the draft letter (via email) to the DD for review, signature, and mailing. The DD places a copy of the signed letter in the case file and also returns (via email) a scanned copy of the signed letter, to be retained by the PSM.

f. The MBPU continues to track the status of any fee schedule appeal case, and maintains an electronic copy of all correspondence. This includes a copy of the draft letter and a scanned copy of the signed letter mailed by the DD.

g. If a denial is subsequently appealed to the RD, the RD must consult with the PSM to obtain copies of relevant bills and documents, and to discuss the appeal. The PSM also provides the RD with a copy of the denial letter signed by the DD. This can be handled via email.

h. After consultation with the PSM, the RD prepares a written response to the provider within 60 days of receipt of the request for review. Where additional payment is denied at the regional level, the letter decision from the RD advises the provider that the decision is final and is not subject to further administrative review. The RD forwards a scanned copy of the

signed letter decision to the PSM. The PSM also retains that response as part of the appeal record.

i. The final outcome of each appeal letter is recorded in the MBPU tracking system to indicate:

(1) Additional payment made.

(2) DD Denial letter.

(3) RD Appeal letter.

(4) Time limit (30 days) has expired for appeal to RD.

(5) The final disposition date for each appeal letter.

It has been updated in v4.3 to:

13. Fee Schedule Review Process. As part of the medical bill review process, program regulations provide for the reconsideration of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service). A provider whose charge OWCP partially pays under the fee schedule has 30 days to request reconsideration of the fee determination.

a. Fee reconsideration circumstances. A medical provider may contest a payment under the OWCP fee schedule under the following circumstances:

(1) The service or procedure was incorrectly identified by the original code; or,

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or,

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

b. A provider is to submit a fee schedule reconsideration involving a DEEOIC claim to the BPA at the medical bill processing mailing address. The fee reconsideration request is to communicate clearly that the provider is contesting a payment under the fee schedule relating to a DEEOIC case file and the applicable fee reconsideration circumstance the provider is pursuing. The provider is to attach any remittance voucher or other accompanying material the provider is using to support the fee reconsideration request.

c. *Once received, the BPA will register the fee reconsideration request and forward it to the MBPU. MBPU will coordinate with the DO with jurisdiction over the claim to assess the reconsideration request. Within 30 days of receiving a fee reconsideration, the responsible DD is to issue a written determination on the reconsideration request. The DD's written determination is to state whether or not an additional amount will be allowable as reasonable considering the information submitted in the reconsideration request. If the DD decides to deny the reconsideration request, the DD is to include the following notice within the written decision:*

> *If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. Direct any request for additional review to the National Administrator for Field Operations (NAFO). You may submit with the application any additional information you wish the NAFO to consider. Mail your application for additional review to the DEEOIC BPA at the following address:*
>
> *<Insert BPA Mailing Address>*

d. *If a provider seeks further review of a denied reconsideration request, the DEEOIC BPA will coordinate with the MBPU to direct the request to the NAFO. The NAFO performs the same functions as, and serves as the equivalent of, a Regional Director, which the regulations reference as having to conduct this review. DEEOIC reorganized its regional offices into National Field Operations, so the position of Regional Director no longer exists. The NAFO will seek any information to allow for a comprehensive review of the application, including review of any information supplied by the provider or maintained by DEEOIC regarding the case file. Once the NAFO completes a review of the application and relevant documentation, the NAFO will prepare a written response to the provider within 60 days of the receipt of the request for further review. The decision will communicate whether or not an additional amount is allowable. If the NAFO denies an additional amount, the NAFO's decision to communicate to the provider that the decision is final and is not subject to further administrative review.*

- **Chapter 29 – Ancillary Medical Benefits and Related Services**
  - Ch. 29.13 has been updated to provide additional guidance regarding the evaluation of claimant requests for vehicle modification, and removes language pertaining to vehicle purchases. The language in v4.2 previously read:

13. Vehicle Modifications and Purchases. This section provides clarification with regard to the evidence needed to approve vehicle modifications and purchases, and provides procedural guidance with regard to the process for review, development, and authorization of such requests.

a. Criteria for Modifications. Upon receipt of a LMN describing a medical need for vehicle modification, and if the claimant's medical needs can be met by modifying or adding accessories/equipment to the claimant's present vehicle, the MBE explores that option first, before considering replacement of the existing vehicle. When considering modifications to an existing vehicle, the MBE takes into consideration the type of vehicle currently owned, its age, and condition. Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical.

b. Proposals. If the MBE determines that the claimant's medical needs warrant vehicle modification, the MBE advises the claimant in writing to submit a detailed written proposal containing the following information:

(1) The year, make, model, and body style of the vehicle to be modified, as well as current mileage, description of general mechanical condition, and any modifications currently needed or anticipated. The same applies regardless of whether the vehicle to be modified is new or used.

(2) Detailed written estimates from two licensed automobile dealers, or custom alteration facilities, itemizing the proposed vehicle modifications necessary to comply with the treating physician's LMN. Estimates must include a breakdown of all parts, labor, and the respective costs associated with each item. The estimates should also state the amount of time required to perform the modifications.

c. Acceptance by the MBE. The MBE has the latitude to approve an estimate that the claimant favors, if the estimates are reasonably similar in scope and cost.

(1) Approval or Denial. Upon review of the evidence, the MBE approves or denies the request by sending a letter decision to the claimant advising of the approval, or reason(s) for denial of the request.

(2) Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant requesting the additional documentation that is necessary to continue with the review process.

(3) Inadequate response. If the claimant does not respond to the development letter, or does not provide sufficient documentation to support the request, after considering all relevant evidence, the MBE issues a letter decision informing the claimant of the authorization denial.

d. Vehicle Purchase. If the claimant provides a LMN establishing that modifications to his or her currently owned vehicle are not feasible or practical, and that a substitute vehicle is required for the claimant to operate, the MBE reviews the case with a supervisor and the NO FO, and may authorize the purchase of a suitable replacement vehicle. Under these circumstances, credit must be taken for the value of the claimant's existing vehicle. Purchase options include the following:

(1) Purchase of a used vehicle, (similar in quality to the claimant's existing vehicle), equipped to accommodate the claimant's disability and transportation needs.

(2) Purchase of a used vehicle that is suitable for modification as described above.

(3) Purchase of a new vehicle, modified, or suitable for modification, to meet the needs of the claimant, arising from an accepted condition.

(4) Whether a new or used vehicle is purchased, it must be a vehicle of comparable value as the vehicle currently owned and operated by the claimant (i.e.; a vehicle in a price range that closely approximates the level of income and/or standard of living of the claimant). For example, if the claimant owns a mid-priced Chevrolet, Ford, Honda or Toyota; purchase of a Cadillac, Lincoln, or Lexus SUV, would not represent a vehicle of comparable value. Once the baseline cost of a comparable quality vehicle has been established, the claimant may (at his or her option) choose to upgrade the baseline model, by adding additional equipment, with the difference in cost being paid for by the claimant.

(5) After determining the baseline cost of a comparable vehicle, the MBE must take credit for (deduct) the wholesale value of the claimant's existing car when determining the allowance to be paid for a replacement vehicle. The wholesale value of the existing vehicle can be determined through a number of internet websites that make this information available free-of-charge. The MBE should advise the claimant of the source of their information, once the wholesale value of the claimant's current vehicle has been determined.

