



RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE  
INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL:  
CHAPTER 2-2000 ECMS - GENERAL, and CHAPTER 2-2100 ECMS -  
DECISIONS.

EEOICPA TRANSMITTAL NO. 10-06

November, 2009

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the text of EEOICPA Part B Procedure Manual (PM) 2-1500 Energy Case Management System in its entirety, and all portions of the Part E PM relating to ECMS coding. This material is to be placed in the new Unified PM binder and is intended to stand as policy guidance for both Parts of the EEOICPA.

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Replace Federal (EEOICPA) Procedure Manual Chapter 2-1500, and portions of the Part E Procedure Manual with this transmittal and Chapters 2-2000 and 2-2100.

Distribution: List No. 3: All DEEOIC Employees  
List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

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1. Purpose and Scope. This chapter describes in general how to use the Energy Case Management System (ECMS). It focuses on the early and developmental stages of a claim. Codes for decisions rendered by the District Offices (DOs), Secondary Claims Examiner (CE2) Unit, and the Final Adjudication Branch (FAB) are addressed in EEOICPA PM 2-2100. The information in this chapter applies to both ECMS B and ECMS E unless otherwise indicated.

2. ECMS Components.

a. Case Information Screen. The Case Information screen is used to maintain core employee-related personal information from Form EE-1 and Form EE-2. Also included on this screen are CE assignment, case and DO locations, both current and historical.

b. Work Site Screen. The Work Site screen is accessed through the case screen and is used to enter and update data on all relevant work sites reported for an employee. This data is found on Form EE-3 (Employment History), and also includes any new worksites discovered throughout development of the case.

c. Claim Screen. The Claim screen is used to maintain individual claim (including employee and/or survivor) relevant information for each claim filed. This includes filing, receipt and creation date in ECMS, as well as a record of actions made for a claimant during the adjudication process in the claim status history. The Special Exposure Cohort (SEC), medical conditions, and payee information are all accessed through this screen.

d. Claim Status History Screen. The Claim Status History screen is used to enter codes for events taking place during adjudication. Claim Status History displays the actions that have taken place and the date of each action.

e. Medical Condition Screen. The Medical Condition screen is used to enter medical conditions reported for each case/claim. All conditions are updated throughout the development process with relevant information, such as ICD-9 codes, condition status, PoC information, medical status effective dates, and diagnosis dates.

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## 2. ECMS Components. (Continued)

f. SEC/SEC Desc Screen (ECMS B only). The SEC/SEC Desc screen is used to enter and update SEC data reported on Form EE-1, Form EE-2, and/or Form EE-3.

If it is claimed that an employee worked at an SEC facility, that SEC ID is entered in this field. This field records that an SEC facility has been claimed, not that it has been verified.

If SEC is marked on the claim form, and no SEC site is listed on the EE-3, use the 'unspecified' in the SEC description field.

g. Payees Screen. The Payee screen is used to enter payee information from Forms EE-1 and EE-2. This screen is updated as payees become eligible or ineligible for compensation. Upon eligibility, updated Electronic Funds Transfer (EFT) or payment mailing information is added.

3. Receipt of Claim in District Office. Case Create procedures are covered in EEOICPA PM 1-300. When a claim is received in the DO, the Case Create Clerk (CCC) enters the data into ECMS. The fields are completed as follows:

a. General case assignment information entered by the CCC.

(1) CE name. From the list box, the CCC selects the responsible CE, based on internal DO procedures.

(2) Location. From the list box, the CCC selects the location of the Responsible CE. The location codes are unique for each individual in a DO and are assigned by the DO

b. Form EE-1/2. The CCC enters the following fields directly from Form EE-1/2:

(1) Employee SSN, Name, and Address.

(2) Survivor Information (if applicable). This includes survivor name, sex (M-Male or F-Female), SSN, date of birth, relationship to the deceased, address, and telephone number(s).

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3. Receipt of Claim in District Office. (Continued)

(3) Employee Census Information. This includes Date of Birth, Date of Death (if applicable), Sex (M-Male or F-Female), Autopsy Indicator (if applicable), and Autopsy Facility 'Y' for Yes (if applicable).

(4) Employee Dependents (if applicable). 'Y' for Yes or 'N' for No is selected for spouse, child, or other.

(5) Employment Classification. If any field (DOE, Atomic, Beryllium, Uranium, Other) is checked on the claim form (Form EE-1/2 prior to April 2005, Form EE-3 for April 2005 or after), then the appropriate field(s) must contain a 'Y' for Yes on this screen. If a field is not checked on the claim form, the following are acceptable: '-', 'N'.

(6) Filed dt. The date the claimant sends Form EE-1/2. This is the earliest of the following: postmark date or date stamp in the Resource Center or DO (but not earlier than July 31, 2001 for Part B or October 30, 2000 for Part E). The envelope must be kept with the claim form and put in the case file.

(7) Rcvd dt. The actual date the DO receives Form EE-1/2, as shown by date stamp.

(8) Signature dt. The date the claimant signed Form EE-1/2, but not earlier than October 30, 2000.

(9) Recvd RECA ind. For the questions "Have you (or the deceased employee) applied for an award under Section 4 of the Radiation Exposure Compensation Act (RECA)?" and "Have you (or the deceased employee) applied for an award under Section 5 of the Radiation Exposure Compensation Act (RECA)?" the CCC selects 'Y' if the "YES" box is checked on either question, or 'N' if the "NO" box is checked on both questions. If neither box is checked, the CCC leaves the indicator blank.

(10) Civil lawsuit ind. For the questions "Have you (or the deceased employee) filed a lawsuit seeking either money or medical coverage for the above claimed condition(s)?" and "Have you (or the deceased

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### 3. Receipt of Claim in District Office. (Continued)

employee) filed any workers' compensation claims in connection with the above claimed condition(s)?" and "Have you or another person received a settlement or other award in connection with a lawsuit or workers' compensation claim for the above claimed condition?" the CCC selects 'Y - SWC Checked Yes on Claim' if the "YES" box is checked on the claim form for either question, or 'N - SWC Checked No on Claim' if the "NO" box is checked. If neither box is checked, the CCC leaves the indicator blank.

b. Worksite. The CCC enters all relevant worksite information directly from the claimant's Form EE-3. This includes all potentially covered worksites and any contractor/subcontractor employment that either is or could possibly be directly related to Department of Energy (DOE) employment. The criterion is whether the CE must gather employment verification for that worksite.

If the CCC is unsure as to whether to enter a worksite, the CCC references the DOE Facility List, or seeks further guidance from a supervisor. If the CCC determines that a worksite might be a contractor or subcontractor, but the DOE facility to which the worksite is connected is undetermined, that worksite is entered with the worksite ID '0998 - Not specific in DOE table', and the contractor/subcontractor name listed out in the 'Notes' field.

The following information for each worksite comes directly from Form EE-3:

(1) Position Title. This field matches the 'Position Title or Mine/Mill Activity' from Form EE-3.

(2) Work Start Dt. This date matches the 'Start Date' field on Form EE-3. The CCC enters the exact date entered on the form, unless the date is partially written. If the month or date is missing, the CCC enters '01/01' as the placeholder. For example, if the form shows 1969, the CCC enters 01/01/1969. If the date is left blank on Form EE-3, the CCC leaves the date blank.

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### 3. Receipt of Claim in District Office. (Continued)

(3) Work End Dt. This date matches the 'End Date' field on Form EE-3. The CCC enters the exact date shown on the form, unless the date is partially written. If the month or date is missing, the CCC enters '12/31' as the placeholder. For example, if the form shows 1969, the CCC enters 12/31/1969. If the date is left blank on Form EE-3, the CCC leaves the date blank in ECMS.

(4) Note. If the CCC enters the Worksite Desc field with the worksite ID for '0998 - Not specific in DOE table', then the contractor/subcontractor name is listed out in the 'Notes' field. Also, if there are several consecutive dates of employment at the same worksite with different contractors/ subcontractors, this can be entered under one worksite entry with the various dates and contractors/subcontractors listed out in the notes field.

(5) Dosim Badge Ind. The CCC completes this field with a 'Y' for Yes, 'N' for No, or leaves it blank based on the answer to the question "Was a dosimetry badge worn while employed?" on the Form EE-3.

(6) Badge No. If a badge number is provided on the Form EE-3, the CCC enters it in this field.

c. Medical Conditions. All reported conditions on Form EE-1/2 must be entered. If there are multiple claimants on a case and they claim different illnesses, generally all claimed illnesses must be entered for all claimants. The exception to this is when an employee files and then dies and the survivor claims something different or if a survivor specifically is not claiming an illness because he or she may have received a state workers' compensation or tort settlement. See EEOICPA PM 1-300 as to whether medical conditions should be entered into ECMS B, ECMS E, or both. The CCC looks at all the conditions claimed on Form EE-1 (Box 8) or Form EE-2 (Box 14) and matches each condition with a code from the list box in the Cond Type field on the Medical Condition Screen.

3. Receipt of Claim in District Office. (Continued)

(1) If the claimant lists an occupational illness under Part B, each condition must be entered individually in the Cond Type field.

CODE	Covered Medical Condition Types
BD	Chronic Beryllium Disease
BS	Beryllium Sensitivity
CN	Cancer
CS	Chronic Silicosis
OL	Other Lung Conditions (Covered for RECA Only)
MT	Metastatic Cancer (Secondary cancers)

(2) For all cancer ('CN') and other lung ('OL') conditions, the CCC enters the specific type of cancer or lung condition reported on the claim form in the Notes text field.

(3) If the case is "B Only", and the claimant lists a non-covered condition, each non-covered condition must be entered individually in the Cond Type field in ECMS B. The CCC selects from the list box any conditions shown on the claim form.

For example, if the illness claimed is hearing loss, the CCC selects 'HL' from the list box in the Cond Type field on the Medical Condition screen. No further explanation is required in the Notes Text field, since the condition type indicates the condition reported.

(4) The CCC selects '99' (Other Condition - not in table) from the list box if the reported condition does not appear in the list box. He or she also types the reported condition in the Note Text field as it appears on the claim form.

For example, if the condition cuts/bruises is reported on the claim form, the CCC selects 99 from the list box and in the Note section types "cuts/bruises."

If the claimant lists multiple non-covered conditions which are not in the list box, the conditions can be listed under one '99' condition type, although each

3. Receipt of Claim in District Office. (Continued)

individual condition must be listed in the Note Text field.

(5) If no condition is reported on Form EE-1/2, the CCC selects 'NR' from the list box.

CODE	Non-Covered Medical Condition Types for Part B
99	Other Condition - not listed in table
AN	Anemia
AS	Asbestosis
BK	Back or Neck problems
BT	Benign Tumors, Polyps, Skin Spots
BU	Burns
CL	CLL (Chronic Lymphocytic Leukemia)
CT	Cataracts
DI	Diabetes
HF	Heart Failure/ Heart Attacks/Hypertension
HL	Hearing Loss
HM	Other Heavy Metal Poisoning (e.g. chromium, cadmium, arsenic, lead, uranium, thorium, and plutonium)
MC	Multiple Chemical Sensitivity
MP	Mercury Poisoning
NE	Neurological Disorder
NR	No condition reported
OL	Other Lung Conditions: Bronchitis; Asthma; Pulmonary Edema (Considered covered only for RECA claims)
PD	COPD (Chronic Obstructive Pulmonary Disease); Emphysema
PK	Parkinson's Disease
PL	Pre-Leukemia
PP	Pleural Plaques
PS	Psychological Conditions
RN	Renal Conditions (kidney failure, kidney stones)
TH	Thyroid Conditions (e.g. Hypothyroidism)

4. General ECMS Coding. Each development action taken requires a claim status code entry. It is necessary to enter the claim status code only in the specific system, B or E, to which the development action pertains.

- a. Part B Only. For these claims, all claim status coding is entered directly into ECMS B.
- b. Part E Only. For these claims, all claim status coding is entered directly into ECMS E.
- c. Part B/E Claims, Both Active. Where Part B and Part E are both still active (i.e., both are currently in development), all development actions (i.e., employment verification, medical or survivorship development) must be entered into both ECMS Part B and ECMS Part E if they apply to both.

For example, upon receiving a Form EE-5 back from DOE, the 'ER' code is necessary in BOTH systems. Since the case is B/E, the code is entered in ECMS B and ECMS E.

Note: Some ECMS entries (coding for Document Acquisition Request (DAR), Former Worker Protection (FWP) requests, Site Exposure Matrices (SEM) usually pertain to Part E development and are usually entered in ECMS E only. However, there are circumstances where DARs, FWP requests, and SEM searches are completed relevant to the development of the Part B case, such as placing an employee on Line 1. In these types of circumstances these usual E only codes can be entered in ECMS B.

- d. Part E/B Claims, Only One Part Active. Where just one part is currently active (i.e., a final decision was issued previously in the B part of the claim, and the only part in development is Part E, or vice versa), development actions will be entered only in the system that corresponds to the currently active Part.

(1) To limit the number of key strokes and ensure that cases are keyed to the same location and transferred at the same time, some information on the first screen is shared between ECMS B and ECMS E. Case information, in addition to case notes and call ups, that automatically transfer between the two systems include:

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#### 4. General ECMS Coding. (Continued)

- CE
- CE Assign Dt
- Dist Office
- Location
- Location Assign Dt
- Employee Name and Address fields
- Worksite fields

(2) However, when different medical conditions are claimed under Parts B and E, the development code is entered only in the relevant part.

For example, if cancer is claimed under Parts B and E, and asbestosis only is claimed under Part E, and a development letter is sent to the claimant requesting additional medical evidence for the Asbestosis claim, the 'DM' code is entered in ECMS E only.

5. Development of a Claim. Although the CCC enters certain data elements from EEOICPA forms, the CE verifies all data entered. The CE is also responsible for updating all data elements throughout the adjudication process.

a. Worksite/Employment Verification. The CE confirms that ECMS correctly identifies all relevant worksite information listed on the Form EE-3, and is responsible for updating the employment information throughout the claims process.

The CE keeps ECMS updated with the latest worksite information in the case file. If claimed employment dates are different than what is ultimately verified, the claimed employment dates are overwritten. Claimed employment that cannot be verified should be removed. If new worksites are verified or claimed, the CE inputs the new worksite information into ECMS. At the time of recommended decision, only verified employment should remain in the worksite section on the case screen.

Upon receipt of an employment verification (DOE, Corporate Verifier, SSA response, Other), the CE updates the following fields with as much information as possible from the verifier. (Note: Each worksite time period could

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## 5. Development of a Claim. (Continued)

possibly be verified from multiple sources. Therefore, if multiple verification sources are used to verify a single timeframe, be sure to enter the overall employment timeframe that is considered verified.)

(1) Covered Emp Ind - This field (located on the case screen) must be completed by the time of the Recommended Decision (RD).

If the CE determines that the employee has covered employment under the EEOICPA, the field must be 'Y' for Yes.

If the CE determines that the employee does not have covered employment, the field must be 'N' for No. (As long as any employment is verified, this field will become 'Y' for Yes.)

(2) Cov Emp Start Dt and Cov Emp End Dt - This field was created with the assumption that employment would be continuous, which is not always the case. Completion of this field is optional.

(3) Worksite Desc - The worksite can be selected by clicking on the 'worksite' button and entering a DOE facility name in the 'worksite description' line and pressing the 'Select' button. If the exact name in the table is unknown, enter at least the first letter of the facility name, and select 'Look Up' to see a list of facilities that meet the search criteria.

If the facility is listed, highlight the correct choice and select the 'OK' button. The worksite can also be added by entering the worksite description number, if known, directly in the blank field next to the 'worksite' button.

If the CE determines that an employer might be a contractor or subcontractor, but it is undetermined where employment occurred, the worksite is entered with the worksite ID '0998 - Not specific in DOE table', and the contractor/ subcontractor name listed out in the 'Notes' field.

5. Development of a Claim. (Continued)

(4) Position Title - If the job title appears differently on the verification document received (Department of Energy (DOE), Corporate Verifier, Social Security Administration (SSA) response, other) than it was listed on Form EE-3, the CE updates the field to reflect the verification document.

(5) Work Start Dt - The 'Work Start Dt' must match the 'From' or 'Start' date per the employer on the verification document received (DOE, Corporate Verifier, SSA response, Other).

(6) Work End Dt - The 'Work End Dt' must match the 'To' or 'End' date on the verification document received (DOE, Corporate Verifier, SSA response, other). If the person is currently still working at the facility being verified, the CE enters the date the verification document was signed by the certifying official as the 'To Dt'.

(7) Note - This field is used at the CE's discretion. However, if the CE identifies that the employee worked for either a contractor or subcontractor, the CE enters the contractor/subcontractor name in this field.

b. RECA Indicator. The RECA Indicator shows whether the Department of Justice (DOJ) confirmed that the claimant or deceased employee received benefits under the Radiation Exposure Compensation Act (RECA). The RECA indicator must be entered on all EEOICPA cases. The CCC enters 'Y' for Yes or 'N' for No, based on what was checked on Form EE-1/2. This includes RECA and non-RECA cases in all four DOs.

(1) The following are entered directly from Form EE-1/2:

(a) 'Y' - Yes - The claimant checked the Y box(es) indicating that he or she or the deceased employee applied for an award under Section 4 or 5 of the RECA.

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5. Development of a Claim. (Continued)

(b) 'N' - No - The claimant checked the N box(es) indicating that he or she or the deceased employee did not apply for an award under Section 4 or 5 of the RECA.

(2) If the CE determines, after reviewing the claim, that it may be a RECA claim filed by a uranium worker or a survivor of a uranium worker, the CE leaves the RECA Indicator (Y/N) blank, or as entered by the CCC, until confirmation is received from DOJ. After a confirmation letter is received from DOJ, the CE inputs one of the following RECA Indicator codes:

(a) '4' - Used when the employee or RECA survivor is confirmed as a RECA Section 4 award recipient.

(b) '5' - Used when the employee or RECA survivor is confirmed as a RECA Section 5 award recipient.

(c) 'X' - The claim is non-RECA. The CE may enter the X indicator at any time to confirm his or her determination that the case is non-RECA. That is, an X entry is not tied solely to receipt of a letter from DOJ that confirms non-RECA status. The X is also used if there is a confirmed RECA Section 4 eligibility where the claimant has opted not to accept the award.

c. State Workers' Compensation (SWC) Indicator (EMCS E Only). This field reflects what is currently known about the status of any state workers' compensation claims.

(1) The following are entered directly from Form EE-1 or EE-2:

(a) 'Y - SWC Checked Yes on Claim' - The claimant checked the Yes box on Form EE-1/2, indicating that the employee/claimant filed a state workers' compensation claim.

(b) 'N - SWC Checked No on Claim' - The claimant checked the No box on Form EE-1/2, indicating

5. Development of a Claim. (Continued)

that the employee/claimant has not filed a state workers' compensation claim.

(2) During development, the CE/Hearing Representative (HR) updates this field to reflect the current status of the employee/claimant's state workers' compensation claim. The State Workers' Compensation Indicator must be entered on all Part E cases, even if no SWC claim was filed.

(a) 'X - Confirmed No SWC Claim' - Used when the employee/claimant is determined to have not filed a state workers' compensation claim.

(b) 'R - Benefits Rec'd; Reduce Comp' - Used when the employee/claimant is determined to have received benefits from state workers' compensation for an accepted Part E medical condition where compensation benefits must be reduced.

(c) 'S - SWC; No Reduce Comp' - Used when the employee/claimant is determined to have state workers' compensation, but there is no reduction in benefits required. This code is also used in the case of a denied SWC claim where the employee received no benefits.

(d) 'P - SWC Pending' - Used when the employee/claimant is determined to have a state workers' compensation claim that is currently pending.

(3) Once the existence of a SWC claim is verified, the CE accesses the 'SWC State' drop-down box and selects the state in which the SWC claim was filed (e.g., 'OH' if the claim was filed in the State of Ohio).

d. SEC Description. If the employee claims to have worked at an SEC worksite, the CCC or CE must identify the worksite in the SEC description field. As new SECs are added, ECMS is updated with the additional SEC facilities and active claims are updated accordingly.

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## 5. Development of a Claim. (Continued)

The SEC can be selected either by clicking on the 'SEC' button and selecting the SEC facility, or by entering the SEC description number directly in the blank field next to the 'SEC' button. This field records that an SEC facility has been claimed, not that it has been verified.

e. Employment Classifications. As discussed in Paragraph 3.b, if any field (DOE, Atomic, Beryllium, Uranium, Other) is checked on the claim form (Form EE-1/2 prior to April 2005, Form EE-3 for April 2005 or after), then the appropriate field(s) must contain a 'Y' for Yes on this screen. If a field is not checked on the claim form, the following are acceptable: '-', 'N'.

These fields are initially completed when the case is created and they are NOT tied to any employment verification received back from any source.

For example, if a claimant checks "Atomic Weapons Facility" on the claim form, this field should be changed to 'Y'. If it turns out the employee did not work at an AWE, or employment was not verified at an AWE, this field does not need to be updated to reflect that lack of employment.

However, the CE must update these fields in certain circumstances to reflect something other than 'Y', '-', or 'N'. These circumstances are outlined below.

(1) Since there is no "Subcontractor" field in ECMS, if the CE determines that an employee could have worked for a subcontractor at a DOE facility, he or she must update the 'DOE' field with an 'S'.

(a) If Form EE-3 or another type of employment documentation (e.g., affidavit) shows that the employee worked for a private employer at a DOE facility (e.g., Joe's Electric Company at Hanford), and the CE determines that a reasonable link exists between the employer (a subcontractor) and a DOE facility, the CE identifies the case as one with a subcontractor.

To do this, the CE selects 'S' (a subcontractor at a DOE facility has been identified) from the DOE list box in the Employment Classifications

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5. Development of a Claim. (Continued)

Field, Case Screen. The 'S' code permanently replaces the 'Y' code in the DOE list box.

(b) After entering the 'S' code, the CE continues to develop the employment aspect of the claim to determine whether employment can be verified with a DOE subcontractor. If the CE determines that the employee did not work for a verified subcontractor at a DOE facility, the 'S' code remains in the DOE list box (Employment Classifications Field, Case Screen).

For the 'S' code to be used, employment with a subcontractor at a DOE facility need not be confirmed, but there must be evidence that such employment was claimed.

(c) The CE enters the 'S' code only once regardless of whether the employee worked for one or multiple DOE subcontractors.

(2) If the CE reviews claimed AWE employment and determines that the period is entirely outside of the weapons-related production period and either partially (meaning partially during the residual contamination period and partially after the residual contamination/non-covered period) or entirely during the site's period of residual radioactive contamination, the CE enters an 'R' into the AWE worksite indicator field. The 'R' represents that employment at an AWE site is qualifying solely on the basis of residual contamination.

This code has not always been in existence and must be backfilled for prior claims as encountered. If employment at multiple AWE sites is claimed and at least one such site's qualifying employment is solely due to residual radiation, utilize the 'R' code.

f. Claim Status History Coding. Generally, for every development action taken by the CE, there is a corresponding claim status history code to document that action. And for every claim status code, there must be

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## 5. Development of a Claim. (Continued)

corresponding file documentation. See Paragraph 6 below for detailed instructions for claim status history coding.

g. Coding Actions Taken by RC. Where the claim was filed at the RC, the RC prepares a memorandum accompanying all submissions of claim materials to the DO/CE2 Unit for case create. The memo chronologically outlines RC actions. The CE reviews the memo and enters the proper coding into ECMS to correspond with the date of occurrence in the RC. No coding is done at the RC.

(1) The CE deletes the 'UN' code upon entry of the code indicating a RC action took place on a date prior to the case create date, since all RC actions must be entered into ECMS corresponding with the actual date upon which they took place.

(2) The CE enters the 'OR' claim status code to correspond with the date on which the ORISE search took place at the RC. The ECMS status effective date is the date the RC searched ORISE. The code is entered whether the ORISE search confirms employment or not.

(3) The CE enters the 'ES' and/or 'CS' claim status code(s) with a status effective date of the date on which such action(s) was taken in the RC. If the CE enters an 'ES', he or she then enters the appropriate reason code from the drop down menu, which includes the Operations Center and that Form EE-5 was sent [e.g., 'AL5 - Albuquerque Operations Office (EE-5)']

(4) The CE enters the 'DO' claim status code, and selects the reason code 'OH - Occupational History' with a status effective date of the date on which the occupational history questionnaire (OHQ) was completed by the RC as noted on the RC memo to the DO. (This applies to completion of OHQs from follow-ups and reworks, discussed below, as well.)

The CE should also "close out" the OHQ assignment (or follow-up or rework) in this manner if the RC attempted to complete the OHQ, but was unsuccessful because the claimant could not be reached or refused

5. Development of a Claim. (Continued)

to complete it. The status effective date in this type of situation is the date of the RC memo to the DO/CE2 Unit explaining why the OHQ could not be completed.

Note: If the OHQ is completed by an authorized rep, it is not valid and should not be coded as completed in ECMS.

(5) The CE enters the 'RC - Resource Center' claim status code when making assignments to the RC on identified existing cases in ECMS that require occupational history development. The CE selects the appropriate reason code from the drop down menu to reflect the appropriate type of assignment to the RC:

(a) 'AS' - Assignment - This reason code is selected when an initial assignment for an OHQ is made to the RC. For example, a claim is filed with the DO instead of the RC and the OHQ needs to be completed. The status effective date is the date of the DO memo to the RC outlining the assignment task.

(b) 'FW' - Follow-up - This reason code is selected when the DO/CE2 Unit identifies a need for a follow-up interview because of issues that arise out of development. The status effective date is the date of the DO/CE2 Unit memo to the RC outlining the follow-up task.

(c) 'RK' - Rework - This reason code is selected when an error is found in the final product from the RC. Reworks are not generated out of an issue identified by the DO as an area in need of additional development, but arise when the CE identifies a deficiency (i.e., incomplete or inaccurate data).

The status effective date is the date of the DO/CE2 Unit's memo to the RC outlining the rework task.

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## 5. Development of a Claim. (Continued)

h. Employee Medical Condition. The CCC enters information directly from the claimant's Form EE-1 or EE-2. The CE updates ECMS with additional medical information as it is received, including new, relevant medical conditions that are reported or discovered during development of the case. The CE is responsible for updating ECMS with the latest medical information in the case file.

ECMS requires entry for each employee medical condition for each claimant. For multiple claimants, the CCC enters and the CE updates all medical conditions claimed for each claimant. [Note: the CE enters and updates any new medical conditions identified for data entry while in the development process.]

(1) Reported Ind - If the claimant reported the medical condition on Form EE-1 or Form EE-2, this field will be 'Y', for Yes. If the CE discovers another medical condition that needs to be developed, the CE enters the new medical condition with the 'Reported Ind' field as 'N', for No.

(2) Cond type - The CE verifies the accuracy of the information entered by the CCC and makes changes as needed. Every condition claimed is entered as a medical condition for each claimant. Even if claimants claim different medical conditions, and they all pertain to the employee, each must be entered for each claim into ECMS B and/or E appropriately.

For example, if there are two child claimants, C1 and C2, where C1 claims lung cancer and C2 claims prostate cancer, both C1 and C2's claim screens would reflect both lung and prostate cancer.

The CE updates the Condition Type field on the Medical Condition screen as new conditions are reported or discovered (possible work-related or covered conditions only, as well as all secondary cancers) during case development. The CE enters these updates as they occur.

(3) Diagnosis dt - The claimant might list a diagnosis date on Form EE-1 or EE-2, and if so, the

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## 5. Development of a Claim. (Continued)

CCC enters the date. However, this date is not always accurate, and the CE must confirm the date through the medical evidence. The diagnosis date is considered the earliest date of any test, pathology or doctor's report evident in the case file referring to the diagnosis of the covered condition.

(4) ICD9 - The ICD9 can be selected by either clicking on the 'ICD9' button and entering a medical condition (or just alpha characters) in the 'V14 ICD9 description' line, and pressing select, or entering the ICD9 number directly in the blank field next to the 'ICD9' button.

This field is required for all conditions where the case file is being sent to NIOSH, and for all conditions that are 'Accepted'. An ICD9 is not required for non-covered conditions in ECMS B, or for medical conditions that are 'Denied' (unless the case was sent to NIOSH) or 'Reported'.

(5) Note - This field is used at the CE's discretion. However, if the employee has a condition not specifically listed in the 'cond type' field, so the condition type is '99-Other (Not Listed)', the CE enters (or assures that the CCC entered) the medical condition claimed in this field.

(6) Cond status - This status code was previously based on the medical evidence known at the time of the RD, and it was used slightly differently in ECMS E and ECMS B. However, the use of this status code has changed. It now represents the outcome of each claimed medical condition at the time of the recommended decision. One exception to this is when the DO/CE2 Unit renders a decision on a consequential injury or inputs a prior approval for medical bill payments. The other exception is for employee cases where there is a previously accepted medical condition with a final decision to accept and there is a new recommended decision to accept an additional condition; these cases must have the medical condition status updated by FAB to avoid premature medical bill payment.

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## 5. Development of a Claim. (Continued)

Also, the code is used the same in ECMS B and ECMS E:

(a) Using the 'R' status code: In the creation of a medical condition entry or in the adjudication of a claim, the medical cond status list box in the Medical Condition screen will default to an 'R' status code. The 'R' status code equals what is 'Reported' by the claimant, usually on Form EE-1 or EE-2.

The medical condition status will remain 'R' until a recommended decision is rendered on that condition. Essentially, 'R' equals pending adjudication. So, if a decision is issued that defers a decision on a medical condition, that condition's medical condition status will remain at an 'R' status.

(b) When a recommended decision is issued that accepts a medical condition, the medical condition status for that condition is changed from an 'R' (Reported) to an 'A' (Accept). An 'A' code indicates that medical benefits associated with that condition should be paid for an employee claimant or that a survivor is eligible for benefits related to the employee's development of that condition. The DO/CE2 Unit can also enter 'A' to award medical benefits for consequential injuries or for bills to be paid on prior approvals.

Note that for employee cases, use of the 'A' code alone will not create an eligibility file for medical benefits. All of the coding discussed in Paragraph 2 of Chapter 2-2100, including a final decision code to accept, must be completed before medical bills will be payable. The FAB must ensure the associated medical coding is correct.

(c) When a recommended decision is issued that denies a medical condition, the medical condition status is changed from an 'R' to a 'D' (Deny). A 'D' code is used any time a condition is being denied, whether the denial is for insufficient

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5. Development of a Claim. (Continued)

medical evidence, inability to establish causation, lack of covered employment, or ineligibility of the survivor. If the condition is not being accepted or a decision on that condition is not being deferred, it is denied.

(d) When a claim for a condition is withdrawn, the associated medical condition field(s) must be deleted, a note entered into ECMS case notes, and the file documented.

(e) When a case is known to be affected by a surplus where the employees medical bill payment must be suspended until the surplus is absorbed, the FAB representative changes the affected medical condition from an 'A' to an 'O' (Offset) status. This prevents medical bills from being paid related to that condition until the surplus is absorbed and the 'O' status is changed back to an 'A'. The remaining medical related coding for offset cases is the same as outlined in this chapter.

(7) Status effect dt - This field defaults to blank whenever a condition is entered on the medical condition screen. This field must be changed for all 'A' or 'Accepted' medical conditions. The 'status effect dt' is equal to the 'filed dt' for all claimed conditions. This field is required for all employee and survivor claims with 'Accepted' conditions.

(a) For multiple survivor claims, ECMS does not allow a status effective date earlier than the claim filing date. The CE enters each survivor's own claim filing date. This field is only required for Accepted medical conditions.

(b) For all medical conditions with the medical status condition of 'R' or 'D', no date is necessary. [In earlier versions, ECMS used to default this field to the current date. It is not considered an error if there is a date entered for conditions of the 'R' or 'D' status.]

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5. Development of a Claim. (Continued)

(8) Elig end dt - This field remains blank unless there is an actual end date to the eligibility of medical benefits. The Elig end dt must be filled in when a condition is 'A' or 'Accepted' and the case file has a recommended or final decision to accept, and the CE is aware of an end date for medical benefits. This happens when an employee files a claim for benefits and then dies during or after adjudication, and some medical bills will be covered prior to death, or a consequential illness is only acceptable over a period of time, or for prior approvals that should be paid for a specific day or period of time. Otherwise, the field remains blank.

(9) PoC (Probability of Causation) - After the CE runs the National Institute for Occupational Safety and Health (NIOSH) Interactive RadioEpidemiological Program (IREP), the results of the 'PoC' are entered. [If the case is a B/E case, the PoC (and date and version of IREP) is entered into ECMS B and ECMS E.]