(6) Sales Tax. State sales tax should be included in the cost of obtaining a replacement vehicle.

(7) Equipment that is medically necessary for the accepted condition should be factory-installed whenever possible.

(8) Maintenance Costs. The MBE authorizes necessary maintenance on the specialized equipment in a modified vehicle, whether installed in a new or used vehicle.

(a) Replacement cost of the specialized equipment, due to normal wear and tear, may be considered as well. Other parts of the vehicle will be maintained at the owner's expense, even if the vehicle purchase was reimbursed by DEEOIC.

(b) Replacement of the vehicle, and all authorized equipment, can be considered if the claimant can establish that the age, mileage, and condition of the vehicle warrant such replacement. Any residual value remaining in the vehicle to be replaced would be applied as a credit toward the cost of a replacement vehicle.

(9) Proof of Insurance. The claimant bears the cost of obtaining automobile insurance and maintaining current vehicular registration in conformance with the laws of the state within which the claimant resides. Claimants are required to carry comprehensive (fire, theft, vandalism) and collision insurance on any vehicle for which DEEOIC has authorized reimbursement, unless the fair market value of the vehicle and its equipment is less than $2,500. The claimant may select the deductible of the insurance policy but will be responsible for any such deductible should an accident occur.

(10) Vehicle No Longer Needed. If the MBE obtains information that a vehicle purchased by DEEOIC is no longer needed, the MBE will send an email to the DEEOIC Bill Pay Box Mailbox alerting MBPU of the situation. DEEOIC is entitled to recover the fair market value of the purchased vehicle, less any percentage contribution the claimant made to the overall purchase price of the vehicle and its modifications. The MBPU will undertake appropriate action to attempt recovery of any funds collectable through sale of a DEEOIC purchased vehicle no longer needed by a claimant.

It has been updated in v4.3 to:

13. Vehicle Modifications. DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their vehicle to accommodate the effect(s) of an accepted, work-related medical condition, as they relate to the use of that vehicle for purposes of medical transportation. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of those vehicle modification costs that are determined to be medically necessary and reasonable in cost. For the purposes of claim processing under the DEEOIC, a medically necessary vehicle modification means a mechanical alteration or addition to a vehicle, owned and operated by the claimant, necessary for purposes of medical transportation.

a. Vehicle Modification Claim Submissions. For the MBE to assess a claim for vehicle modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.

(1) Letter of Medical Necessity (LMN). The claimant must provide a LMN from a qualified physician who has conducted a face-to-face examination with the patient, prescribing vehicle modifications to address the effect of a work-related illness or injury, and providing a medical rationale for how those modifications relate to an accepted medical condition. The face-to-face examination must occur within 60 days of the date of the LMN. Specifically, the LMN must provide an explanation as to how the prescribed modification to the claimant's vehicle will accommodate the claimant's need for medical transportation.

(2) Evidentiary Requirements. Evidence supporting the need for specific vehicle modifications must include a description of the required equipment and/or labor operations necessary to modify the claimant's current vehicle, along with product information such as pamphlets, or technical diagrams, depicting the materials/equipment being proposed as part of the modification process. (For example: the claimant might provide a product brochure with photographs and technical information describing the installation of a lift device, designed for the purpose of transporting the claimant's DEEOIC prescribed mobility device.) The product information may be included with the submission of written estimates, or submitted separately to DEEOIC. Any unique or exceptional circumstances, regarding the nature of the requested modification and estimates for the cost of installation or modifications, are to be explained by the claimant, in a written statement, with supporting documentation, if applicable.

(3) Competitive Estimates. The claimant must obtain and submit three, independent, written estimates from appropriately licensed businesses or DEEOIC enrolled providers, detailing the proposed modifications that align with the medical rationale supplied by the

claimant's physician. The scope of the estimates must identify the same equipment and/or alterations specified in the LMN. Labor charges for modification of the existing vehicle and/or installation of DME are to be identified separately on the estimate. (This is important, as claims for DME purchase, and labor charges for installation, must be itemized separately when submitting claim forms for reimbursement.)

(a) Estimates for equipment added to a vehicle (e.g., scooter lift platform, motorized wheelchair lift platform, etc.) must specifically identify the description of the durable medical equipment (DME) being purchased. Information must include manufacturer or brand name, model number, and any other identifying information unique to the item described in the estimate.

(b) Estimates for installation costs (labor and materials), for the permanent attachment of DME to the claimant's vehicle (e.g., receiver or other permanent mounting devices attached to the vehicle for mounting purposes) must be provided in separate estimates.

b. MBE Assessment of Medical Evidence. Upon receipt of medical evidence supporting a claim for vehicle modification, the MBE conducts a review to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's vehicle to facilitate the use of that vehicle for the purpose of medical transportation.

(1) Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant's treating physician and the employee, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested vehicle modification is linked to a DEEOIC accepted medical condition(s). If, upon review, either of these conditions are not satisfied, the MBE undertakes development with the claimant and the treating physician seeking the necessary evidence.

(2) The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested vehicle modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the physician's accurate and comprehensive knowledge of the claimant's medical history, diagnostic, and clinical status.

(a) *In situations where the MBE determines additional information is needed to explain the medical necessity of a vehicle modification, the MBE initiates development with the claimant's treating physician. The treating physician is the principle point of contact for obtaining medical input. The MBE allows the claimant's physician the opportunity to respond to, or provide clarification with respect to, any development issue identified by the MBE. Additionally, the MBE may make referrals to DEEOIC nurse consultants, during the development process, for assistance in clarifying issues, obtaining information, or in seeking recommendations for additional development.*

(b) *In those instances, where development occurs with the treating physician, the MBE allots 30 days for the submission of necessary evidence to support a vehicle modification claim. For an initial request, the MBE allots 15 days to allow for a response. If the MBE does not receive the requested evidence within the 15-day period, the MBE sends a second development letter, providing an additional 15 days for submission of the requested evidence.*

(c) *When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed vehicle modification, the MBE refers the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested vehicle modification. Upon receipt of the SECOP results, the MBE reviews the SECOP report and conducts a full examination of the case evidence, including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a vehicle modification, as prescribed by the claimant's physician, the MBE proceeds with a review of the cost estimates for the modifications.*

If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the recommendation of the SECOP, and issues a recommended decision; or, the MBE can request that the claimant revise and resubmit any requested vehicle modification. If, for whatever reason, including

receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a vehicle modification, the MBE proceeds with a referral for a referee examination. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving conflicting medical opinions.

(d) Depending on the outcome of medical development, the MBE proceeds with adjudication of the claim. Where the medical evidence establishes the necessity for a vehicle modification, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity for a vehicle modification, the MBE issues a recommended decision denying the claim.

c. MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a vehicle modification, the MBE reviews the competitive estimates from the claimant. It is the responsibility of the claimant to produce valid, complete, and accurate competitive estimates that reflect only the work necessary to accommodate the claimant's need for medical transportation. Unless exceptional reasons exist, that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the estimates to determine if the scope of the requested modification(s) reasonably aligns with the modifications prescribed in the physician's LMN. The MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the written estimates reflect a medically necessary accommodation of the claimant's transportation needs. MBEs may also request input from nurse consultants regarding alternatives for accommodating the claimant's medical transportation needs.