For a single cancer, the total from the '99th Percentile' line is entered in this field. For multiple cancers, the CE runs each primary cancer 'Probability of Causation for Multiple Primary Cancers'. The grand total, under 'Result: Total PC', is entered for PoC for each cancer included.

For every cancer included on the NIOSH Referral Summary Document (including any Amended NRSD), a PoC is required in that medical condition's PoC field, even if an IREP is not run for that particular cancer.

For example, if three primary cancers are sent to NIOSH, and the dose reconstruction includes an IREP for only one cancer since the PoC is already over 50%, the total result is entered for all cancers sent to NIOSH.

If there are additional metastatic cancers that are not sent to NIOSH, the PoC result is not entered in ECMS for these cancers. The med cond status, however, must be updated to 'A' or 'D' based on the result of the dose reconstruction.

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5. Development of a Claim. (Continued)

(10) PoC dt - The PoC date is the date the NIOSH-IREP is run in the DO/CE2 Unit, as reflected on the NIOSH IREP Probability of Causation Results printout.

(11) IREP version - The CE takes the NIOSH-IREP version directly from the CDC/NIOSH website. For example, the IREP heading states, 'Interactive RadioEpidemiological Program, NIOSH-IREP v5.2'. The actual IREP version is '5.2'. The CE enters 5.2 in this field. The version is also listed on the NIOSH IREP Probability of Causation Results printout. For CLL cancer-only, where no IREP is run, the CE enters 'N/A' in this field.

i. Medical Exceptions for ECMS Coding. There are two exceptions to the above coding requirements. One occurs when an employee files a claim and dies prior to an acceptance, and the other occurs when the CE must set up payment options for medical appointments, consultants and records before the case is accepted.

(1) Since ECMS was set up to download medical information from employee claims to the eligibility file that is used by the bill processing contractor, the employee's claim needs to be updated with certain data to allow for payment of medical bills between the employee's filing date and date of death.

When an employee dies prior to the adjudication of the claim, additional claimant(s) file, and ultimately medical conditions are accepted for the new claimant(s), the deceased employee's claim must reflect the accepted medical conditions. To ensure that data is downloaded for medical benefits, the CE must:

(a) Enter the employee's date of death on the case screen.

(b) Enter the 'C3' claim status code, with a status effective date of the date when the Resource Center, DO/CE2 Unit, or FAB was notified of the death (i.e., phone call, letter), whichever is earlier.

5. Development of a Claim. (Continued)

(c) For ALL accepted medical conditions on the case, the CE enters or updates the following information for the employee claim:

- (i) Correct medical condition type.
- (ii) Correct ICD-9 of the condition.
- (iii) Med cond status of 'A' (for accepted).
- (iv) Status effective date, which is the employee's claim filing date.
- (v) Eligibility end date, which is the employee's actual date of death.

(d) Other than the 'C3' claim status code, and accepted medical condition coding, no additional coding is generally entered for the employee claim after his or her death.

However, an exception to this rule occurs if an employee dies prior to a final decision, but EEOICP is unaware of the death until after the final decision was issued. If there is/are surviving claimant(s), the employee's final decision may need to be vacated and appropriate claim status coding (see Paragraph 12 in Ch 2-2100) would follow the 'C3' code.

(2) When a case is referred to a District Medical Consultant (DMC), sent out for a second opinion, or approved for payment of fees for the release of medical records to DOL, the CE uses ECMS to set up the 'prior approval' process through the medical bill processing contractor. The CE enters the prior approval as if entering a new medical condition. The following fields are required:

- (a) cond type - Select 'PA', for prior approval
- (b) ICD-9 code - See chapter 2-0800 for the appropriate ICD-9 code to enter in different situations.

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5. Development of a Claim. (Continued)

(c) status effective date - Enter the date of the medical exam for second opinions, or the date of referral for DMC or authorization for medical records.

(d) eligibility end date - Enter the date of the medical exam for second opinions, or the date the DMC's response or medical records are date-stamped as received in the DO.

(e) medical condition status - Change the medical condition status to 'A'.

j. Payee Information. The CCC enters information directly from the claimant's Form EE-1 or EE-2.

(1) Change of Address and/or Phone Number - If address changes are documented, the CE forwards that information to the PCA (Payee Change Assistant) to update ECMS. The CE updates ECMS with any changes to the claimant's telephone number.

(2) Eligibility Ind - This field identifies whether or not a claimant is eligible for compensation, either in the form of a lump sum payment or medical benefits. This field defaults to 'N', for No, and the CE updates the Eligibility Ind only if a case is in posture for a Recommended Accept decision. The Eligibility Ind is then changed to 'Y', for Yes. During adjudication, and if the case is in posture for a Recommended Denial decision, the indicator remains 'N', for No.

6. Claim Status History Coding. Generally, for every development action the CE takes, there is a corresponding claim status history code to document that action. And, for every claim status code, there must be corresponding file documentation.

Only development actions taken on that particular claim are to be entered for a claimant. For example, any employment action codes to DOE, Corporate Verifiers, or SSA are related to all claims in the case, and are entered for each claimant. However, if individual development actions are related to a particular

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## 6. Claim Status History Coding. (Continued)

claimant(s) only, then the claim status codes are entered for the applicable claimant(s) only.

Note: Telephone calls recorded in the Telephone Management System (TMS) do not qualify as actions that require a claim status code (except for telephone calls to a corporate verifier, see 'DE' and 'CS' coding, discussed in this chapter).

If, for example, the CE telephones the claimant and asks for medical documentation, that is not considered the development action. The CE follows up in writing for any requested information sought over the telephone. For the letter documenting the requested information, the CE enters the appropriate claim status coding. The following are the current claim status codes, organized by action type:

- a. Development Action Codes. When selecting which code to enter, the development code is to be as specific as possible to the corresponding action. If there are multiple issues included in one letter, select the development code that best fits the overall content.

For example, if a single letter requests both medical 'DM' and survivor 'DO' information, the CE would select 'DO' because it represents the contents of the letter better than 'DM', which would exclude the survivorship development. Only one code is to be entered, since the development was done in one letter.

Since every development action requires a development code, if two actions are taken on the same date, such as requesting medical information from the claimant and sending a NIOSH smoking history questionnaire, these are different actions. The development letter is coded 'DM', while the NIOSH smoking history questionnaire is coded 'DO.' Even though they might be mailed in the same envelope, they are still considered separate actions.

Only development actions pertinent to the adjudication of the claim require a code. Items such as acknowledgement letters do not require a code.

- (1) DB - 'Developing Both Medical and Employment'- For development that includes both medical and employment,

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## 6. Claim Status History Coding. (Continued)

the CE enters the 'DB' code. This could be either one development action that includes both medical and employment, or two separate actions, one for medical and one for employment, but completed on the same date.

This should not include initial employment verification requests or follow-up on employment verification to DOE, SSA, CPWR, or a corporate verifier. [All initial requests require use of the 'ES', 'CS', 'SS', or 'US' code with the appropriate reason code, and follow-up to the various employment verification sources requires use of the 'DE' code with the appropriate reason code.]

The status effective date is the date of the letter.

(2) DE - 'Developing Employment' - When developing initial or follow-up employment directly with the claimant, searching the subcontractor database, or as a follow-up to DOE (for DARS or EE-5s), a corporate verifier, CPWR, or the Social Security Administration (SSA), the CE enters the 'DE' (Developing Employment) claim status code.

The status effective date of the 'DE' code is either the date of the letter to the claimant, the date the subcontractor database is searched, or the date of the follow-up action to the employment verifier. 'DE' is not used for initial development to employment verifiers (except for the CPWR database search), only follow-up.

Certain corporate verifiers have asked to be contacted by telephone. For those verifiers, the printout of the telephone call will serve to document the development action. The CE enters the 'DE' with the status effective date of the telephone call. Verification will still need to be in writing though.

Upon entry of the 'DE' code, the CE selects a specific reason code from the 'reason cd' field. This field is a drop-down box that corresponds with the 'DE' claim status code. Included in the reason cd field are both

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## 6. Claim Status History Coding. (Continued)

the full reason for the 'DE' code and a two-character code representing each option. The reason codes available for the 'DE' claim status code are:

(a) Follow-up Letter to Claimant/Other(s)- 'LE' - Used for initial or follow-up letters mailed directly to the claimant or other entity (for miscellaneous employment issues, such as affidavits or subcontractor issues) when asking for employment clarification or information.

(b) Follow-up to DOE- 'DE' - Used exclusively for follow-up to the DOE for employment verification (EE-5).

(c) Follow-up to Corporate Verifier-'CS' - Used exclusively for follow-up to a Corporate Verifier.

(d) Follow-up to CPWR - 'US' - Used exclusively for follow-up to CPWR.

(e) Follow-up to SSA - 'SS' - Used exclusively for follow-up to the SSA.

(f) Document Acquisition Request - 'DAR' - Used for DAR second requests.

(g) CPWR Subcontractor Database Searched - 'CD' - Used when the CPWR subcontractor database is searched.

(3) DJ - 'Developing Department of Justice' - Deactivated. This code was used when a letter was sent to the DOJ requesting Section 5 award status, but it has been deactivated.

(4) DM - 'Developing Medical' - For any medical development the CE enters the 'DM' code, whether or not there is a claimed covered condition. If the CE sends a letter to the claimant stating that no covered condition was claimed, or if a covered condition is claimed and more medical evidence is sought, either from the claimant or a physician/hospital, the 'DM'

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## 6. Claim Status History Coding. (Continued)

code is used. This includes any initial development and/or follow-up.

The status effective date is the date of the development action. Upon entry of the 'DM' code, the CE has the option to select a reason code.

A reason code is not required for general medical development as listed above. However, there are two types of specific medical development letters that do require a reason code. The reason codes available for the 'DM' claim status code are as follows:

(a) DMB - Deny Specific Medical Benefits on Accepted Conditions - This reason code must be selected when an initial letter is sent to deny a specifically requested medical benefit (that is not currently being paid) on an accepted condition.

For example, a claimant requests a vehicle modification, but it is deemed "not medically necessary," and the request is denied. If the claimant challenges the decision, a more formal decision is required (see the decision coding section in Chapter 2-2100.)

(b) RMB - Reduce Medical Benefits on Accepted Condition - This reason code must be selected when an decision is made to reduce a medical benefit that is currently being paid for an accepted condition.

For example, an employee was receiving home health care, but upon further evaluation, it is determined that the in-home health care is unnecessary and will no longer be a covered medical expense. If the claimant challenges the decision, a more formal decision is required (see the decision coding section in Chapter 2-2100.)

(5) DO - 'Developing Other' - When sending an initial or follow-up letter that does not solely address medical or employment issues, but includes some other

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## 6. Claim Status History Coding. (Continued)

development action (e.g., survivorship), or when sending initial or follow-up NIOSH questionnaires, the CE enters the 'DO' code with no associated reason code.

The status effective date is the date of the development letter. More specific development actions can be captured by selecting one of the following from the corresponding reason code drop down menu:

(a) OH - 'Occupational History' (E only) - Selected to reflect that an OHQ was completed or attempted.

(b) IM - 'Impairment' (E only) - Selected when letter developing impairment is sent.

(c) TD - 'Toxic Exposure Development' (E only) - Selected when a letter developing toxic exposure is sent.

(d) WL - 'Wage Loss' (E only) - Selected when a letter developing wage loss is sent.

(e) WI - 'Wage Loss and Impairment' (E only) - Selected when a letter developing wage loss and impairment is sent.

(f) EHP - 'Email to Health Physicist' - Selected when an e-mail/documentation regarding a case is sent to the health physicist for review.

(g) EIH - 'Email to Industrial Hygienist' (E only) - Selected when an e-mail/documentation regarding a case is sent to the industrial hygienist for review.

(h) ETX - 'Email to Toxicologist' (E only) - Selected when an e-mail/documentation regarding a case is sent to the toxicologist for review.

(6) 'SM' - Site Exposure Matrix Searched - The CE enters this code into the claim status history when searching SEM for the first time. No coding is

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6. Claim Status History Coding. (Continued)

required for additional SEM searches unless SEM is consulted to develop causation for another claimed condition at another time.

Regardless of the outcome of the SEM search, the CE places the search results in the case file to show that the search was conducted. The status effective date of the code is the date of the search, as reflected on the bottom right hand corner of the SEM printout.

b. Medical Action Codes.

(1) MS - 'Sent to Medical Consultant' - When a CE identifies a case for referral to a District Medical Consultant (DMC) or medical expert, the Medical Scheduler prepares the file for mailing. If the Medical Scheduler has claim status coding capability, he or she must enter the 'MS' code into ECMS. Otherwise, the Medical Scheduler must notify the CE once the package is mailed to the medical specialist so the CE can enter the 'MS' code.

The status effective date for the 'MS' code is the date of the cover letter of the referral package to the DMC. When entering the 'MS' code, the CE must select the appropriate reason code that describes the subject matter of the request.

The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a referral related to an impairment evaluation.

(b) Causation (E only)- 'CA' - Used for a referral related to establishing causation.

(c) Medical Condition Referral - 'MC' - Used for a referral related to establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a referral related to establishing wage loss.

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6. Claim Status History Coding. (Continued)

(e) Other/Referred for Multiple Issues - 'OT' - Used for a referral encompassing several different reasons or any reason not listed above.

(2) MR - 'Received Back from Medical Consultant' - Upon completion of the review, the DMC returns the narrative report and the completed HCFA-1500 to the CE within 30 days. Upon receipt of the narrative report and the bill, the CE enters the code 'MR'.

The status effective date for the 'MR' code is the date the report from the DMC is stamped "received" by the DO. If the report received is insufficient, the CE should not code the MR code until a corrected report is received. When entering the 'MR' code, the CE must select the appropriate reason code that describes the subject matter of the response. The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a response related to an impairment evaluation.

(b) Causation (E only)- 'CA' - Used for a response related to establishing causation.

(c) Medical Condition Referral - 'MC' - Used for a response related to establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a response related to establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a response encompassing several different referral reasons or any reason not listed above.

(3) 2S - 'Sent for 2<sup>nd</sup> Opinion' - When a CE identifies a case requiring a medical second opinion, the Medical Scheduler prepares the documentation for mailing. If the Medical Scheduler has claim status coding capability, he or she must enter the '2S' code into ECMS. Otherwise, the Medical Scheduler must notify

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6. Claim Status History Coding. (Continued)

the CE once the package is mailed to the medical specialist so the CE can enter the '2S' code.

The status effective date for the '2S' code is the date of the cover letter of the referral package. When coding the '2S' code, the CE must select the reason code that describes the subject matter of the request. The reason codes available are listed below

(a) Impairment (E only)- 'IM' - Used for a second opinion examination in support of impairment.

(b) Causation (E only)- 'CA' - Used for a second opinion examination in support of causation.

(c) Medical Condition Referral - 'MC' - Used for a second opinion examination in support of establishing a claimed illness.

(d) Wage Loss (E only) - 'WL' - Used for a second opinion examination in support of establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a second opinion examination encompassing several different referral reasons or any reason not listed above.

(4) 2R - 'Received 2<sup>nd</sup> Opinion' - Once the CE receives the medical narrative from the second opinion specialist and determines that it adequately addresses the CE's questions, the CE enters the '2R' code.

The status effective date for the '2R' is the date the medical narrative is date-stamped in the DO. When entering the '2R' code, the CE must select the reason code that describes the subject matter of the response. The reason codes available are:

(a) Impairment (E only)- 'IM' - Used for a response related to a second opinion examination in support of impairment.

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6. Claim Status History Coding. (Continued)

(b) Causation (E only)- 'CA' - Used for a response related to a second opinion examination in support of causation.

(c) Medical Condition Referral - 'MC' - Used for a response related to a second opinion examination in support of establishing a claimed illness.

(c) Wage Loss (E only) - 'WL' - Used for a response related to a second opinion examination in support of establishing wage loss.

(e) Other/Referred for Multiple Issues - 'OT' - Used for a response related to a second opinion examination encompassing several different referral reasons or any reason not listed above.

c. Employment Action Codes.

(1) CS - 'Employment Verification Request Sent to a Corporate Verifier' - When an initial employment verification request is sent to a corporate verifier, the CE enters the 'CS' code. A 'CS' code is entered for each initial request. If the CE sends requests to two different corporate verifiers, then the CE enters two 'CS' codes.