(1) Comparing Competitive Estimates. The MBE examines the estimates to determine whether the scope of the proposed vehicle modification aligns with the physician's opinion of medical necessity. Each estimate must represent a proposal from a separate and distinct bidder desiring to perform the medically necessary vehicle modification. Estimates must be similar in their description of the equipment to be installed or work to be performed. For modifications to the existing vehicle, such as hand controls, modified driver seat, etc., the estimates must provide an itemization of the cost of materials, and the associated labor charge for each operation performed. As outlined above, DME, and the cost of modifying the vehicle to accommodate the DME,

must be itemized in separate estimates. Unusual or exceptional circumstances, associated with the requested modification, must be clearly described in the estimate. The MBE is to undertake a careful, comparative analysis to determine if each estimate represents a viable proposal for completing a cost-effective modification consistent with the physician's LMN. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular service provider, or any other factors that relate to the requested modification.

(2) Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work, detailed in the contractor bids, is inconsistent with either the LMN or the condition (i.e., year, make, model) of the claimant's owned vehicle, or, if a viable alternative modification, or alternative transportation option exists, the MBE prepares a letter to the claimant. The letter should outline the deficiency(ies) in what is being claimed, and specifically describe the evidence needed from the claimant to support further assessment of the claim. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to contact the claimant directly, to explain a problem and describe the necessary steps for submission of needed evidence. When a development letter is necessary, the MBE allots the claimant a total of 30 days for the submission of the requested evidence. For initial requests, the MBE allots 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the initial 15-day period, the MBE sends a second development letter, allotting an additional 15 days for a response.

(a) Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary vehicle modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.

(b) If a deficiency is found to exist, with a request for prior authorization of reimbursement for a vehicle modification, and the claimant is unable to produce evidence or information that addresses the deficiency, the MBE determines whether the deficiency prevents the MBE from proceeding with consideration of the reasonably

comparable estimates. If the determination is that the MBE cannot proceed because of that deficiency, the MBE proceeds with the issuance of a recommended decision denying the request for prior authorization of reimbursement. In the recommended decision, the MBE must clearly explain the specific deficiency(ies) in the evidence resulting in an inability to grant prior authorization of the reimbursement request.

(3) Issuing Authorization Decisions. Upon reaching a decision to grant a request for prior authorization of reimbursement, the MBE writes a detailed letter-decision to the claimant advising of the approval. The letter should specifically describe the modification(s) being approved and should include a blank Form OWCP-915 with instructions to use that form when submitting reimbursement requests. For approvals involving the installation of DME on a vehicle, the approval letter should instruct the claimant to separately list the purchased DME from labor charges necessary to complete the installation.

d. Retroactive Requests for Reimbursement. In those instances, where a claimant did not request prior authorization from DEEOIC and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide an LMN that meets the same evidentiary requirements as a prior authorization request, i.e., it must be sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's vehicle. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.

(1) Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement for a vehicle modification, the MBE collects all available information from the claimant regarding the completed modification. With the exception of requiring three estimates, the evidentiary requirements for a retroactive review are no different than those previously outlined for prior authorization requests. The MBE reviews the available evidence to determine if the claimed expenses appear reasonably in line with similar modification requests. The MBE calculates and deducts any costs for materials and/or labor not related to, or not necessary to complete the requisite vehicle modification. Upon completion of a thorough review, the MBE prepares a memo to file outlining any calculations performed and provides an explanation as to how the MBE arrived at a final cost for approval of any reasonable and medically necessary vehicle modifications.

(2) Issuing a Decision. Having determined that reimbursement is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE's final calculations of documented and/or reasonable costs represent an amount less than the amount claimed, or if the MBE recommends a denial of the requested amount, the MBE issues a recommended decision. In that decision, the MBE must fully explain the analysis of available evidence and how the MBE arrived at the recommended amount of reimbursement. This explanation must include any reference materials or other information, utilized by the MBE, to calculate the reimbursable amount.

- Ch. 29.14 has been updated to provide clear guidance for assessing the medical necessity of a claim for home modification. The language in v4.2 previously read:

14. <u>Housing Modifications</u>. This section provides clarification with regard to the evidence needed to approve housing modifications, and provides procedural guidance with regard to the process for review, development, and authorization of housing modifications. The MBE considers home modification only when deemed medically necessary due to an accepted condition. A MBE's responsibility is to grant authorization to modify an existing structure to accommodate the claimant's medical needs. The treating physician must describe in a LMN the particular home modifications needed to accommodate the claimant's work-related illness.

a. Modifications to Owned Property. Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical, with respect to the quality of construction materials and workmanship.

(1) Modifications may include certain additions where warranted. For example, if a ground-floor recreation room is converted to a bedroom, to accommodate a wheelchair-bound individual, and if no ground-floor bathroom facilities exist, then the addition of a bathroom on the ground floor could be approved. Similarly, if there is no suitable space for conversion of a bedroom on the ground floor, then the addition of a bedroom on the ground floor could be approved, if no other reasonable alternative exists.

(2) Modifications may include certain appliances, such as air conditioning or air filtration equipment, if deemed to be medically necessary by the treating physician, and necessary for the relief of accepted medical conditions. For example, if the claimant suffers from respiratory or cardiac conditions that have been accepted, his or her physician may order that the claimant be kept in an air conditioned environment, in which case the expense for these modifications would be allowed.

(3) When considering modification requests, the MBE should consider whether a portion of a home can be modified, as compared to a whole-house modification. An example of this would be one or two room air conditioning units, versus installing a whole-house air conditioning system.

(4) Maintenance expenses. The MBE approves maintenance expenses for equipment furnished to the claimant, as well as replacement costs, after the normal life expectancy of the appliance.

b. Modifications to Non-Owned Property. Any modifications to property not owned by the claimant, and his or her family, are subject to approval by the landlord or owner. This is in addition to the preceding guidelines established for owned property. When presented with a request for modifications to non-owned property, the MBE considers the following points:

(1) Rental property may be subject to federal Americans with Disabilities Act (ADA), state, or local statutes that mandate barrier-free accessibility for persons with disabilities. The claimant should discuss any change in housing needs with his or her landlord, who may be able to offer modifications or alternative accommodations better suited to the needs of the individual.

(2) If the landlord is unable or unwilling to pay for modifications, or offer other suitable accommodations, approval must still be obtained from the landlord prior to making any changes or alternations to the non-owned property. Any such changes must be made at the claimant's expense, and are subject to review and approval by DEEOIC, prior to any reimbursement.

(3) If the landlord/owner will not permit modifications, or if the costs are excessive, and if suitable housing arrangements are available elsewhere, within the same geographic area, it may be more cost-effective to consider paying relocation expenses rather than paying for modifications at the current location. If changing locations is the most cost-effective alternative, the MBE may authorize a subsidy for any increase in rent, if warranted, in addition to the relocation expense. For example, if the claimant lives in an apartment with stairs, and is no longer able to climb stairs due to his or her accepted condition(s), DEEOIC would reimburse the claimant for the most nearly comparable apartment available that offers an elevator and any other accommodations required to fulfill the claimant's medical needs arising from the claimant's accepted condition(s).

(4) The Government is entitled to reimbursement only for the value of special equipment that can be removed and sold separately, once the claimant no longer needs that equipment. Improvements or modifications, and any increase in property value resulting from such changes, accrue to the benefit of the owner.

c. Proposals. If the MBE determines that the claimant is eligible for housing modifications, the MBE asks the claimant to submit a detailed written proposal for review and consideration. The MBE advises the claimant that the proposed housing modifications should be of a quality and grade consistent with the existing architecture and construction materials, not superior to them. Further, the claimant should be cautioned that structural modifications must not compromise the integrity of the existing structure.

Modifications will be no more expensive than necessary to accomplish the required purpose. For example, when remodeling a bathroom, it may be feasible to re-install an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one.

Conversely, modifications must be in keeping with the standard of the décor of the current or pre-illness accommodations. For example, if the claimant's dwelling requires that a sink or commode be changed for handicap accessibility, and if it is necessary to tear out and replace tile, then the tile in the entire bathroom or kitchen may have to be replaced with similar quality tile in order to maintain the architectural décor of the room.

Proposals must include the following information:

(1) A medical report detailing the physical limitations for which the requested modifications are necessary. This report should be prepared by a physician who is a recognized authority in the appropriate medical specialty.

(2) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical or rehabilitation professional familiar with the needs of the disabled.

(3) If the claimant lives in a rented or non-owned premise, a written statement from the landlord/owner must be obtained, approving and authorizing the specific plans and proposed modifications.

(4) The MBE reviews the itemized proposal and determines if the specified modifications are warranted. If the MBE identifies

technical issues regarding implementation, the MBE develops the issue further to identify alternate solutions.

d. Fees and Bids.

(1) Reasonable fees may be paid for the medical or rehabilitation professional's visit to the site, and for the preparation of the detailed report. The same applies to any architectural drawings that are required for significant structural changes.

(2) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an AR remains the claimant's obligation.

(3) The claimant must provide two or more bids for the proposed changes from licensed and/or certified contractors. The bids submitted must be for exactly the same modifications so that comparison of the competitive bids can be made.

(a) If construction work is required, the bids obtained must be for binding estimates of the cost. No fees will be paid for the bids or estimates.

(b) If special accessories or devices are required, the MBE stipulates that the price quoted by the vendor includes any necessary installation.

(4) The MBE reviews the bids to determine that the same workmanship and materials are specified in the competitive bids, and normally selects the lowest cost bid, unless there is a sound reason for a higher-cost alternative, such as increased durability. If the MBE selects a bid other than the lowest-cost bid, a memorandum to the file is required, explaining any variance or the justification for accepting a higher bid.

(5) Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant requesting additional documentation that is necessary to continue with the review process.

e. Approval and Payment Options. Upon approval of the request, the MBE writes a detailed letter decision to the claimant advising of the approval (Exhibit 29-6 provides a sample of the home modification approval letter.) The approval letter is to include guidance to the claimant of the payment options available and requests that the claimant respond in writing, indicating his/her preferred payment option. For payment of home modification, the following is necessary:

(1) The claimant submits medical evidence and two proposals for home modifications. Upon review the MBE approves the lower cost bid proposal and sends a letter to claimant stating DEEOIC agrees to the approved scope and cost of repairs, and, at the claimant's request, will make direct payment to the enrolled contractor, once the agreed upon work has been completed. The letter states that upon completion of the agreed-upon work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that payment be made to the contractor. The MBE sends a courtesy copy of this letter to the contractor.

(2) Upon receipt of the claimant's attestation and request to pay the contractor, the MBE acknowledges the claimant letter and advises that the enrolled contractor should submit Form OWCP- 1500, along with a final invoice, in order to receive payment of the agreed upon price. The OWCP Code for HOME MODIFICATION - HSMDF is used, when preparing the Form OWCP-1500.

(3) In certain situations, the MBE may authorize payment of a pre-construction deposit if required by the contractor whose bid has been accepted by the MBE. In these situations, the contractor is to specify the total cost for specified home modification, along with the amount of any deposit (up to one-third of the total cost) required to initiate work. With MBE approval, the contractor may then submit Form OWCP-1500, to receive partial payment for the deposit amount of the estimated cost. The OWCP code for HOME MODIFICATION - HSMDF is used when preparing the Form OWCP-1500. Upon completion of the work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that final payment be made to the contractor. The contractor submits a separate Form OWCP-1500, requesting payment of the balance of the agreed upon amount.

(4) For guidance regarding problems encountered during the course of home modifications, or for other billing questions, (e.g.; billing difficulties, disputes or other irregularities), the MBE should contact the NO Policy Branch for assistance.

It has been updated in v4.3 to:

14. <u>Housing Modifications</u>. DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their residence to accommodate the effect(s) of an accepted, work-related illness. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of

those home modification costs that are determined to be medically necessary. For the purposes of claim processing under the DEEOIC, a medically necessary home modification means an alteration, addition to, or repair of an existing residential structure to overcome a deficiency limiting or preventing the claimant, with an accepted, work-related illness, from performing activities of daily living.

a. Home Modification Claims Submissions. For the MBE to assess a claim for home modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.

(1) Letter of Medical Necessity (LMN). A qualified physician who has conducted a face-to-face examination with the patient is to submit a LMN prescribing home modifications to address the effect of a work-related illness or injury, and how those modifications relate to an accepted condition. The face-to-face examination must occur within 60 days of the date of the LMN. The LMN must provide the physician's rationale justifying the medical need for a modification to the claimant's residential structure. Specifically, within the narrative of the LMN, the physician has to explain the reasons for a home modification and how the modification will serve to overcome an established inability of the claimant to perform an activity of daily living arising from an accepted medical condition.

(2) Evidentiary Requirements. The claimant must submit evidence substantiating the need for home modifications, including a description of the required modifications, digital photographs of the existing areas requiring modification, and any other plans, drawings, or documentation, supporting the required modifications. This information should clearly depict the area or areas requiring modification and should show evidence of the existing grade and quality of construction in the home. The claimant my include this information with the initial submission of written estimates, or submit it separately. Any unique or exceptional circumstances regarding the nature of the requested modification and the competitive estimates are to be explained by the claimant in a written statement with accompanying supportive documentation, if applicable. Any modification to property not owned by the claimant is subject to approval by the landlord or owner.

(3) Competitive Estimates. The claimant must obtain and submit three, independent written estimates, from appropriately licensed contractors or vendors, detailing the proposed modifications that align with the medical rationale supplied by the claimant's physician. The estimates must include the same alterations, additions, or repairs as specified in the LMN. These estimates are

to include itemized unit costs, broken down into materials and labor, for each operation (e.g. number of square feet of drywall or flooring, with the associated cost of materials and labor per square foot). Construction estimates are to include the grade of proposed construction materials and contain specifics describing the type and manufacturer of fixtures and appliances (such as sinks, cabinets, bathtubs, flooring materials, etc.). Building materials and construction quality, described in the construction estimates for a medically necessary home modification, must conform to the same construction quality as the existing structure. Any additional services, improvements, or upgrades, desired by the claimant, which are not within the scope of medically necessary modifications, are to be itemized distinctly and separately in the estimate. Such services, improvements, or upgrades are not reimbursable as a medically necessary home modification.

b. MBE Assessment of Medical Evidence. Upon receipt of the evidence supporting a claim for home modification, the MBE first conducts a review and assessment of the medical evidence. The function of this review is to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's residence to accommodate the effects of a work-related illness on the employee's ability to perform activities of daily living.