The status effective date is the date of the letter to the corporate verifier. If the request is faxed, it is the date the fax was sent. (When the CE follows up on the initial request, no 'CS' claim status code is entered; rather, the CE enters the 'DE' claim status code with the 'CS' reason code.)

Certain corporate verifiers have asked to be contacted by telephone. For those verifiers, the printout of the telephone call serves to document the development action. The CE enters the 'CS' with the status effective date of the telephone call.

(2) CR - 'Complete Employment Verification Received from a Corporate Verifier' - The CE uses the 'CR' code only when the response from the corporate verifier is

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## 6. Claim Status History Coding. (Continued)

sufficient to establish that all information available has been provided. Such a response may address all of the claimed employment, or it may address some or none of the employment, if the corporate verifier notes that no other information is available. Such a response may also state that the corporate verifier has no employment records for the individual.

The status effective date of the 'CR' code is the date the DO/CE2 Unit received the response, i.e., the date the written response is received.

The 'CR' code is NOT used when a follow-up to the corporate verifier is required because the response is returned blank, the information provided is confusing or incomplete, or the response does not indicate which period of employment is or is not verified.

(3) EC - 'Employment Verification Process Complete' - When multiple "sent" codes ('ES', 'CS') exist, and the CE receives a single response that confirms all outstanding employment dates, the claim is coded 'EC'. The 'EC' code signifies that a response has been received that fully addresses the employment issue and that further employment development is unnecessary.

The CE also uses the 'EC' code when issuing RDs to deny benefits if he or she determines that further development of the employment verification issue is unnecessary, since other evidence (or lack thereof) will result in a recommended denial. Only one 'EC' code is used no matter how many outstanding "sent" codes are in ECMS.

Whenever an 'EC' code is entered into ECMS, the CE completes the EC Code Justification Memo (Exhibit 1) for the case file. The status effective date of the 'EC' code is the date of the EC Code Justification Memo.

(4) ES - 'Employment Verification Sent to DOE'- This code is used when a Form EE-5 is sent to the DOE, when a Document Acquisition Request (DAR) is made, or when

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## 6. Claim Status History Coding. (Continued)

the initial contact letter is sent to DOJ requesting employment verification/RECA award status.

When an employment information request is sent to the DOE or DOJ, the CE enters the 'ES' code. An 'ES' code is entered for each initial request sent to a DOE Operations Center or DOJ. If the request is sent to two different Operations Centers, then the CE enters two 'ES' codes.

The status effective date is the date the request is made. (When the CE follows up on the initial request, no 'ES' claim status code is entered; rather, the CE enters the 'DE' claim status code with the appropriate reason code. For follow-up to DOJ if no response has been received, the CE enters a DO code with corresponding case note).

(a) For EE-5 (or DOJ) employment verification requests, the CE selects the DOE Operations Center and notes the sending of a Form EE-5 from the reason cd field that corresponds with the 'ES' claim status code being recorded. The three-character code and the DOE Operations Center to which the Form EE-5 is sent are included on the same line, so only one selection will be made from the drop-down box.

For example, if Form EE-5 is sent to the Chicago Operations Center, the CE selects 'CH5 - Chicago Operations Center (EE-5)' from the reason cd drop-down menu. For the initial contact letter sent to DOJ requesting employment verification/RECA award status, the CE selects 'RE5 - RECA employment (EE-5)' from the reason cd drop-down menu.

Note: If a CE sends one Form EE-5 to one Operations Center, and that Operations Center sends a copy of Form EE-5 to more than one facility for response, the CE enters one 'ES' code for the appropriate Operations Center.

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6. Claim Status History Coding. (Continued)

(b) For DARs, the CE selects the appropriate reason code from the drop down menu that reflects that a DAR was sent, as well as where it was sent (e.g., 'ALD - Albuquerque Operations Office (DAR)'). The ES code is equipped with drop down boxes that include a breakdown of DOE Operations Centers for DAR submissions sent to DOE. The CE selects the proper DOE Operations Center from the drop down box when submitting the DAR package.

The ECMS status effective date of the code is the date reflected on the DAR request form.

DARs can also be made to the DOJ on RECA cases. In these types of cases, the CE will select the reason code 'RED - RECA Employment (DAR)'.

(5) ER - 'Employment Verification Received from the DOE' - The CE uses the 'ER' code when the DAR response is received, when the DOJ response is received, or when Form EE-5 from DOE is sufficient to establish that all the information available has been provided (i.e., the response addresses all of the claimed employment; addresses some, or none, of the employment, if DOE notes that they have no other information; or states that DOE has no employment records for that individual.)

The 'ER' date is the date the response is date-stamped in the DO. The 'ER' code is NOT used if Form EE-5 is returned blank, or the information provided is confusing or incomplete, or the response does not indicate which period of employment is or is not verified.

(a) For EE-5 (or DOJ employment/award) responses, the CE selects the DOE Operations Center from which a Form EE-5 was received from the reason cd field that corresponds with the 'ER' claim status code being recorded. The three-character code and the DOE Operations Center from which Form EE-5 is returned included on the same line, so only one selection will be made from the drop-down box.

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6. Claim Status History Coding. (Continued)

Example 1: If Form EE-5 is returned from the Chicago Operations Center, the CE selects 'CH5 - Chicago Operations Center (EE-5)' from the reason cd drop-down menu. The CE enters an 'ER' for each Form EE-5 received from the Operations Center(s).

Example 2: If the CE receives one Form EE-5 from the Richland Operations Office and another from the Ohio Field Office, the CE enters the 'ER' code with reason code 'RI5-Richland Operations Office (EE-5)' for Richland, and a separate 'ER' code with reason code 'OF5-Ohio Field Office (EE-5)' for the Ohio Field Office.

If a CE sends one Form EE-5 to one Operations Center, and that Operations Center sends a copy of Form EE-5 to more than one facility for response, the CE enters one 'ES' code for the appropriate Operations Center.

Where DOE notifies the CE as to how many copies the Operations Center sent to the facilities (oftentimes Oak Ridge Operations Office), or when the CE is aware that multiple Forms EE-5 are expected from that original inquiry, the CE enters the corresponding 'ER' code only after all anticipated EE-5 forms are returned.

Note: If an unsolicited Form EE-5 is received after a documented Form EE-5 was already received and for which an 'ER' was previously entered, the additional Form EE-5 must also be documented in ECMS as a new 'ER' if Form EE-5 contains additional/new information. This means that entries of 'ES', 'ER', 'ER' may potentially appear in ECMS. This is acceptable since DOE may send out follow-up Form EE-5 documents which could further clarify employment verification.

When the DOJ response regarding employment verification/RECA award status is received, the CE selects 'RE5 - RECA employment (EE-5)' from the 'reason cd' drop-down menu.

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6. Claim Status History Coding. (Continued)

(b) For DAR responses, the CE selects the appropriate reason code from the drop down menu (described above), [e.g., 'ALD - Albuquerque Operations Office (DAR)'] to show that the DAR response was received and to denote which DOE Operations Center responded. For DAR responses from the DOJ, the CE will select the reason code 'RED - RECA Employment (DAR)'.

(6) OR - 'ORISE Employment Evidence Received' - When a claim is initially reviewed, if it is determined that a request for employment verification is appropriate, and the employee worked at one of the facilities on the ORISE list, the CE searches the ORISE database.

Regardless of whether the information from the ORISE database addresses all, part or none of the employment data, the CE enters the 'OR' status code, with the status effective date as the date on the printout of the results of the ORISE database search.

(7) SS - 'Employment Verification Request Sent to Social Security' - When an employment verification request (Form SSA-581) is sent to the Social Security Administration (SSA), the CE enters the 'SS' claim status code in ECMS.

The status effective date is the date the SSA-581 form is sent to SSA. The CE date stamps the form at the time the form is sent to SSA and a copy is kept for the case file. (When the CE follows up on the initial request, no 'SS' claim status code is entered. Instead, the CE enters the 'DE' claim status code with the 'SS' reason code.)

(8) SR - 'Employment Verification Received from Social Security' - When employment verification is received from the Social Security Administration (Form SSA-L460, the end product of Form SSA-581), regardless of whether the response addresses all, part or none of the employment data, the CE enters the 'SR' code.

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## 6. Claim Status History Coding. (Continued)

The status effective date is the date the response is date-stamped in the DO. (Note: The SR code is not entered if the SSA records are received from the claimant or another source.)

(9) US - 'Union Sent' - When an employment verification request is sent to the Center for Construction Research and Training (CPWR), the CE or Point of Contact (POC) enters the 'US' code. The status effective date is the date of the referral mailing. The 'US' code signifies that all actions pertaining to a CPWR mailing, including release of a completed referral package and mailing of a cover letter to the claimant(s), are complete.

Upon entry of the 'US' code, the CE must select the number of CP-2s that are sent to CPWR from the corresponding drop-down box. The drop-down menu will allow the CE to select only a number between one and twenty. In the rare occurrence that more than twenty CP-2s are sent to CPWR, the CE will enter an additional 'US' code and select the remaining number of CP-2s (greater than twenty) that are being mailed.

For example, if twenty-five CP-2s are being sent to CPWR, the CE will have to enter one 'US' code and select '20' from the drop-down menu. Then the CE will have to enter a second 'US' code and select '5' from the drop down menu.

After entering the 'US' code, a note must be entered in the 'Worksite Desc' field on the main case screen. For each facility where employment is claimed and for which CPWR is assisting in collection of employment evidence, the CE or POC must enter the following note using the first 13 characters of the 'Worksite Desc' field for outstanding CPWR referrals: 'CPWR pending'. This note is not to replace any existing entry pertaining to the site.

The CE also enters a 40-day call-up effective the date of referral to notify the POC of the overdue request if needed. The POC is to input a claim status code of 'DE' with the reason code 'US' in the claim status

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## 6. Claim Status History Coding. (Continued)

history screen effective the date contact is made with CPWR concerning an overdue response.

Notes of all phone calls or e-mails are to be recorded in the case file. The POC has three working days to report all overdue referrals to CPWR. Also, he or she must update the status of the referral in the CPWR tracking program.

(10) UR - 'Union Received'- Upon receipt of a CPWR response, the CE or POC enters the claim status code 'UR' (Received from Union) in the claim status history screen . The status effective date is the date the DO received the referral, according to the date-stamp. Upon entering the 'UR' code, the CE must select a 'VN-Verified None', 'VS-Verified Some', or 'VA-Verified All' from the corresponding drop-down box.

(a) 'VN - Verified None' - Selected when none of the data requested from CPWR was used to verify the claimed covered employment.

(b) 'VS - Verified Some' - Selected when some portion of the data requested from CPWR was used to verify the claimed covered employment.

(c) 'VA - Verified All' - Selected when all of the data requested from CPWR was used to verify the claimed covered employment.

(11) SF - 'Records Request Sent to Former Worker Program' - When a records request is made to the Former Worker Program (FWP), the CE enters the claim status code 'SF' into the claim status history screen with a status effective date equal to the date of the cover letter/memo to the FWP.

(12) RF - 'Response Received From Former Worker Program' - Upon receipt of records from the FWP, the CE enters the claim status code 'RF' into the claim status history screen. The status effective date is the date the response was received in the DO/CE2 Unit, according to the date stamp.

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6. Claim Status History Coding. (Continued)

d. NIOSH Action Codes.

(1) NI - 'Sent to NIOSH for Dose Reconstruction' - While the NI code is used in both ECMS B and ECMS E, the use of the code varies on B only cases versus BE cases:

(a) For B Cases - the 'NI' claim status code is entered for each individual claimant within a case sent to NIOSH for dose reconstruction. When a case is sent to NIOSH, the CE prepares the NIOSH Referral Summary Document (NRSD), which includes a listing of all of the claimants. When this form is signed by the Senior or Supervisory CE, the 'NI' is coded for each claimant included on the NRSD. The status effective date is the date of the Senior or Supervisory CE's signature on the NRSD.

If the case is already at NIOSH and the DO/CE2 Unit receives a claim from a new claimant, the CE prepares an Amended NIOSH Referral Summary Document, which includes all additional claimants since the original NRSD. (Note: All claimants on the case should be forwarded to NIOSH, regardless of survivorship eligibility at the time of the referral.) When this form is signed by the Senior or Supervisory CE, the 'NI' is coded for each new claimant included on the Amended NRSD. The status effective date is the date of the Senior or Supervisory CE signature on the Amended NRSD.

If the case is already at NIOSH and the DO/CE2 Unit receives notice of a new claimed cancer, the CE prepares an Amended NIOSH Referral Summary Document, which includes all additional cancers since the original NRSD. When this Amended NIOSH Referral Summary Document is sent to NIOSH, no additional NI code is needed.

(b) For B/E cases - When a non-SEC cancer claim is referred to NIOSH, or was originally referred

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## 6. Claim Status History Coding. (Continued)

to NIOSH as a Part B claim and a new Part E claim now exists, the CE does not input the 'NI' (SENT TO NIOSH) code into ECMS E to show that the claim is pending dose reconstruction at NIOSH. The 'NI' code is input into ECMS B only (unless the case is a RECA Section 5 case with claim for cancer other than lung cancer). The CE must concurrently develop for exposure to toxic substances.

When toxic exposure development is complete and the CE cannot accept causation, the CE creates a memorandum to file stating that the toxic exposure development is complete and then codes 'NI' into ECMS E. The status effective date is the date of the memorandum.

(c) PEP - 'Rework Based on Program Evaluation Plan' - This reason code is available for selection for Part B or B/E cases in association with the 'NI' claim status code. When it is determined a case needs a rework based on a program evaluation plan/report (PEP/PER), an amended NIOSH referral summary document (ANRSD) is prepared and submitted to NIOSH. The 'NI' code is entered with a 'PEP' reason code to indicate the case is being referred to NIOSH for a rework based on a program evaluation plan/report. The status effective date of the 'NI' code with 'PEP' reason code is the date of the ANRSD.

Again, the 'NI' status code with 'PEP' reason code should only be entered in ECMS E after toxic exposure development is complete and the CE has placed a memo the file stating that toxic exposure development is complete. The CE then enters status code 'NI-PEP' into ECMS E with the date of the memorandum as the status effective date.

If the NI code had been entered into ECMS E prior to the rework and there are no new claimed

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## 6. Claim Status History Coding. (Continued)

conditions, the 'NI-PEP' should be coded into ECMS E with a status effective date of the ANRSD, just as in ECMS B, and no new memo is required.

Since this is considered a new dose reconstruction, the CE should not change the existing NR/DR status code to NR/RW as typically done for rework cases. Furthermore, if a PoC value is already entered into ECMS, the CE should not delete the PoC. The new PoC will simply be updated into both ECMS B and E once it is calculated.

(2) NO - 'NIOSH, Administrative Closure' - For cases at NIOSH, Form OCAS-1 is provided to the claimant after completion of the dose reconstruction report. The claimant is required to sign and return the form to NIOSH before NIOSH can return the case to DOL.

If none of the claimants sign the OCAS-1 form or submit comments within 60 days, NIOSH will close the case administratively and send a letter/e-mail to DOL addressing the closure. The CE enters the 'NO' claim status code in ECMS B, with a status effective date of the receipt of the letter/e-mail from NIOSH. (If the district office cannot obtain an OCAS-1 from any claim on the case, the case will also need to be administratively closed with DOL by entering a 'C2' code on the claims.)

If the case is a B/E case where toxic exposure development is complete and the 'NI' code has already been entered into ECMS E, the CE enters the 'NO' code into ECMS E as well. If toxic exposure development has not yet been completed and the 'NI' code has not yet been coded into ECMS E, the CE does not enter the 'NO' code into ECMS E.

(3) NR - 'NIOSH Dose Reconstruction Received' - When a case is returned from NIOSH with a dose reconstruction, or it is returned from NIOSH because a dose reconstruction could not be performed, the CE enters the 'NR' (Received from NIOSH) claim status code into ECMS B. If the case is a B/E case where

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## 6. Claim Status History Coding. (Continued)

toxic exposure development is complete and the 'NI' has already been coded in ECMS E, the 'NR' code is entered into ECMS E as well. The status effective date is the date the DO received the dose reconstruction (according to the date-stamp).

The PoC and IREP information must be entered into ECMS B and E on B/E cases regardless of whether an NI was previously entered into ECMS E.