(1) Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant and the treating physician, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested home modification is linked to the DEEOIC accepted medical conditions. If, upon review, either of these conditions is not satisfied, the MBE undertakes development with the claimant and the treating physician, seeking the necessary evidence.

(2) The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested home modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the following: the physician's accurate and comprehensive knowledge of the claimant's medical history; diagnostic and clinical status; living circumstances; and functional capacities. The LMN should include the physician's consideration of such information and how the physician relates the need for, and the scope of any home modification, to an established deficiency in the claimant's capacity to perform activities of daily living arising from an accepted, work-related illness.

(a) *In those situations, where the MBE determines that additional information is necessary to explain the medical necessity of a home modification, the MBE is to initiate development with the claimant's treating physician as the principle point of contact for obtaining medical input. Moreover, the MBE is to allow the claimant's physician the opportunity to respond to, or provide clarification with respect to, the development issue identified by the MBE. At any time in this process, the MBE may make referrals to DEEOIC nurse consultants for assistance in clarifying issues, obtaining information, or recommending additional development.*

(b) *In those instances, where development occurs with the treating physician, the MBE should allot 30 days for the submission of necessary evidence to support a home modification claim. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period, the MBE sends a second development letter providing an additional 15 days to submit the requested documentation. No further time will be granted for a response from the treating physician, unless extenuating circumstances exist and are documented.*

(c) *When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed home modification during the allotted 30 days, the MBE is to refer the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested home modification.*

Once the SECOP medical examination is complete, the MBE will need to review the SECOP report and conduct a full examination of the case evidence including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a home modification, as prescribed by the claimant's physician, the MBE is to proceed with a review of the cost estimates for the modifications.

If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that

the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the recommendation of the SECOP, and issues a recommended decision. In the alternative, the MBE can request that the claimant revise and resubmit any planned home modification. If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a home modification, the MBE is to proceed with a referral for a referee examination. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving a conflict of medical opinion.

(d) Depending on the outcome of medical development, the MBE will proceed with adjudication of the claim. Once the medical necessity of a home modification is established by the weight of medical evidence, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity of a home modification, the MBE is to issue a recommended decision denying the claim.

c. MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a home modification to accommodate the claimant's inability to perform an activity of daily living, the MBE reviews competitive estimates, submitted by the claimant, to accomplish the proposed home modification. The claimant is responsible for producing valid, complete, and accurate, competitive estimates that reflect the work to be done to accommodate a medically necessary modification. Unless exceptional reasons exist that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the three estimates to determine if the scope of the requested modification(s) reasonably aligns with the information supplied in the physician's LMN. If necessary, the MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the proposals reflect a medically necessary accommodation of the claimant's needs and whether those modifications align with the treating physician's LMN. MBEs may also request input from nurse consultants regarding medically feasible options or alternatives for accommodating a medical need. If a claimant chooses to also have improvements outside the scope of medical necessity performed at the same time, the bids should provide a distinction between the medically necessary portion of the work and the personal improvements requested by the claimant.

(1) Comparing Competitive Estimates. The MBE examines the contractor estimates to determine whether the scope of the proposed home modifications aligns with the physician's opinion of medical necessity. Each bid must represent a proposal from a separate and distinct contractor, desiring to perform the medically necessary home modifications as spelled out in the LMN, which will serve to accommodate the claimant's medical need. Estimates must be similar in their description of the operations to be performed. Further, estimates must contain an itemization of the cost of materials and the associated labor charge for each operation performed. All estimates must reflect the use of construction materials comparable to the existing quality or grade of the structure to be modified. Unusual or exceptional circumstances associated with the requested modification must be clearly described in the estimate. The MBE is to undertake a careful comparative analysis to determine if each estimate represents a viable proposal for completing a cost-effective modification to the claimant's residence to accommodate an established medical need. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular contractor, or any other factors that relate to the requested modification.

(2) Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work detailed in the contractor bids is inconsistent with either the LMN or the existing grade and quality of the claimant's dwelling; or if viable alternative modification options exist, the MBE prepares a letter to the claimant. The letter should outline any deficiencies, and specifically describe the evidence needed from the claimant to support further assessment of the request. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to contact the claimant directly, to explain a problem, and describe the necessary steps for submission of needed evidence. In those instances in which the MBE issues a development letter to the claimant, the MBE allots 30 days for the submission of the necessary evidence. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15-day period provided, the MBE sends a second development letter providing an additional 15 days to submit the requested documentation. No further time will be granted for the submission of this documentation, unless extenuating circumstances exist and are documented.

(a) *Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary home modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.*

(b) *If a deficiency is found to exist, and the claimant is unable to overcome it, the MBE is to issue a recommended decision denying the request for home modification reimbursement. In the recommended decision, the MBE clearly explains the specific deficiencies in the evidence.*

(3) *Issuing Authorization Decisions. Upon reaching a decision to grant prior authorization of a reimbursement request, the MBE writes a detailed letter decision to the claimant advising of the approval. (Exhibit 29-4 provides a sample of the home modification approval letter.) In the letter, the MBE provides guidance to the claimant regarding the payment options available (as detailed in the exhibit letter) and requests that the claimant respond in writing, indicating the preferred payment option.*

d. *Retroactive Requests for Reimbursement. In those instances where a claimant did not request prior authorization from DEEOIC, and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide a LMN that is sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's residence. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.*

(1) *Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement of a home modification, the MBE must collect all available information from the claimant about the home modification that occurred. With the exception of requiring three estimates, the evidentiary requirements are no different from those previously outlined for prior authorization requests, and the burden of proving reasonableness of cost remains with the claimant. Supportive evidence could include diagrams, blueprints*

or floor plans, pictures, written descriptions, manufacturer and model number of appliances or fixtures, invoices, estimates, paid receipts, or other descriptive information. To the extent possible, the claimant must also document the pre-modification condition of the residence including photographic evidence and a description of preexisting structural grade and quality. In assessing a reimbursable amount, the MBE is to evaluate all the available evidence to ascertain only those materials and labor expenses that reasonably align with the cost of completing a medically necessary modification. The MBE must exclude any costs associated with materials and/or labor not necessary to complete the requisite home modification. Moreover, the MBE may calculate and deduct adjusted costs for any building materials or labor charges determined to exceed the pre-modification construction grade or quality of the residence. Once the MBE has conducted a thorough consideration of the available evidence and calculated the reasonably necessary cost required to accomplish the medically necessary modification (s), the MBE is to complete a memo to file, outlining in detail the analysis performed and calculations used in arriving at the reimbursable amount.

(2) Issuing a decision. Once the MBE has determined that reimbursement to the claimant is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE is unable to obtain evidence supporting reimbursement at the claimed amount, or if the MBE's calculation of allowable costs represents a figure that is less than the amount claimed, the MBE will issue a recommended decision. Within the content of the recommendation, the MBE is to provide a detailed accounting of the MBE's analysis of available evidence and how the MBE determined the reimbursable amount. This includes any reference materials or other tools utilized to calculate those costs that are attributable to modifying the claimant's residence at a cost comparable to the existing grade and quality of construction.

- **Chapter 32 – Coordinating State Workers' Compensation Benefits**
  - Chapter 32.4 has been edited to clarify the circumstances under which coordination is required as it relates to an election of employee benefits by a survivor. The language in v4.2 previously read:

4. <u>When Coordination is Required</u>. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary received benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, then determines who the beneficiary of the SWC benefits was before determining whether

coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is also asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.
Similarly, in cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits through the date of employee's death awarded to the survivor requires coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.
However, if the employee or the deceased employee's estate (considered same as the employee) receives SWC benefits for asbestosis and the accepted covered illness for which the survivor is entitled to Part E benefits is also asbestosis, the CE will not consider this claim for coordination (unless that survivor also received some form of SWC benefits for asbestosis, such as death benefits).

It has been updated in v4.3 to:

4. <u>When Coordination is Required</u>. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary receives benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, and then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.

Similarly, where there is an election to receive the employee's benefits by the survivor (refer to Chapter 20.12b for specific requirements for a survivor who elects to receive the employee's benefits rather than survivor benefits), coordination is required if the employee received SWC benefits for the same covered illness. Coordination is required because the survivor is taking the place of the employee in this situation. For example, if the employee received a SWC payment for asbestosis and the survivor elects to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the benefits payable to the survivor.
In cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits awarded to the survivor through the date of the employee's death are subject to coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.

- Chapter 32.5 has been edited to add a new exception to coordination of SWC benefits. The language in v4.2 previously read:

5. Exceptions. The following are exceptions to the coordination requirement. Review Exhibit 32-1 for additional scenarios and determination as to whether coordination is required.

a. Multiple illnesses. If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.

For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.

b. Covered illness. Because a "covered illness" is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a non-DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).

c. Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under $200.

If a waiver is to be granted, the CE prepares a memo to the file, approved by the DD, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.

d. Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.

It has been updated in v4.3 to:

5. Exceptions. The following are exceptions to the coordination requirement. Review Exhibit 32-1 for additional scenarios and determination as to whether coordination is required.

a. Multiple illnesses. If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising

out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.

For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.

b. Covered illness. Because a "covered illness" is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a non-DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).

c. Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under $200.

If a waiver is to be granted, the CE prepares a memo to the file, approved by the DD, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.

d. Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.

e. Survivor Claim. In a survivor claim (except as noted in Section 4), the CE does not coordinate even if the employee or the deceased employee's estate received SWC benefits based on the same covered illness as the survivor's Part E claim (unless that survivor also received some form of SWC benefits, such as death benefits). For example, if the employee received a SWC payment based on asbestosis and the survivor Part E claim was also based on asbestosis, the CE will not consider this claim for coordination because the survivor did not receive the SWC benefits.

Archived EEOCIPA Bulletins

Bulletin No.	Subject	Final Disposition
02-01	Modification Orders and ECMS Status Code Updates	Superseded by PM Ch. 27
02-02	DOL Verification of Employment at Certain Facilities	Superseded by PM Ch. 13
02-03	NIOSH Referral Summary	Superseded by PM Ch. 17
02-04	Rectal Cancer as a Specified Primary Cancer	Superseded by PM Ch. 14
02-05	Effect of Tort Suits Against Beryllium Vendors and AWEs on Eligibility for Compensation Under EEOICPA	Superseded by PM Ch. 30
02-06	Expanding Covered Timeframes for AWEs and Beryllium Vendors.	Superseded by PM Ch. 13
02-07	Covered Timeframes for the Eight Statutory Beryllium Vendors	Superseded by PM Ch. 13
02-08	Clarification of the Onset Period for Specified Cancers and the 250-day Employment Requirement at a GDP	Superseded by PM Ch. 14
02-09	Determination of 250 Workdays of Employment for EEOICPA Claimants	Superseded by PM Ch. 14
02-11	Updated ECMS - Release Notes (v.1.4.9.88)	Expired
02-12	Compensation Payment Process	Superseded by PM Ch. 32
02-13	Chronic Lymphocytic Leukemia (CLL) Cases	Superseded by Bulletin 12-01

Bulletin No.	Subject	Final Disposition
02-14	Requests for Employment Information From SSA	Superseded by PM Ch. 13
02-15	Chondrosarcoma of the Cricoid Cartilage of the Larynx as a Specified Primary Cancer	Superseded by PM Ch. 14
02-16	Ureter Cancer as a Specified Primary Cancer	Superseded by PM Ch. 14
02-17	New Interpretation in the Use of BAL BeLPT in diagnosing CBD	Superseded by PM Ch. 18
02-18	Interim Procedures for Obtaining Employment Verification Information From ORISE	Superseded by PM Ch. 13
02-19	Processing NIOSH Cases	Superseded by PM Ch. 17
02-20	Deducting Payments Received for Final Judgments or Settlements From EEOICPA Benefits	Superseded by Bulletin 05-04
02-22	Suspension Code for Marshall Islands Cases	Superseded by Bulletin 03-28
02-23	ECMS Closure Codes	Superseded by Bulletin 03-22
02-25	Telephone Management System (TMS)	Expired
02-26	Referrals to Dr. Lee Newman	Superseded by Bulletin 03-02
02-28	Tonsil Cancer as a Specified Primary Cancer	Superseded by PM Ch. 14
02-30	Reissue - Suspension Code for Marshall Islands Cases	Superseded by Bulletin 03-28

Bulletin No.	Subject	Final Disposition
02-34	Procedures for Using the On-Line ORISE Database	Superseded by PM Ch. 13
03-01	Medical Second Opinions	Superseded by PM Ch. 16
03-02	Referring Case Files to the DMC for Review.	Superseded by PM Ch. 16
03-03	Issues Concerning Cases Sent to NIOSH	Superseded by PM Ch. 17
03-04	RECA Indicator	Expired
03-05	Subcontractor Code	Expired
03-06	Claims Filed for Non-Covered Condition(s) and Claims Filed with No Reported Condition(s)	Expired
03-07	Employment Verification Codes	Expired
03-08	Diagnosed Cancer and Claimed Employment at a Beryllium Vendor	Superseded by PM Ch. 13
03-09	Travel Over 200 Miles Round Trip	Superseded by Bulletin 08-17
03-10	DOE Requests for DEEOIC Claimant Files	Superseded by Bulletin 03-19
03-11	Additional Cancers Considered as Primary Cancers	Superseded by PM Ch. 14
03-12	WS/WR Codes	Expired
03-13	Verifying Employment of Dupont Employees at the Hanford Nuclear	Superseded by PM Ch. 13

Bulletin No.	Subject	Final Disposition
	Weapons Site	
03-14	Revised use of Medical Condition Status Codes in ECMS.	Expired
03-16	Processing Cancellations of Lump-Sum Payments From the Department of Treasury in ECMS	Superseded by Bulletin 04-10
03-17	Implementation of Final Rule 20 CFR Part 30	Expired
03-18	Covered Facilities Update to the Federal Register	Expired
03-19	DOE Requests for DEEOIC Claimant Files.	Expired
03-20	Quality Control Checklists	Expired
03-21	Coverage of Uniformed Members of the Military	Superseded by PM Ch. 13
03-22	Reissue - ECMS Closure Codes	Expired
03-23	Review of Dose Reconstruction in the FAB Hearing Process	Superseded by PM Ch. 17
03-24	PoC Instructions for Certain Special Circumstances	Superseded by PM Ch. 17
03-25	Revised Employment Verification Sheet EE-5	Expired
03-26	Eligibility Status of an Employee of a Government Agency Who Can be Considered to be a "DOE Contractor Employee”	Superseded by PM Ch. 13