Upon entry of the 'NR' code, the CE selects a specific reason code from the 'reason cd' field. This field is a drop-down box that corresponds with the 'NR' claim status code. Included in the reason cd field are both the full reason for the 'NR' code and a two-character code representing each option. The reason codes available for the 'NR' claim status code are:

(a) Dose Reconstruction Received, POC-'DR' - Used when the DO receives a routine dose reconstruction (not fitting one of the other specific reason codes listed below).

(Even though the CE might not yet have had an opportunity to review the dose reconstruction report, this is the appropriate reason code to use at this time. If it is determined after review that the reason code needs to be changed, e.g., for a rework, the CE updates the reason code.)

(b) Reworks of Dose Reconstruction, no POC-'RW' - Used exclusively if it is determined that the received dose reconstruction is not to be used, based on the review by the Health Physicist at National Office (NO). Once the Health Physicist determines the case must be returned to NIOSH for a rework, the CE changes the reason code for the 'NR' claim status code from 'DR' to 'RW.' If a PoC was entered into ECMS, it should be removed.

(Note: A new 'NR' claim status code is not to be entered. Only the reason code for the existing 'NR' code is to be updated with the new reason

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6. Claim Status History Coding. (Continued)

code of 'R'. However, the date of the original claim status code is not changed or updated. This is because the 'NR' code documents the receipt date of the dose reconstruction disc.)

Once the CE prepares the rework and a new Amended NIOSH Referral Summary Document (ANRSD) is ready to be sent back to NIOSH, a new 'NI' claim status code is entered, with a status effective date of the ANRSD.

(c) CLL only, no POC- 'CL' - In Part B cases when after full medical development the only claimed primary cancer is CLL, the CE enters the 'NR' claim status code in ECMS, even though there will not be an 'NI' code. On these cases, the status effective date of the 'NR' code with the 'CL' reason code is the date of the RD to deny based on CLL (0% PoC). The CE should not bother entering the 'NR' code with the 'CL' reason code in ECMS E because of the presumption of a 0% PoC with regards to radiation exposure, only toxic exposure development would be pursued under Part E.

(d) No Dose Reconstruction Possible, SEC - 'ND' - Used for non-SEC cancers claimed at an SEC facility where NIOSH determines that no dose reconstruction is possible. Note: Denials based on this situation are coded D7/F9.

(e) Partial Dose Reconstruction, SEC - 'PD' - Used for non-SEC cancers claimed at an SEC facility where NIOSH can only perform a partial dose reconstruction, such as occupational medical x-ray doses only or external dose only. The dose reconstruction report must be carefully reviewed to determine if a partial dose reconstruction was performed.

(4) NW - 'NIOSH, Returned without a Dose Reconstruction' - When withdrawing a case from NIOSH for any reason (e.g., the CE realizes there was no covered employment and the case should not have been

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## 6. Claim Status History Coding. (Continued)

sent to NIOSH), and the DO will not be sending the case back to NIOSH, the CE requests the return of the case from NIOSH without a dose reconstruction and enters the 'NW' code in ECMS B. The CE only enters the 'NW' code into ECMS E on BE cases where the toxic exposure development was completed and the 'NI' code had been entered into ECMS E. The CE notifies NIOSH that the dose reconstruction is no longer needed for the case. The status effective date is the date of the notification to NIOSH.

There are also instances when NIOSH requests that DOL withdraws a case that is currently at NIOSH (e.g., during NIOSH interview claimant claims additional cancer or employment period which requires development, claimant passes away). In these types of situations, the file must be documented with the TMS record of the NIOSH call requesting withdrawal and the CE codes an 'NW' with a status effective date of the NIOSH email. Please note, the 'NW' code is not applicable in instances where NIOSH advises DOL that the case is pended at NIOSH. Cases pended at NIOSH do not required ECMS coding.

Please note that an administrative closure of a claim in ECMS does not "close out" a pending NIOSH case. For example, if an employee dies while his or her case is at NIOSH, an 'NW' code and a 'C3' code must be entered. The 'C3' code alone is not sufficient.

(5) NAR - 'No Additional Review Needed' with Reason Code NRC - 'NIOSH Returned Case' - This code indicates that all processing is completed on a case that was returned from NIOSH with an 'NR' or 'NW' code and no further processing is necessary. Typically a case should be returned or withdrawn from NIOSH ('NR'/'NW') before a recommended and/or final decision is issued, but there are some rare instances that the case is returned or withdrawn after a recommended and/or final decision is rendered and there is no additional development required on the case. Another circumstance where this code combination would be used is when the claim is withdrawn from NIOSH after a claim has been closed.

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## 6. Claim Status History Coding. (Continued)

When a decision is issued or a claim is closed on a case that is currently at NIOSH and the dose reconstruction is received or the claim is withdrawn after the fact, the 'NAR' claim status code with 'NRC' reason code is entered. Otherwise, reports would show that a decision or closure were pending, which would be inaccurate.

The 'NAR' claim status with 'NRC' reason code must be approved by the District Director, Assistant District Director, FAB Manager, and/or designated person. Once the CE/HR determines that the 'NAR/NRC' code is applicable, he/she prepares a memo to the file explaining the context in which the 'NAR/NRC' code is needed and the applicable ECMS system (Part B, E or both) for the claim. The designated person then approves and signs off on the memo and codes the 'NAR/NRC' code in ECMS accordingly, with a status effective date of the date of the approved memo.

(6) LNS - 'Letter Sent to NIOSH' - This code is used when a letter is sent to NIOSH inquiring as to the applicability of a Program Evaluation Report (PER) on a case's previous dose reconstruction. The status effective date is the date the letter is sent to NIOSH. This is a B/E code, but is only entered into ECMS E if the 'NI' had previously been entered, indicating the toxic exposure development was complete.

(7) LNR - 'Letter Received from NIOSH' - This code was initially created to document NIOSH's response to our request (LNS). However, the use of LNR is now used to document the receipt of an Individual Case Evaluation/Individual PER from NIOSH indicating that the case was evaluated against a PER and any other changes that may affect the dose reconstruction. The status effective date is the date stamp received into the DO. This is a B/E code, but is only entered into ECMS E if the 'NI' had previously been entered, indicating the toxic exposure development was complete.

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## 6. Claim Status History Coding. (Continued)

The LNR code has several associated reason codes. The reason codes represent the EEOICPA Bulletin that addresses a particular PER or possibly multiple PERs. The applicable reason code must be selected from the reason code drop down list (i.e. '824' - PER/ICE addressed in Bulletin 08-24). New reason codes are added as new PERs are released.

### e. Additional Action Codes.

(1) 15 - 'EE-15 Form Sent' - Deactivated. The '15' code was previously used when the CE mailed Form EE-15 (which was required with older versions of Form EE-1/2) with a status effective date of the date the form was mailed. However, the EE-15 is no longer used. When a CE requests information similar to what was on Form EE-15, such as tort suit information, the CE will enter the 'DO' code, instead of a '15'.

(2) RD - 'Development Resumed' - The 'RD' code is used to resume development on claims two ways in ECMS. The first use is when a case has a Final Decision, and a current claimant on the case submits a subsequent claim form for a new medical condition. The status effective date of the 'RD' in this case is equal to the new filing date (postmark date, if available, or received date) for the new claim form.

The second use is when a claim has been closed prior to adjudication, and the claimant (or DOJ, in the case of a pending RECA claim) writes a letter asking to resume development on the claim. The CE then enters the 'RD' code and resumes development.

The status effective date of the 'RD' in this case is equal to the date-stamp of the letter requesting development be resumed. This code can be used in conjunction with the following closure codes: 'C0', 'C1', 'C2', 'C9', or 'C10' where the claimant was not at MMI, since none of these closure codes refer to the death of a claimant (Note: This code is not to be used for the Reopening of Claims due to Director's Orders.)

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## 6. Claim Status History Coding. (Continued)

(3) UN - 'Unadjudicated' - The 'UN' code is a default claim status code created when a new claim is entered in ECMS. This code is generated by the system when a claim is created, and the CE does not use it as a development code. If Resource Center development pre-dates the 'UN' code, the 'UN' code should be deleted when the development actions are entered.

(4) SE - 'Confirmed SEC Claim' - When a CE determines a claim meets the SEC criteria, the CE enters the 'SE' code into ECMS B. The status effective date is equal to the date of the recommended decision awarding SEC benefits. If FAB is the first to become aware of the SEC criteria being met, they should code it the date of their decision (reverse to accept or remand if further development is required.) This code is required for all accepted SEC claims.

This code must also be entered into ECMS E if the basis for the Part E decision is the Part B/SEC acceptance. The status effective date is the date of the Part E recommended decision.

(5) WS - 'Washington, DC: Sent to' - When the CE or HR identifies a policy or procedural issue that requires NO attention, other than a technical issue regarding health physicist, toxicologist, and/or industrial hygienist review, the CE prepares the WS/WR Referral/Response Form (Please see exhibit 2). After the Supervisory CE and District Director (DD) or FAB Manager reviews the case file and the referral form and agrees to send the issue to NO, the DD or FAB Manager (or designate) enters the 'WS' code. The status effective date is the date the DD or FAB manager signs and dates the WS/WR Referral/Response Form.

On these types of reviews, the use of the 'WS' code is restricted to the DD and FAB Manager, to ensure that he or she agrees with the CE's rationale for the referral to NO and also agrees that the CE cannot continue working on the case until the outstanding issue is resolved. Included in the 'reason cd' field

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## 6. Claim Status History Coding. (Continued)

are both the full reason for the 'WS' code and a two-digit code for each option. The reason codes that should be selected for these types of reviews is PR - 'Policy Review' - Used for referral to NO for general policy review (not including review by Health Physicist or Medical Director).

For cases that require technical review by the Health Physicist, Toxicologist, and/or Industrial Hygienist, the CE will select the 'DO' reason code with the EHP, EIH, or ETX reason code. If the scientist reviewing the file determines the issue is complex and will require a significant time to review (30 days or more), they will notify the DD via email and enter the 'WS' code into ECMS. If the scientist has the case file, they will print a copy of this email to associate with the case file. If the DO still has the case file, DD will print a copy of this email for the file. The date of the 'WS' code will be the date of the email. Depending on who is conducting the review, the appropriate reason code is selected:

(a) HP - 'Health Physicist Review' - Used for a referral to NO for review by the Health Physicist.

(b) IH - 'Industrial Hygienist Review' (E only) - Used for referrals to the Industrial Hygienist.

(c) TX - 'Toxicologist Review' (E only) - Used for referrals to the Toxicologist.

(d) OP - 'Overpayment Review' - Used for referrals to NO because either for review of a potential overpayment or for overpayment processing/handling.

(e) FR - 'Facility Review' - Used for referrals to NO for a determination on whether a facility should be covered or for expansion of dates of a covered facility.

(f) RDR - 'RECA Dose Reconstruction' - This code was used to identify those claims that were held

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6. Claim Status History Coding. (Continued)

in the DO until it was determined how NIOSH was to perform dose reconstructions on RECA cancers.

(6) TL - 'Terminal Claimant Designated by DD/FAB Manager' - This code is used when a determination has been made that the claimant is in a terminal condition. Use of this code is restricted to the DD or FAB Manager or their designee. If the case is a B/E case, the TL code must be coded into both ECMS B and ECMS E. The status effective date of the code is equal to the date the DD or FAB Manager determines the claim is in need of expedited processing due to a terminal illness, such as the date of a phone call (with corresponding TMS message printout), email, or other communication.

(7) WR - 'Washington, DC: Received Back From' - When NO resolves a pending 'WS' issue, the Branch of Policy, Regulations and Procedures will return the WS/WR-Referral/Response Form to the District Office. The 'WR' response for technical reviews could also be an email or memo. The District Director enters the 'WR' in ECMS, with an effective date of the receipt of the WS/WR-Referral/Response Form/memo/email.

(8) IC - 'Impairment Claimed' (E only) - Used when the claimant informs DEEOIC in writing of intent to pursue an impairment claim. The status effective date is the postmark date of the letter, if available, or the date the letter is received in the DO/RC. If impairment is claimed multiple times, the IC code needs to be entered only once (unless it is claimed again after the final decision or when withdrawn 'C10' - 'NM').

Also, if the claimant does not submit a written claim for impairment, but submits an impairment rating, this is treated as a claim for impairment and the IC code is entered.

(9) WC - 'Wage Loss Claimed' (E Only) - Used when the claimant informs the DEEOIC in writing of intent to pursue a wage-loss claim. The status effective date is the postmark date of the letter, if available, or

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## 6. Claim Status History Coding. (Continued)

the date the DO/RC receives the letter. If wage loss is claimed multiple times, the WC code needs to be entered only once (with the initial claim for wage loss) until a decision is rendered (unless it is claimed after the final decision or when withdrawn 'C10' - 'WLW').

(10) NIM - 'Not Claiming Impairment' (E Only) - This code is used when the claimant informs the DEEOIC in writing that he or she is not claiming impairment (even though it was never actually claimed) or after the appropriate development for an impairment claim has been completed and the claimant has been unresponsive. The status effective date is the date the letter is received in the DO from the claimant stating they do not wish to claim impairment or the date on a letter sent to the claimant confirming an impairment claim will not be pursued at this time because of the lack of response.

NIM has an optional reason code that must be selected in circumstances where the maximum payable benefit has already been paid, so a claim for impairment is not being solicited. This reason code is 'MBM - Maximum Payable Benefits Met'. This code is not to be used if impairment has been claimed. In those circumstances, the claim must be withdrawn by the claimant or adjudicated.

(11) NWL - 'Not Claiming Wage Loss' (E Only) - This code is used when the claimant informs the DEEOIC in writing that he or she is not claiming wage loss (even though it was never actually claimed) or after appropriate development for a wage loss claim has taken place and the claimant has been unresponsive. The status effective date is the date the letter is received in the DO from the claimant stating they do not wish to claim wage loss or the date on a letter sent to the claimant confirming a wage loss claim will not be pursued at this time because of the lack of response.

NWL has an optional reason code that must be selected in circumstances where the maximum payable benefit has

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## 6. Claim Status History Coding. (Continued)

already been paid, so a claim for wage loss is not being solicited. This reason code is 'MBM - Maximum Payable Benefits Met'. This code is not to be used if wage loss has been claimed. In those circumstances, the claim must be withdrawn by the claimant or adjudicated.

(12) NA - 'No Action Necessary - SEC/PEP/PER' - This code has several associated reason codes. Each reason code is generally specific to a Bulletin number regarding a new SEC or PEP/PER (B only). On occasion the reason codes are associated with a special project (B or E). Use of the 'NA' code and its associated reason code indicates that a claim was reviewed under the pertinent instructions and no action is necessary at this time. New reason codes are added as new SEC/PEP/PERS (or special projects) are released.

(13) ISL - 'Initial SEC Screening, Likely SEC' (B only) - This code is used when the CE screens a case and determines that it is likely to meet the criteria for inclusion into an SEC class, as per a Bulletin. The status effective date of the 'ISL' code is to correspond with the completion date of the screening worksheet.

(14) ISU - 'Initial SEC Screening, Unlikely SEC' (B only) - This code is used when the CE screens a case and determines that it is unlikely to meet the criteria for inclusion into an SEC class, as per a Bulletin. The status effective date of the 'ISL' code is to correspond with the completion date of the screening worksheet.

(15) ISD - 'Initial SEC Screening, Development Needed' (B only) - This code is used when the CE screens a case and determines that development may be needed in order to reach a determination on SEC class inclusion, as per a Bulletin. The status effective date of the 'ISL' code is to correspond with the completion date of the screening worksheet.

7. Case Management. ECMS contains 'Notes' and 'Call-Ups' sections, as well as a Telephone Management System (TMS), to assist the claims staff with managing cases,

a. Notes and Call-Ups. The 'Notes and Call-ups' are intended primarily as a tool for CEs, Senior CEs, HRs, and Supervisory CEs in managing their caseloads. Each call-up is a note with an associated 'action date' used to display pending actions by date and type.

(1) Each ECMS note consists of up to 255 characters of text, note type, code claim type associated with note, DO Code, call-up date priority, public flag, update, current owner id, and date created by/transferred to current owner. (See below for detailed information about these data elements),

(2) Each note is Public, and visible to all authorized ECMS users. Notes are included in the case file for any FOIA requests. ECMS no longer allows for the saving of private notes.