Bulletin No.	Subject	Final Disposition
03-27	Establishing Covered Subcontractor Employment	Superseded by PM Ch. 13
03-28	EEOICPA Coverage of Citizens of the Marshall Islands	Superseded by PM Ch. 13
03-29	Interim Procedures for Processing Claims for New Medical Conditions on Existing EEOICP Claims	Superseded by PM Ch. 11
03-30	Verifying Employment for Bechtel Power Corporation Employees at the Hanford Site	Superseded by PM Ch. 13
03-32	Clarification by NCI of Certain Primary Cancers	Superseded by PM Ch. 14
04-01	Instructions for Reworks of NIOSH Dose Reconstruction Reports	Superseded by PM Ch. 17
04-02	Case Transfer Sheet	Expired
04-03	Reopening Claims	Superseded by PM Ch. 27
04-04	Processing Electronic Applications	Superseded by PM Ch. 7
04-05	Medical Documents Received from the Medical Bill Pay Contractor	Superseded by PM Ch. 13
04-06	Employment Verifications Over 90 Days	Superseded by PM Ch. 13
04-07	Revised ECMS Employment Verification Coding	Expired
04-08	Revised Procedures for Deducting Judgement or Settlement Payments	Superseded by Bulletin 05-04

Bulletin No.	Subject	Final Disposition
04-09	Center to Protect Workers' Rights (CPWR)	Superseded by Bulletin 06-09
04-10	Processing Cancellations of Lump-Sum Payments	Superseded by PM Ch. 32
04-11	The Use of Reason Codes for the 'DE' and 'NR' Claim Status Codes in ECMS	Expired
04-12	Eligibility of Employees of Wholly-Owned Subsidiaries of AWEs for Benefits Under the EEOICPA	Superseded by PM Ch. 13
05-01	Administration of Part E of EEOICPA in the Period Prior to the Effective Date of Interim Final Regulations	Expired
05-02	Processing Residual Contamination Site Claims	Superseded by PM Ch. 13
05-03	Mallincrodt SEC Class (1942-1948)	Superseded by Bulletin 06-03
05-04	Procedures for Deducting Payments Received for Final Judgments or Settlements from EEOICPA Benefits under Part B and/or new Part E	Superseded by Bulletin 07-10
05-05	Resource Center Procedures	Superseded by PM Ch. 10
05-07	ECMS Procedures Related to Co-Located FAB	Expired
06-01	Issuing Multiple Payments to the Same Payee in ECMS E	Expired
06-02	Director's Order-Delegation of Signature Authority	Superseded by PM Ch. 27
06-04	SEC for Y-12, 1943 – 1947, and IAAP Radiographers, 1948 - 1949	Subsumed by Bulletin 08-41

Bulletin No.	Subject	Final Disposition
06-07	Potential Eligibility of RECA Section 4 Compensation Under Part E	Superseded by PM Ch. 19
06-08	Establishing Causation for Specific Medical Conditions Under the EEOICPA	Superseded by Bulletin 06-13
06-09	Center to Protect Workers' Rights (CPWR)	Superseded by PM Ch. 13
06-10	Illnesses That Presently Have No Known Causal Link to Toxic Substances	Superseded by Bulletin 06-14
06-11	Supplemental Guidance for Processing Claims for the SEC Class for the Y-12 Plant, March 1943 – December 1947	Subsumed by Bulletin 08-41
06-12	Evaluating Permanent Impairment to the Breast (Male or Female)	Superseded by PM Ch. 21
06-13	Establishing Causation for Specific Medical Conditions Under the EEOICPA	Superseded by PM Ch. 15
06-14	Illnesses That Presently Have No Known Causal Link to Toxic Substances Under the EEOICPA	Superseded by Bulletin 08-38
07-01	Ames Laboratory SEC Class, January 1, 1942 - December 31, 1954	Subsumed by Circular 12-03
07-02	Amended Procedures for Coordinating EEOICPA Part E Benefits With Payments Received Under a SWC Program for the Same Covered Illness	Superseded by PM Ch. 31
07-03	De-listing National Bureau of Standards (NBS) – Van Ness Street (DC), Picatinny Arsenal (Dover, NJ), Seneca Army Depot (Romulus, NY), and	Expired

Bulletin No.	Subject	Final Disposition
	Frankford Arsenal (Philadelphia, PA) as AWEs	
07-06	Educating Claimants on Impairment and/or Wage-Loss Benefits	Expired
07-07	Procedures for Rating Impairment for Mental Disorders Under Part E	Superseded by PM Ch. 21
07-10	Procedures for Deducting Payments Received for Final Judgments or Settlements from EEOICPA Benefits under Part B and/or new Part E	Superseded by Bulletin 07-12
07-11	New SEC Class for Covered Employees With Exposure to Radioactive Lanthanum (RaLa) at Work Locations Within LANL; September 1, 1944 – July 18, 1963	Subsumed by Bulletin 10-22
07-12	Procedures for Deducting Payments Received for Final Judgments or Settlements from EEOICPA Benefits under Part B and/or new Part E	Superseded by PM Ch. 30
07-13	Implementing NIOSH December 2006 Report	Superseded by PM Ch. 13
07-14	Fee Schedule Appeal Process (Medical Bill Pay)	Superseded by PM Ch. 28
07-15	Allied Chemical Corporation Plant SEC Class; January 1, 1969 – December 31, 1976	Superseded by Bulletin 08-22
07-17	General Atomics SEC Class; January 1, 1960 – December 31, 1969	Subsumed by Circular 15-02
07-18	New SEC Class for Monsanto Chemical Company in Dayton, OH; January 1, 1943 – December 31, 1949	Expired (De-Listed as AWE on 2/6/2012)

Bulletin No.	Subject	Final Disposition
07-19	NIOSH PER for Evaluation of Highly Insoluble Plutonium Compounds	Expired
07-20	Authorizing In-Home Health Care	Superseded by Bulletin 08-09
07-21	NIOSH PER for Lymphoma	Expired
07-22	Authorizing In-Home Health Care, Specically Billing Codes and Usage of Billing Codes for HHAs and CNAs	Superseded by Bulletin 08-09
07-23	New SEC Class for covered employees of LANL; March 15, 1943 through December 31, 1975	Subsumed by Bulletin 10-22
07-26	Supplemental Guidance for Additional Cases Affected by NIOSH PER for Lymphoma	Expired
07-27	Supplement to OCAS-PER-012, Evaluation of Highly Insoluble Plutonium Compounds	Expired
07-28	NIOSH PER for the Paducah GDP	Expired
07-29	NIOSH PER for Mallinckrodt and Blockson Chemical Company's TBD Revision	Expired
08-01	Rocky Flats SEC Designations	Subsumed by Circular 14-05
08-02	Supplemental Guidance on Processing Cases Affected by OCAS-PER-012 “Evaluation of Highly Insoluble Plutonium Compounds	Expired