(3) Assigning a priority is strictly at the discretion of the owner of the note (1 = highest priority, 5 = lowest priority). A user can sort notes and call-ups by selecting the Manage Call-ups/Notes under the 'Inquiry' menu option based on priority, but this is not required. The default is '1'.

(4) A 'call-up date' can be entered in the notes screen to serve as a "tickler" system for the CE. ECMS will then prompt the assigned CE to read the associated note when the call-up date is reached. It will continue to prompt the CE until the 'task completed' field is changed from 'N' to a 'Y' (or the call-up date is changed to a future date).

b. Telephone Management System (TMS). The TMS was established to document each incoming call received and outgoing call placed, particularly calls related to existing case files. There is no single "TMS" Screen in ECMS. Rather, TMS refers to a combination of screens and functions related to on-line telephone message tracking and management. For example, the phone message screen is accessed by clicking the red phone icon, and phone message

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## 7. Case Management. (Continued)

reports are accessed through the 'Inquiry' menu in ECMS or through clicking the ECMS Reports icon.

An automated telephone record must be created for every telephone call received or initiated by DOL, regardless of whether the caller is a DEEOIC claimant or a representative or other interested party to a DEEOIC claim (including NIOSH, DOE, and DOJ). For example, calls taken by contact representatives, workers' compensation assistants, and supervisors must be entered into the system and, if needed, assigned to specific individuals for return calls.

### (1) Entering phone calls into ECMS.

(a) Incoming phone calls: All incoming calls from DEEOIC claimants, survivors, attorneys, Congressional Offices and/or any other parties to a DEEOIC claim (including NIOSH, DOE, and DOJ) must be recorded in TMS, whether or not a return call is required, under the case number in ECMS.

Calls from medical representatives, members of interest groups, or elected officials (or their staff members) must be documented. Also, calls that result in sending informational packets or application forms related to the EEOICPA to potential claimants or any other persons must be recorded in TMS, under each office's "dummy SSN", with a description in the text field of what was sent, to whom, and when.

If the person receiving an incoming telephone call answers it completely (i.e., no return call is needed), he or she immediately enters the call into the system as an incoming call and the call will be marked 'Y' in the Call Completed field.

(b) Outgoing phone calls - A call initiated by claims personnel, to a claimant or a party to the claim, must be entered as a phone message into TMS. After entering all appropriate data to record, the call will be marked 'Y' in the Call Completed field, and ensure that the phone message is closed.

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7. Case Management. (Continued)

If an outgoing call generates the need for a call-up, the person making the call first must document the call in the phone message screen, then open the Notes and Call-ups screen to enter a call-up note and date.

(2) Fields to be completed - When a call requiring TMS entry is taken, the required data that must be entered into TMS are:

(a) Call Reason - Select from list; use 'other' if none apply.

(b) Claim Type - Select from list; 'other' values are available for calls unrelated to existing claims.

(c) Note - The individual taking the call enters a note - up to 2000 characters - describing the substance of the inquiry. This note is known as the Primary Phone Message.

(d) Caller Name - Enter name of caller.

(e) Call For - Enter name and/or title/position of person to whom the caller asked to speak; use 'N/A' if specific person was not requested.

(f) Relation - Select from list - caller's relationship to the claimant identified in Claim Type field.

(g) Received by - System will default to logged-in user id.

(h) Call Type - Select from list:

'D-Direct Call' when an incoming phone call is received and completed without requiring a return call.

'O-Outgoing Call' when the CE or other DOL employee initiates a phone call to any source and completes it, as long as the call

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7. Case Management. (Continued)

is not a return call as part of a previously opened return call.

'R-Return Call' when returning a phone call that could not be completed at the time of the incoming or outgoing phone call, and required the DOL employee to return the telephone call.

(i) Receive date - System will default to current date.

(j) Callback No. - Enter caller's phone number, if provided by caller.

(k) Assign to - Select from list - any user in DO. The user name entered in the Assign to field becomes the 'owner' of the telephone note.

(l) Call Completed - 'Y' or 'N' - phone call will remain open and pending until 'Y' is entered and saved to this field. The CE must ensure that the date corresponds with the call return. Return calls are the only call type that do not automatically have a call completed status of 'Y'.

(m) Returned by - Select from list; the user ID of the person who returned the phone call.

(3) Calls Requiring a Return Call. The owner (user name appearing in the Assign to field) of the phone call is responsible for returning it and closing out the TMS phone message. After returning an open or pending call, he or she must take two actions to close out the pending call in TMS:

(a) Return/completed call messages must be entered on a supplemental message screen (Callback/Addendum Notes) accessed via the bottom portion of the phone message screen. (The TMS user moves the cursor into one of the rows in the grid and then depresses the <INSERT> key to add a new callback/addendum note.)

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## 7. Case Management. (Continued)

A blank callback/addendum note will appear on the screen - the user enters the details of the return call here. A callback note must comprehensively describe the reply to the caller's inquiry. TMS will allow up to 1000 characters.

After this addendum note is saved, it appears as a new row in the grid view at the bottom of the Phone Message Screen. Double-clicking on the specific row for a Callback/Addendum note displays the full text of the note.

(b) After the addendum note is entered and saved, the CE or other user must return to the telephone message Add/Update screen and click the 'Y' in the Callback Completed box, and ensure that the (Callback Completed On) date reflects the actual return call date.

If 'Y' is selected, the call will no longer appear on the pending phone messages list. If 'N' is selected, the TMS system will not close out the call and the call will appear on the owner's pending phone message list.

### (4) General Information about TMS.

(a) Any return telephone call entered into TMS will remain an open call until closed out in TMS.

(b) The note field of the primary phone message must not be modified or updated, except in two instances:

(i) By the creator of the message, and then only to correct or clarify the text entered on the date of call creation.

(ii) By the owner of the message (or supervisory personnel), to explain why he or she is reassigning the message to another user.

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7. Case Management. (Continued)

(c) When a user logs into ECMS, TMS displays a message identifying the number of pending phone messages which have been logged (that is, assigned to, or owned by) for that user. By selecting the 'Open Phone Msgs' option, TMS displays all the outstanding return calls that do not contain a completed call date.

(d) Once a phone call is assigned to a person, it is owned by that person. TMS permits only the person who owns a call, or supervisory personnel, to reassign a phone call. TMS permits reassignment of an individual phone message from within that message screen - the current owner simply selects the new owner of the message from among the list of users in the Assign To box.

When reassignment occurs in this manner, the owner must type his or her user ID and the date within the 'Notes' portion of the primary message, along with a brief reason for the reassignment.

The owner will reassign a phone call only when he or she does not actually speak to the caller. The call will not be closed out until a return call is made.

For example, a customer service representative answers a call and refers it to CE-1. CE-1 receives the referral and becomes the owner; however the case is actually managed by CE-2. CE-1 does not return the call, and reassigns the case to CE-2. CE-2 then becomes responsible for returning the call timely.

(e) While in any one of the telephone screens, the user may go into another ECMS screen to check the status of the case. All claim-related telephone call messages must be printed and spindled down in the case file, but only after the phone call record is closed, i.e., for calls requiring a response, after the response is recorded in the Callback/Addendum Note.

7. Case Management. (Continued)

(f) Documentation of all calls not related to a specific case must be printed and kept in a central location in the office for reference and tracking purposes.

Superseded

EC CODE JUSTIFICATION MEMO

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Claimant Name(s)(if other than employee: \_\_\_\_\_

Response to employment verification requests are no longer required based on the following criteria:

- \_\_\_\_\_ ORISE verification received
  - \_\_\_\_\_ DOE employment verification received
  - \_\_\_\_\_ Corporate verification received
  - \_\_\_\_\_ Social Security verification received
  - \_\_\_\_\_ Rec. Decision-Deny -
  - \_\_\_\_\_ Medical evidence insufficient
  - \_\_\_\_\_ Employment evidence insufficient
  - \_\_\_\_\_ Survivor evidence insufficient
  - \_\_\_\_\_ Other: \_\_\_\_\_
- 

Claims Examiner: \_\_\_\_\_ Date: \_\_\_\_\_

WS/WR - REFERRAL/RESPONSE FORM

Employee Name: \_\_\_\_\_ Case #: \_\_\_\_\_ District Office: \_\_\_\_\_

Claimant's Name (if other than employee): \_\_\_\_\_ Relationship: \_\_\_\_\_

Manner of Referral: Case File: \_\_\_\_\_ Copies of Documents: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Type of Issue(s): Policy: \_\_\_\_\_ Procedure: \_\_\_\_\_

Medical \_\_\_\_\_ Employment \_\_\_\_\_ Survivorship \_\_\_\_\_ Other: \_\_\_\_\_

DO: Issue(s)

CE's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

SCE's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

DD's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

BPRP: Response

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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1. Purpose and Scope. This chapter describes how to use the Energy Case Management System (ECMS) with respect to decisions rendered by the District Offices (DOs), Secondary Claims Examiner (CE2) Unit, and the Final Adjudication Branch (FAB). It also addresses ECMS coding procedures as it relates to alternative filings, reconsiderations, closure of claims, and claims filed for new conditions after a final decision. EEOICPA PM 2-2000 addresses ECMS coding in general, focusing on the early and developmental stages of a claim. The information in this chapter applies to both ECMS B and ECMS E, unless otherwise indicated.

Decisions specify which benefits are awarded/accepted, denied, or under development, and under which Part of the Act (B or E or both). Recommended Decisions and Final Decisions are reflected in ECMS by decision code/reason code combinations that relate to the Part B portion in ECMS B, and to the Part E portion in ECMS E. This is necessary to ensure accurate statistics about decisions made under Parts B and E.

2. Required Coding for Approvals. All approved claims must contain at least one medical condition with a medical condition type, an ICD-9 code, a diagnosis date, and an "A" for Accepted in the cond status field. [For Part B cases, the medical condition type must be equal to BD, BS, CN, CS, MT, OL (for RECA), or PD (for RECA)].

The medical status effective date must be equal to the claim filing date. If the case is a B/E case with different filing dates under Part B and E, then ECMS B and E will reflect different filing dates and status effective dates. The earliest of the two status effective dates for a Part B/E condition will be transmitted to central bill pay for medical eligibility processing.

Any verified worksite data must be updated with information from the verification(s) received, and the Covered Employment Ind field (case screen) and the Payee Eligibility field (located on the payee screen) must be "Y," for "Yes."

A recommended decision code to fully or partially accept (A0, A1, A2, A8) must be entered in the Claim Status History with an appropriate reason code. See Paragraphs 4 and 5 below for an in-depth discussion of recommended decision coding.

3. Required Coding for Recommended Denials. A recommended denial claim status code (D1, D3, D4, D5, D7) and associated reason code (for D5 and D7 only) are required in the Claim Status History. See Paragraphs 4 and 5 below for an in-depth discussion of recommended decision coding.

The recommended denial code must correspond with the primary reason for recommendation of denial under that Part of the Act (B or E). That means that the claim status code should match with the most reasonable basis for the denial. Therefore, only one claim status code is entered per claimant (per part - B or E). The hierarchy is as follows:

- a. 'D3' Code. If a claimant files who is an ineligible survivor, the claim should be denied on the basis of being an ineligible survivor, regardless of any lack in medical or employment evidence.
- b. 'D4' Code (B only). If a claimant files only for a non-covered condition, the CE develops for a covered occupational illness. Until a covered condition is found, employment is not developed. If a covered occupational illness is never claimed, the claim should be denied on the basis of a non-covered condition ('D4').
- c. 'D7' Code. If a claimant files for a covered occupational illness, and employment is developed, but after development there is not enough medical evidence to support the covered condition, the claim is denied because of insufficient medical evidence to support a covered condition ('D7'). This is true whether or not employment verification has been completed and regardless of whether employment is covered.
- d. 'D1' Code. If a claimant files for a covered occupational illness and enough medical evidence is received to accept the medical portion of the claim, but the employment requirements are not met after development, the claim is denied due to lack of covered employment ('D1').

4. General Decision Coding. When a recommended or final decision is issued, the Claims Examiner (CE), Senior Claims Examiner (SrCE), or Hearing Representative (HR) enters the appropriate claim status code(s) into ECMS. The coding must match the wording in the decision. There are three possible

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#### 4. General Decision Coding. (Continued)

outcomes for each claimed element: accept, deny, or defer. Deferring a decision means that a decision is not being made on that element at this time because further development is needed, essentially holding the decision in abeyance.

It is important that decisions do not state that a decision on additional elements is being deferred unless additional elements have actually been claimed. For example, a decision should not state, "A decision regarding impairment and wage loss benefits is being deferred pending further development" if those items have never been claimed. These types of statements in decisions lead the claimant to believe they will be receiving decisions on those items, which they will not, unless claimed. If matching deferral coding is input into ECMS, it will cause reporting problems.

a. Primary Decision Codes. All decisions require at least one 'primary' decision code. If the decision addresses Part B benefits only, a primary decision code is entered into ECMS B. If the decision addresses Part E benefits only, a primary decision code is entered into ECMS E only. If the decision addresses Part B and Part E benefits, there is a primary decision code entered into ECMS B and a separate primary decision code in ECMS E. Generally, there is no more than one primary decision code in either ECMS B or ECMS E, per decision. Exceptions will be listed in this chapter. The status effective date for the decision codes is the date of the decision.

When selecting a primary decision code, the CE/SrCE/HR must look at what is happening overall on the decision for Part B or Part E, separately. For example, if a decision is accepting lung cancer under Part B and denying it under Part E because the survivor is ineligible, the coding must reflect a primary decision code in ECMS B that only reflects an acceptance (A0/F0), while ECMS E must only reflect a denial (D3/F3). It is not coded as a partial accept/partial deny (A8/F9) in both systems.

Some primary decision codes also have reason codes associated with them that give more detail as to what is being accepted or denied. Primary recommended decision codes and their associated reason codes are discussed in detail in Paragraph 5. Primary final decision codes and

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#### 4. General Decision Coding. (Continued)

their associated reason codes are discussed in detail in Paragraph 7.

b. Secondary Decision Codes. On Part E decisions that are more than straight acceptances or denials, it is necessary to enter a second claim status code that gives additional information on what is being denied or deferred in the decision. This additional claim status code is called a 'secondary' decision code.

A secondary decision status code must be used in ECMS E only and must be used in conjunction with a 'primary' decision status code entered with the same status effective date of the primary decision status code. There should never be more than one of each of the secondary decision status codes per decision. Secondary decision status codes (and their reason codes) are listed and described below.

(1) The 'PD' [Partial Deny] secondary decision status code must never be used without tandem entry in ECMS E of a primary decision status code describing a partial Part E acceptance or denial. That is, 'PD' must never be entered without first entering, with the same status effective date, one of the following 'primary' decision status codes in ECMS E: A2/G2 (Partial Accept/Partial Develop/Partial Deny), A8/F8 (Partial Accept/Partial Deny), D5/F5 (Deny-cancer not work related), D7/F9 (Non-cancer causation/insufficient medical denial), or F6 (FAB Reversed to Accept).

The 'PD' status code can be used in conjunction with the D5/F5 or D7/F9 denial code to address multiple types of denials, such as insufficient medical in addition to a non-cancer causation denials or to a cancer not work related denial (See example 4 below).

The 'PD' status code can be used in conjunction with the 'F6' (FAB Reversed to Accept) code if at least one portion of the recommended decision is reversed from a denial to an acceptance, and there is still another element being denied in the final decision. The reason code associated with F6 would encompass whatever is being accepted and the reason code under

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#### 4. General Decision Coding. (Continued)

the 'PD' status code would reflect what is being denied.

Once the 'PD' status code is entered, the CE/SrCE/HR selects the reason code from the drop-down menu that corresponds with the element(s) being denied. Both the DO/CE2 Unit and FAB use this code when issuing decisions that require partial denial coding.

(a) IN - 'Insufficient Medical to Establish Claimed Illness' - Used when a covered illness is claimed under E but medical evidence is insufficient to establish the illness.

(b) CAU - 'Causation' - Used when a covered illness is claimed under E, but causation cannot be established.

(c) WAG - 'Wage Loss' - Used when claimed wage loss is being denied.

(d) CAW - 'Causation and Wage Loss' - Used when a covered illness is claimed under Part E, but causation cannot be established and claimed wage loss must also be denied.

(e) IM0 - 'Impairment - 0%' - Used when the claim for impairment is being denied because the impairment rating is 0% based upon the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(f) IMN - 'Impairment - Not Ratable' - Used when the claim for impairment is being denied because the claimed impairment is non-ratable, such as certain psychiatric conditions.