Bulletin No.	Subject	Final Disposition
08-03	SEC Class Designation for the Early Years at Hanford Engineer Works	Subsumed by Bulletin 10-04
08-04	NIOSH PER-017, Evaluation of Incomplete Internal Dosimetry Records from Idaho, Argonne East and Argonne West National Laboratories	Expired
08-05	NIOSH's PER-018, Los Alamos National Laboratory TBD Revision	Expired
08-06	SEC Class Designation for Wilhelm Hall Renovation Workers Ames Laboratory	Subsumed by Circular 12-03
08-08	SEC Class for Covered Employees of LANL; March 15, 1943 December 31, 1975	Subsumed by Bulletin 10-22
08-09	Authorizing In-Home Health Care	Superseded by PM Ch. 36
08-10	NIOSH's PEP for Construction Trade Workers	Superseded by Bulletin 08-31
08-11	New Coding Instructions for Cases Reviewed Under a New SEC or PEP/PER	Expired
08-13	NIOSH PER-016, Implementation of IREP Procedures for Claims Near 50% POC	Expired
08-15	Part E Claims for Parkinsonism and Parkinson's Disease (PD)	Superseded by PM Exhibit 15-4
08-16	NIOSH PER-016, Implementation of IREP Procedures for Claims Near 50% POC	Expired

Bulletin No.	Subject	Final Disposition
08-18	NIOSH Coding in ECMS E	Expired
08-20	Lawrence Livermore National Laboratory (LLNL) SEC Class From January 1, 1950, through December 31, 1973	Subsumed by Bulletin 10-12
08-22	SEC Coding	Expired
08-24	NIOSH PER, Chapman Valve, Argonne National Laboratory – West, General Steel Industries, and the Huntington Pilot Plant (Reduction Pilot Plant)	Expired
08-25	NIOSH OCAS-PER-011, K-25 TBD and TIB Revisions	Expired
08-26	NIOSH OCAS-PER-029, Hanford/ PNNL	Expired
08-27	OCAS-PER-027, Clarksville	Expired
08-28	OCAS-PER-026, Pantex and OCAS-PER-028, Pinellas	Expired
08-29	OCAS-PER-031, Y-12	Expired
08-30	OCAS-PER-012, Super S	Expired
08-31	OCAS-PER-014, Construction Trade Workers	Expired
08-32	NIOSH PER-030, Savannah River and & PER-032 Nevada Test Site	Expired
08-33	Additional Hanford SEC Class	Subsumed by Bulletin 10-04

Bulletin No.	Subject	Final Disposition
08-38	Rescinding Bulletins 06-10 and 06-14	Superseded by PM Ch. 15
08-39	Privacy Act - Personally Identifiable Information (PII)	Superseded by PM Ch. 6
08-40	Processing Cases With a Recommended Decision Pending at FAB in Excess of One Year	Superseded by PM Ch. 25
09-01	Delegating the Reopening of Claims with New Evidence	Superseded by PM Ch. 27
09-02	Subcontractor Database for Verification of Contractual Relationship at Covered Facilities	Superseded by PM Ch. 13
09-04	"LNR" Coding in ECMS for ICEs Related to OCAS-PER-016, IREP Procedures and OCAS-PER-018, LANL	Expired
09-05	Processing Claims for End-Stage Terminally Ill Claimants	Superseded by PM Ch. 11
09-06	Obtaining Signed Responses on State Workers' Compensation Claims, Lawsuits and Fraud	Superseded by PM Ch. 30 and PM Ch. 31
09-10	Processing Social Security Administration Form SSA-581	Superseded by Bulletin 15-01
10-08	Laryngeal Cancer and Solitary Plasmacytoma as Specified Cancers	Superseded by PM Ch. 14
10-15	EM Quality Assurance Plan	Superseded by Bulletin 13-02
11-02	Ames Laboratory SEC Class (January 1, 1955 - December 31, 1960)	Subsumed by Circular 12-03

Bulletin No.	Subject	Final Disposition
11-08	Guidance for Using the Colorado Department of Public Health and Environment (CDPHE) Database (Ruttenber Database)	Superseded by Circular 14-05
12-02	Implementing NIOSH August 2011 Report	Expired
13-01	Authorizing Massage Therapy	Superseded by PM Ch. 29
13-03	Authorizing Durable Medical Equipment	Superseded by PM Ch. 29
13-04	OWCP Imaging System	Expired
14-01	National Instant Criminal Background Check System (NICS) Improvement Amendments Act of 2007 (NIAA).	Superseded by PM Ch. 8
14-02	Renewed EEOICPA Forms	Expired
14-04	Authorized Representatives Conflict of Interest	Superseded by PM Ch. 36
14-06	Authorization Adjustments for Home Health Care	Superseded by PM Ch. 36
15-01	New Guidance for Expedited Processing Form SSA-581	Superseded by PM Ch. 13
15-02	Authorizing Oxygen Therapy DME and Oxygen Medical Supplies	Superseded by PM Ch. 29
15-03	Transition to the ICD-10-CM Coding System	Superseded by PM Ch. 28
16-01	Criteria for Establishing Caustion for Asthma Claims Under Part E of the EEOICPA	Superseded by PM Ch. 15

Bulletin No.	Subject	Final Disposition
16-02	Presumptions Available for Accepting COPD under Part E of the EEOICPA	Superseded by PM Ch. 15
16-03	Instructions for Use of the Direct Disease Linked Work Processes (DDLWP) in SEM under Part E of the EEOICPA	Superseded by PM Ch. 15
17-01	Processing Part E Survivor Election of Benefits Claims.	Superseded by PM Ch. 20
17-02	Prior Authorization Required for Enteral Formula	Superseded by PM Ch. 29
18-01	Rehabilitative Therapy	Superseded by PM Ch. 29
19-04	Updated Exhibit to Federal (EEOICPA) PM Ch. 26 –FAB Decisions	Superseded by PM Ch. 26
19-05	Updated Exhibits to Federal (EEOICPA) PM Chapters 35 and 36	Superseded by PM Ch. 35 & 36
20-01	Update to Federal (EEOICPA) PM Chapters 2, 28 and 29	Superseded by PM Ch. 2, 28 & 29
20-02	Updated Exhibit to Federal (EEOICPA) PM Chapter 15, Exhibit 15-4	Superseded by PM Ch. 15, Exhibit 15-4

Archived EEOICPA Circulars

Circular No.	Subject	Final Disposition
07-01	DOE Facility Description of Line 1 (Division B) at the Iowa Ordnance Plant	Superseded by Circular 07-03
08-07	Presumption of CBD in Situations With a Diagnosis of Sarcoidosis and History of Beryllium Exposure	Superseded by Circular 15-01
08-08	Clarification of the Term "Child" as Defined under the EEOICPA	Superseded by PM Ch. 20
10-04	Ionizing Radiation Health Effects Under Part E	Superseded by PM Ch. 15
12-13	(1) Sarcoma of the Lung is a Specified Cancer (2) When Cancer of the Fallopian Tubes is Considered to be Ovarian Cancer, Which is a Specified Cancer	Superseded by PM Ch. 14
13-06	Review of Denied Bladder Cancer Cases Under Part E	Superseded by PM Ch. 15
13-12	Review of Denied Ovarian Cancer Cases under Part E	Superseded by PM Ch. 15
15-04	Review of Cases Involving Exposure to TCE and the Development of Kidney Cancer	Superseded by PM Ch. 15
15-05	Occupational Exposure Guidance Relating to Asbestos	Superseded by PM Ch. 15
15-06	Post 1995 Occupational Toxic Exposure Guidance	Superseded by Circular 17-04

Circular No.	Subject	Final Disposition
17-06	Updating SSA Fax Number	Superseded by PM Ch. 13
18-01	Idiopathic Disease Diagnosis	Superseded by PM Ch. 18
19-03	Targeted Case Management	Superseded by PM Ch. 30