(g) IMR - 'Impairment - Resolved' - Used when the claim for impairment is being denied because the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

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#### 4. General Decision Coding. (Continued)

(h) IOW - 'Impairment (0%) and Wage Loss' - Used when wage loss and impairment are both the only portions being denied. The claim for impairment is denied because it has a 0% rating based upon the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(i) INW - 'Impairment (Not Ratable) and Wage Loss' -Used when wage loss and impairment are being denied. Impairment is denied because the condition being claimed is not ratable for impairment, such as certain psychiatric conditions.

(j) IRW - 'Impairment (Resolved) and Wage Loss' - Used when wage loss and impairment are both being denied. The claim for impairment is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(k) COW - 'Causation, Impairment (0%) and Wage Loss' - Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment is denied because the impairment rating is 0% based upon the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(l) CNW - 'Deny Causation, Wage Loss, & Impairment (Not Ratable)' - Used when claims are made for causation, wage loss, and impairment, all of which are being denied. The impairment is being denied because it is for a non-ratable condition, such as certain psychiatric conditions.

(m) CRW - 'Causation, Impairment (Resolved), and Wage Loss' - Used when claims for causation, impairment and wage loss are being denied simultaneously as portions of the claim as a whole. The impairment claim is being denied

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#### 4. General Decision Coding. (Continued)

because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(n) CA0 - 'Causation and Impairment (0%)' - Used when causation and 0% impairment based upon the AMA Guides are being denied simultaneously or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(o) CAN - 'Causation and Impairment (Not Ratable)' - Used when causation and a non-ratable impairment are being denied simultaneously.

(p) CAR - 'Causation and Impairment (Resolved)' - Used when causation and impairment, that is resolved prior to the issuance of the decision, are being denied simultaneously.

(q) MBM - Maximum Payable Benefit Met' - Used when the maximum payable benefit is already paid and a decision is required for an impairment and/or wage loss claim.

(2) The 'DV' [Partial Develop] secondary decision status code is used exclusively in ECMS E to record findings in a decision that describe a partial deferral for a claimed element under Part E. The 'DV' status code is entered in conjunction with a primary decision status code. Both the primary and secondary decision codes have the same status effective date (the date the decision is issued).

The 'DV' status code must be used in conjunction with one of the following 'primary' decision status codes in ECMS E: A2/G2 (Partial Accept/Partial Develop/Partial Deny) or A1/G1 (Partial Accept/Partial Develop); and can be used with D5/F5 (Deny-cancer not work related), D7/F9 (Non-cancer causation/insufficient medical denial), or F6 (FAB Reversed to Accept).

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#### 4. General Decision Coding. (Continued)

The 'DV' status code can be used in conjunction with the D5/F5 or D7/F9 denial codes to address partial deny/partial develop decisions. The reason code associated with D5/F5 or D7/F9 would encompass whatever is being denied and the reason code under the 'DV' status code would reflect what is being deferred.

The 'DV' status code can also be used in conjunction with the 'F6' (FAB Reversed to Accept) code if at least one portion of the recommended decision is reversed from a denial to an acceptance and there is still a decision on another element being deferred in the final decision. The reason code associated with F6 would encompass whatever is being accepted and the reason code under the 'DV' status code would reflect what is being deferred.

The associated primary decision code could also be in ECMS B if the decision only addresses Part B benefits and completely defers the adjudication of any pending Part E element(s). (See example 1 below).

Once the 'DV' status code is entered, the CE/SrCE/HR selects the reason code from the drop-down menu that corresponds with the element(s) being held in abeyance for further development. Both the DO/CE2 Unit and the FAB use this code when issuing decisions that require partial development or deferral codes.

(a) CAU - 'Causation' - Causation for another claimed condition requires further development.

(b) CAW - 'Causation and Wage Loss' - Causation for another claimed condition and wage loss require further development.

(c) CAI - 'Causation and Impairment' - Causation for another claimed condition and impairment require further development.

(d) IMP - 'Impairment' - Claimed impairment requires further development.

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#### 4. General Decision Coding. (Continued)

(e) WAG - 'Wage Loss' - Claimed wage loss requires further development.

(f) IMW - 'Impairment and Wage Loss' - Claimed impairment and claimed wage loss require further development.

(g) CIW - 'Causation, Impairment, and Wage Loss' - Causation for another claimed condition, claimed impairment and claimed wage loss require further development.

c. Examples. A decision that accepts a claimed condition under E and denies a second claimed condition under B is not considered a 'partial' decision outcome for coding purposes. Instead, the 'A0' acceptance status code in ECMS E and the appropriate 'D\_' denial status code in ECMS B should be used. It is incorrect to consider the ECMS E outcome as 'A8' [Partial Accept/Partial Deny] because the partial deny outcome does not apply to Part E. The following examples further illustrate these rules.

Example 1: If there is a recommended decision to deny cancer for Probability of Causation (PoC) under Part B, and the Part E case has yet to be developed for causation based on toxic exposure, so that the Part E decision is deferred, the coding would be: 'D5' [Recommended Deny - Cancer not work related/PoC<50%], with Reason Code 'B' [Part B] in ECMS B, and 'DV' [Partial Develop] with no primary recommended decision status code in ECMS E (the tandem primary code is in ECMS B).

The final decision code, if upheld by FAB, would be: 'F5' [Final Deny - Cancer not work related/PoC<50%] in ECMS B, with Reason Code 'B' [Part B] and 'DV' [Partial Develop] with no primary final decision status code in ECMS E (assuming the Part E claim is still under development).

Example 2: If there is a recommended decision to accept CBD for both Parts B and E, but the claims for wage loss and impairment are being deferred under Part E, the coding would be: 'A0' [Recommended Accept] in ECMS B, with Reason Code 'B' [Part B] (since all of the medical conditions are accepted and completed in Part B), and 'A1' [Recommended

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#### 4. General Decision Coding. (Continued)

Partial Accept/Partial Develop] in ECMS E, with Reason Code 'CAU', since the CBD is being partially accepted (for causation).

To record in ECMS E that the claims for wage loss and impairment are being deferred (the case is only deferred if there is an actual claim for wage loss/impairment in the case file), status code 'DV' [Partial Develop], with Reason Code 'IMW' [Impairment and Wage Loss], would be entered.

The final decision coding, if upheld by FAB, would be: 'F0' [Final Accept] in ECMS B, with Reason Code 'B' [Part B] and 'G1' [Final Partial Accept/Partial Develop] in ECMS E, with Reason Code 'CAU.' To record in ECMS E that the claims for wage loss and impairment are being deferred, status code 'DV' [Partial Develop], with Reason Code 'IMW' [Impairment and Wage Loss], would be entered.

Example 3: If there is a recommended decision to accept Asbestosis in Part E, and defer wage loss and impairment, and also to deny cancer in both Parts B and E (because the claimant did not prove he or she had cancer), the coding would be: 'D7' [Recommended Deny - medical information insufficient to support claim/non-cancer causation denial], with Reason Code 'B' [Part B] in ECMS B (since the cancer was denied for insufficient medical evidence), and 'A2' [Recommended Partial Accept/Partial Deny/Partial Develop] in ECMS E, with Reason Code 'CAU' (for accepting Asbestosis for causation).

To record in ECMS E that the claims for wage loss and impairment related to Asbestosis are being deferred, status code 'DV' [Partial Develop], with Reason Code 'IMW' [Impairment and Wage Loss], would be entered. To record in ECMS E that the claim for cancer is being denied, status code 'PD' [Partial Deny], with Reason Code 'IN' [Insufficient Medical to establish claimed illness], would be entered.

The final decision coding, if upheld by FAB, would be nearly identical to the recommended decision coding: Status Code 'F9' [Final Deny - medical information insufficient to support claim/non-cancer causation denial] with Reason Code 'B' in ECMS B and 'G2' [Final Partial Accept/Partial

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#### 4. General Decision Coding. (Continued)

Deny/Partial Develop] with Reason Code 'CAU' in ECMS E, along with status codes 'DV', with Reason Code 'IMW'; and 'PD', with Reason Code 'IN'.

Example 4: If there is a recommended decision to deny cancer and asbestosis in Part E because causation could not be established and peripheral neuropathy is denied because medical evidence was not provided to support a diagnosis of the claimed illness and wage loss is also being denied, the coding would be 'D5'[Recommended Deny - Cancer not work related] with Reason Code 'CAW' [to encompass the cancer and asbestosis causation denials and wage loss denial] followed by 'PD' [Partial Denial], with Reason Code 'IN', to capture the denial of peripheral neuropathy because of the lack of evidence of a diagnosis.

The final decision coding, if upheld by FAB, would be nearly identical to the recommended decision coding: 'F5'[FAB Affirmed Deny - Cancer not work related] with Reason Code 'CAW' [to encompass the cancer and asbestosis causation denials and wage loss denial] followed by 'PD' [Partial Denial], with Reason Code 'IN', to capture the denial of peripheral neuropathy because of the lack of evidence of a diagnosis.

5. Recommended Decision Codes. The CE/SrCE must enter the appropriate recommended decision code when issuing a recommended decision. The status effective date of the code equals the recommended decision issuance date.

a. A0 - 'Recommended Accept - Sent to FAB'. When the CE/SrCE renders a recommended decision on a claim for approval for benefits, where there are no other pending elements on the claim (including additional medical conditions, wage loss, or impairment), the DO/CE2 Unit enters the 'A0' code. The status effective date is the date of the recommended decision.

Upon entering the 'A0' code, the CE/SrCE must select a specific reason code from the "reason cd" field, which is a drop-down box corresponding to the 'A0' claim status code.

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5. Recommended Decision Codes. (Continued)

To record any accepted Part B component of the decision, the CE must select reason code 'B' [Part B] for entry in ECMS B.

To record any accepted Part E component of the decision, the CE must select one of the following reason codes from the drop-down menu to record all claimed elements (causation, wage loss, and/or impairment) being accepted in the current decision. These drop-down codes are required exclusively for Part E ECMS.

(1) CAU - 'Causation Accepted' - Used when causation is established under Part E, which results in medical benefits for an employee or death benefit for an eligible survivor.

(2) CAW - 'Causation and Wage Loss Accepted' - Used when causation and wage loss are being accepted simultaneously under Part E.

(3) CAI - 'Causation and Impairment Accepted' - Used when causation and impairment are being accepted simultaneously under Part E.

(4) IMP - 'Impairment Only Accepted (Causation Previously Accepted)' - Used when causation was established on a previous decision and impairment is all that is being accepted in this decision under Part E.

(5) WAG - 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all that is being accepted in this decision under Part E.

(6) IMW - 'Impairment and Wage Loss Accepted' - Used when causation was established in a previous decision and the current decision accepts for wage loss and impairment.

(7) CIW - 'Causation, Impairment, and Wage Loss Accepted' - Used when causation, impairment, and wage loss are all being accepted in the current Part E decision.

5. Recommended Decision Codes. (Continued)

(8) DEF - 'Decision Deferred' - Deactivated. This code was only to be entered by the FAB in certain rare circumstances where a decision to accept was made without the DO/CE2 Unit having issued a recommended decision. **This code has been deactivated with the potential to be reactivated if the need arises.**

b. A1 - 'Recommended Partial Accept/Partial Develop'. When the CE/SrCE renders a recommended decision where part of the claim is approved for benefits, while another part of the claim needs further development (including additional medical conditions, wage loss, or impairment), the DO/CE2 Unit enters the 'A1' code. The status effective date is equal to the date of the recommended decision. This code allows benefit disbursement, if FAB upholds the decision, while other development continues.

For Part B cases only, the CE/SrCE should use status code 'A1' with reason code 'B' [Part B] for Recommended decisions that describe a partial acceptance for at least one claimed condition under Part B and partial development for one or more other conditions under Part B.

For Part E cases only, the CE/SrCE must select the appropriate reason code from the drop-down menu for input into ECMS E. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

(1) CAU - 'Causation' - Used when causation for a claimed condition is accepted for benefits and additional development of another claimed element is required.

(2) CAW - 'Causation and Wage Loss' - Used when causation and wage loss are being accepted and additional development of another claimed element is required.

(3) CAI - 'Causation and Impairment' - Used when causation and impairment are being accepted and additional development of another claimed element is required.

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5. Recommended Decision Codes. (Continued)

(4) IMP - 'Impairment' - Used when causation has been previously accepted and impairment alone is being accepted and the additional development of another claimed element is required.

(5) WAG - 'Wage Loss' - Used when causation has been previously accepted and wage loss alone is being accepted and additional development of another claimed element is required.

(6) IMW - 'Impairment and Wage Loss' - Used when causation has been previously accepted, impairment and wage loss are both currently being accepted, and additional development of another claimed element is required (e.g., a cancer that is undergoing dose reconstruction at the National Institute of Occupational Safety and Health (NIOSH)).

(7) CIW - 'Causation, Impairment, and Wage Loss' - Used when causation is accepted along with both impairment and wage loss and additional development of another claimed element is required (e.g., a cancer that is undergoing dose reconstruction at NIOSH).

The portion(s) of the claim being held in abeyance for additional development is/are identified by the secondary decision status code 'DV' [Partial Develop] and corresponding reason code set out in Paragraph 4 above.

c. A2 - 'Recommended Partial Accept/Partial Deny/Partial Develop'. When the CE/SrCE renders a recommended decision where part of the claim is approved for benefits, while another part of the claim is denied, and yet another part of the claim needs further development (including additional medical conditions, wage loss, or impairment), the DO/CE2 Unit enters the 'A2' code . The status effective date is the date of the recommended decision. This code allows for benefits to be administered, if FAB upholds the decision, while other development continues.

For Part B cases only, status code 'A2' is used with reason code 'B' [Part B] in ECMS B for recommended decisions that describe a partial acceptance for at least one claimed

5. Recommended Decision Codes. (Continued)

condition under Part B and partial denial and partial development for one or more other conditions under B.

For Part E cases only, the CE/SrCE must select the appropriate reason code from the drop-down menu in ECMS E. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

- (1) CAU - 'Causation' - Used when causation for a claimed condition is accepted for benefits, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (2) CAW - 'Causation and Wage Loss' - Used when causation and wage loss are being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (3) CAI - 'Causation and Impairment' - Used when causation and impairment are being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (4) IMP - 'Impairment' - Used when causation has been previously accepted, impairment alone is being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (5) WAG - 'Wage Loss' - Used when causation has been previously accepted, wage loss alone is being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (6) IMW - 'Impairment and Wage Loss' - Used when causation has been previously accepted, impairment and wage loss are both currently being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.
- (7) CIW - 'Causation, Impairment, and Wage Loss' - Used when causation is accepted along with impairment

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5. Recommended Decision Codes. (Continued)

and wage loss, a portion of the claim is being denied, and a portion of the claim requires additional development (e.g., a cancer is undergoing dose reconstruction at NIOSH).

The portion(s) of the claim being denied or held in abeyance for additional development are identified by the secondary decision status codes 'PD' [Partial Denial] and 'DV' [Partial Develop] and corresponding reason codes set out in Paragraph 4 above.

d. A8 - 'Recommended Partial Accept/Partial Deny'. When the CE/SrCE renders a recommended decision where part of the claim is going to be approved for benefits, while another part of the claim is going to be denied, the DO/CE2 Unit enters the 'A8' code in ECMS. The status effective date is equal to the date of the recommended decision. This code allows for benefit administration, if FAB upholds the decision, while development continues.

For Part B cases only, the CE/SrCE should use status code 'A8' with reason code 'B' [Part B] in ECMS B for recommended decisions that describe a partial acceptance for at least one claimed condition under Part B and partial denial for one or more other conditions under B.

For Part E cases only, the CE/SrCE must select the appropriate reason code from the drop-down menu. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

(1) CAU - 'Causation' - Used when causation for a claimed condition is accepted for benefits and a portion of the claim is being denied.

(2) CAW - 'Causation and Wage Loss' - Used when causation and wage loss are being accepted and a portion of the claim is being denied.

(3) CAI - 'Causation and Impairment' - Used when causation and claimed impairment are being accepted and a portion of the claim is being denied.

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5. Recommended Decision Codes. (Continued)

(4) IMP - 'Impairment' - Used when causation has been previously accepted, claimed impairment alone is currently being accepted, and a portion of the claim is being denied.

(5) WAG - 'Wage Loss' - Used when causation has been previously accepted, wage loss alone is currently being accepted, and a portion of the claim is being denied.

(6) IMW - 'Impairment and Wage Loss' - Used when causation has been previously accepted, impairment and wage loss are both currently being accepted, and a portion of the claim is being denied.

(7) CIW - 'Causation, Impairment, and Wage Loss' - Used when causation is accepted along with impairment and wage loss, and a portion of the claim is being denied (another claimed medical condition).

The portion(s) of the claim being denied is identified by the secondary decision status code 'PD' [Partial Deny] and corresponding reason code set out in Paragraph 4 above.

e. D1 - 'Recommended Deny - Non-Covered Employment'. When the CE/SrCE renders a recommended decision to deny benefits due to employment that is not covered, the CE/SrCE enters the 'D1' code. The status effective date is equal to the date of the recommended decision. There are no associated reason codes.

f. D3 - 'Recommended Deny - Survivor Not Eligible'. When the CE/SrCE renders a recommended decision to deny benefits because the claimed survivor is not eligible, the DO/CE2 Unit enters the 'D3' code. The status effective date is equal to the date of the recommended decision. There are no associated reason codes.

g. D4 - 'Recommended Deny - Condition Not Covered' (B only). When the CE/SrCE renders a decision to deny Part B benefits because the condition is not covered under Part B, the DO/CE2 Unit enters a 'D4' code. The status effective date is equal to the date of the recommended decision. There are no associated reason codes.

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5. Recommended Decision Codes. (Continued)

h. D5 - 'Recommended Deny - Cancer Not Work Related (PoC)'. When the CE/SrCE renders a recommended decision to deny benefits based wholly or in part on the PoC result from NIOSH being less than 50%, the DO/CE2 Unit enters the 'D5' code. The status effective date is equal to the date of the recommended decision. This means if more than one condition is being denied, but at least one of them is a cancer case that went to NIOSH, the 'D5' primary decision code must be selected. This is also the only decision status code approved for use when denying a cancer claim based upon the PoC being less than 50% under both B and E. This code is also to be used in cases of CLL-cancer only, wherein the PoC is presumed to be zero.

Upon entry of the 'D5' code, the CE/SrCE selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'D5' claim status code. The only reason code allowable for ECMS B is 'B' [Part B]. The remaining reason codes available for the 'D5' claim status code are to be used in ECMS E.

Note 1: In ECMS E, the 'D5' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/SrCE enters the 'D5' code with a reason code denoting what is being denied. The CE/SrCE then enters the 'DV' status code and appropriate associated reason code listed in Paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

Note 2: If there is also a finding in the Part E decision to deny one or more claimed conditions because medical evidence was not provided to support diagnosis of the claimed condition, in addition to the cancer(s) specifically included in the NIOSH PoC determination (described by using the 'D5' code), it is appropriate to enter, in tandem with the 'D5' entry, status code 'PD' [Partial Deny] with 'IN' reason code to describe/record the additional denial. Essentially, the coding would be deny/partial deny. This captures one or more conditions were denied because causation could not be established and at least one other condition had insufficient medical to

5. Recommended Decision Codes. (Continued)

establish the diagnosis of the claimed illness. Additional elements being denied, such as impairment, wage loss, and other causation denials can be captured in the reason code for 'D5', unless specifically requested in relation to the condition(s) being denied under 'PD'.

For example, if prostate cancer and wage loss are denied for lack of causation (PoC and toxic exposure) and asbestosis is denied because medical evidence was not provided, the Part E case would be coded 'D5/F5-CAW' and 'PD-IN'.

The reason codes associated with the 'D5' code are:

(1) B - 'Part B' (B only) - Used when cancer is claimed under Part B, but is being denied based on the NIOSH PoC.

(2) CAU - 'Causation' (E only) - Used when cancer is claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development).

(3) WAG - 'Wage Loss' (E only) - Used in the rare circumstance when a wage loss claim is received and adjudicated after a cancer denial.

(4) CAW - 'Causation and Wage Loss' (E only) - Used when cancer and wage loss are claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development) and wage loss must also be denied.

(5) IM0 - 'Impairment - 0%' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial. The impairment rating may not have been completed because causation was not established or if one was provided with a 0% impairment rating.

(6) IMN - 'Impairment - Not Ratable' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and

5. Recommended Decision Codes. (Continued)

the claim for impairment is for a non-ratable condition, such as certain psychiatric conditions.

(7) IMR - 'Impairment - Resolved' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(8) IOW - 'Impairment (0%) and Wage Loss' (E only) - Used when wage loss and impairment related to a previously denied cancer are both being denied. The claim for impairment is denied because it has a 0% rating or because an impairment rating was not completed due to lack of causation.

(9) INW - 'Impairment (Not Ratable) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied related to a previously denied cancer. The claim for impairment is denied because the condition being claimed is not ratable for impairment, such as certain psychiatric conditions.

(10) IRW - 'Impairment (Resolved) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied related to a previously denied cancer. The claim for impairment is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(11) COW - 'Causation, Impairment (0%) and Wage Loss' (E only) - Used when claims for causation, impairment, and wage loss are denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

(12) CNW - 'Causation, Impairment (Not Ratable), and Wage Loss' (E only) - Used when a claim is made for causation, wage loss, and impairment, all of which are being denied simultaneously. The impairment claim is

5. Recommended Decision Codes. (Continued)

being denied because it is for a non-ratable condition.

(13) CRW - 'Causation, Impairment (Resolved), and Wage Loss' (E only) - Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment claim is denied because the impairment was resolved (i.e., does not exist anymore) prior to issuance of the decision.

(14) CA0 - 'Causation and Impairment (0%)' (E only) - Used when causation and 0% impairment are being denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

(15) CAN - 'Causation and Impairment (not ratable)' (E only) - Used when causation and an impairment for a non-ratable condition, such as certain psychiatric conditions, are being denied simultaneously.

(16) CAR - 'Causation and Impairment (Resolved)' (E only) - Used when causation and an impairment that is resolved (i.e., does not exist anymore) prior to the issuance of the decision are being denied simultaneously.

h. D7 - 'Recommended Deny - Medical Information Insufficient to Support Claim/Non-Cancer Causation Denial'. This code is used when the CE/SrCE renders a recommended decision to deny benefits because, after developing the claimed covered condition(s), there is insufficient medical evidence to support an acceptance; the decision is for a non-cancer causation denial; the maximum payable benefit is met; or the decision solely addresses impairment and/or wage loss claims where the related condition was not previously denied under D5.

The status effective date is the date of the recommended decision. Upon entry in ECMS of the 'D7' code, the CE/SrCE selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'D7'

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5. Recommended Decision Codes. (Continued)

claim status code. The reason codes available for the 'D7' claim status code are listed below. The reason code 'B' [Part B] is only to be used in ECMS B.

Note 1: In ECMS E, the 'D7' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/SrCE enters the 'D7' code with a reason code denoting what is being denied. The CE then enters the 'DV' status code and appropriate associated reason code listed in Paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

Note 2: If the decision contains findings to deny multiple claimed conditions, and one denial is for insufficient medical evidence to establish the claimed illness and another denial is for inability to establish causation, impairment or wage loss, the CE/SrCE should enter 'D7' with the reason code describing the causation/impairment/wage loss denial. In tandem with the 'D7' entry, the CE/SrCE should enter 'PD' [Partial Deny] with reason code 'IN' to record the denial for insufficient medical to establish illness.

(1) B - 'Part B'(B only) - Used when a condition is denied in ECMS B.

(2) DMB - 'Deny Specific Medical Benefits on Accepted Condition' (B and/or E) - Used when a specific medical benefit is being denied on an accepted condition in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

(3) RMB - 'Reduce Medical Benefits on Accepted Condition' (B and/or E) - Used when a medical benefit on a previously paid item for a covered condition is reduced in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

(4) IN - 'Insufficient Medical to Establish Claimed Illness'(E only) - Used when a covered illness is

5. Recommended Decision Codes. (Continued)

claimed under Part E but medical evidence is insufficient to establish the illness.

(5) R4C - 'RECA 4 Cancer' (E only) - Used when a Part E cancer case is denied because the claimant had received benefits under RECA Section 4.

(6) CAU - 'Causation' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established.

(7) WAG - 'Wage Loss' (E only) - Used when the claim for wage loss is being denied due to lack of medical evidence to support the claimed period of wage-loss is causally related to the covered illness.

(8) CAW - 'Causation and Wage Loss' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established and claimed wage loss must also be denied.

(9) IM0 - 'Impairment - 0%' (E only) - Used when the claim for impairment is being denied because the impairment rating is 0% under the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(10) IMN - 'Impairment - Not Ratable' (E only) - Used when the claim for impairment is being denied because the claimed impairment is non-ratable, such as certain psychiatric conditions.

(11) IMR - 'Impairment - Resolved' (E only) - Used when the claim for impairment is being denied because the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(12) IOW - 'Impairment (0%) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied. The claim for impairment is denied because it has a 0% rating or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

5. Recommended Decision Codes. (Continued)

(13) INW - 'Impairment (Not Ratable) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied. The claim for impairment is denied because the condition being claimed is not ratable for impairment, such as certain psychiatric conditions.

(14) IRW - 'Impairment (Resolved) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied. The claim for impairment is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(15) COW - Causation, Impairment (0%) and Wage Loss' (E only) - Used when claims for causation, impairment, and wage loss are denied simultaneously. Impairment is denied because the impairment rating is 0% or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(16) CNW - 'Causation, Impairment (Not Ratable), and Wage Loss' (E only) - Used when a claim is made based on causation, wage loss, and impairment, all of which are being denied. The impairment is being denied because it is for a non-ratable condition.

(17) CRW - 'Causation, Impairment (Resolved), and Wage Loss' (E only) - Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment claim is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(18) CA0 - 'Causation and Impairment (0%)' (E only) - Used when causation and impairment are being denied simultaneously. Impairment is denied because the impairment rating is 0% or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(19) CAN - 'Causation and Impairment (Not Ratable)' (E only) - Used when causation and an impairment that is not ratable are being denied simultaneously.

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5. Recommended Decision Codes. (Continued)

(20) CAR - 'Causation and Impairment (Resolved)' (E only) - Used when causation and an impairment that is resolved prior to the issuance of the decision are being denied simultaneously.

(21) MBM - 'Maximum Payable Benefit Met' (E only) - Used when the maximum payable benefit is already met and a formal decision is required for an impairment and/or wage loss claim.

6. Between Recommended and Final Decisions. When the FAB receives a case from the DO, the case is transferred in ECMS using the codes discussed in EEOICPA PM 1-0700, Exhibit 2. The date the file is "transferred in" is the date the transfer sheet is date stamped in.

When the case is transferred in, the 'FD' (FAB Received RD) code is entered into the Claim Status History for each active claimant with a status effective date of the date FAB received the case.

At this time, ECMS automatically generates a docket number for each claim, viewable at the top of the ECMS claim screen and payee screen. This number is generated the first time the case goes to FAB. Subsequent decisions that go to the FAB for review are not given new docket numbers. This number is referenced on decisions issued by the FAB and is used on published decisions.

a. 'FN' - FAB Initial Review Complete. After the case is transferred into FAB and coded 'FD'/"docketed", it is assigned to the appropriate CE or Hearing Representative (HR). The CE/HR completes an initial review of the case, assigns a CE2 if necessary, and enters an 'FN' (FAB Initial Review Complete). The status effective date of the 'FN' code is the date the CE/HR completes the initial review.

b. 'FJ' - FAB Received Waiver of Objections. When FAB receives a waiver of objections, a 'FJ' code is entered into the claim status history for the claimant who provided the completed waiver.

The status effective date of the 'FJ' code is the date that the waiver is received and date stamped into any FAB office only (not the DO, National Office, or a Resource Center).

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6. Between Recommended and Final Decisions. (Continued)

ECMS requires the selection of a reason code from the associated drop-down box. The reason codes available for the 'FJ' status code are:

- (1) 'PW'- Partial Waiver - Used when a bifurcated waiver is received, waiving the right to object to a portion of the decision and reserving the right to object to another.
- (2) 'WF' - Full Waiver - Used when a waiver is received waiving the right to object to all findings and conclusions in the recommended decision.

When choosing between a full waiver and a partial waiver, the CE/HR must look at what is being done in Parts B and E separately (as with the decisions). Here are some sample scenarios illustrating the use of this code:

Example 1: If a decision grants benefits under Part E and denies under Part B, and a partial waiver is received (waiving the Part E decision and reserving the right to object to the Part B decision), the CE/HR would enter an 'FJ-WF' (full waiver) in ECMS E and nothing in ECMS B. Essentially there is a full waiver on the Part E decision and no waiver on the Part B decision.

Example 2: If the Part B decision is an acceptance and the Part E decision is a partial accept/partial deny, and a bifurcated (partial) waiver is received, the CE/HR would enter a 'FJ-WF' (full waiver) into ECMS B and an 'FJ-PW' (partial waiver) into ECMS E. Please note that if a bifurcated waiver is received for a recommended decision pertaining to one part of the Act and the final decision to accept is issued prior to the final decision to deny because the claimant has reserved his or her right to object to the denial, that decision must be coded as a "partial develop" because a portion of the decision has been deferred. In this particular example the Part B decision would be coded 'F0-B' and the first Part E decision would be coded 'G1' (partial accept/partial develop) with an appropriate reason code + 'DV' (partial develop) with an appropriate reason code. The second Part E decision that would be issued after the objection period

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6. Between Recommended and Final Decisions. (Continued)

expired, would be coded as a denial (assuming nothing changed from the recommended decision).

c. Coding Objections. If the claimant submits an objection, it must be coded into ECMS. While every claimant is affected by an objection, the objection only needs to be coded for the claimant who submits it.

However, based on the portion of the decision (Part B or Part E) to which the claimant is objecting; it is coded only into ECMS B or ECMS E. If it is unknown whether the objection pertains to Part B or E, or the claimant specifies both, the objection will be coded into both ECMS B and ECMS E.

A claimant who objects may request either a review of the written record or an oral hearing. In either case, the Appeals screen must be completed. To access the appeals screen, the CE/HR clicks on the "Appeals/Recons" button on the claim screen. The CE/HR then goes to the section marked appeals, selects an area in that field and clicks "Insert". This will take the CE/HR to the appeals screen, for which completion is discussed below. These fields are completed as the appropriate information becomes available:

(1) Rec Decision - This field will be populated with the recommended decision code entered by the DO/CE2 Unit. If multiple recommended decisions have been issued, select the one referenced in the objection from the drop-down menu.

(2) Auth Rep - This field is completed with the name of the claimant's authorized representative, if any. If there is no authorized representative, this field is left blank.

(3) FAB Rep - This field is completed with the ID of the FAB employee assigned to the case by using the drop-down menu.

(4) Appeal Rcpt Dt - This field is completed with the date that the objection was received in any FAB office only (not the DO, National Office, or a Resource Center).

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6. Between Recommended and Final Decisions. (Continued)

(5) Dist Office - This field is automatically populated with the office location of the FAB representative.

(6) Ext Thru - This is an optional field used for the CE/HR's information if an extension is granted. If time allows, the CE/HR can grant one extension, at the claimant's request, for submission of additional evidence.

(7) Appeal Type - This field is used to indicate how the objection is being addressed. The following reasons are available via the drop-down menu:

(a) 'FQ - Hearing' - Selected when the claimant has requested an oral hearing.

(b) 'FT - Hearing Teleconference' - Selected when the claimant requests a telephonic hearing.

(c) 'FW - Review of the Written Record' - Selected when the claimant requests a review of the written record or if the claimant objects and fails to specify that a hearing is desired.

(8) Objection - This field is used to specify the main reason that the claimant is objecting. There is a drop-down box that describes several types of objections, such as more evidence available, secondary exposure, general, etc. The CE/HR selects the one that best applies to the claimant's objection.

(9) Date to FAB Rep - This field is completed with the date the objection is assigned to the CE/HR.

(10) AckReq Dt - This field is completed with the date FAB sends a letter to the claimant acknowledging that the objection has been received.

(11) Hearing Scheduled Dt - This field is completed only for hearing requests, using the date the hearing arrangements were made.

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6. Between Recommended and Final Decisions. (Continued)

(12) Notice Sent Dt - This field is completed only for hearing requests, using the date the hearing notification letter was sent to the claimant.

(13) Hearing Dt - This field is completed only for hearing requests, using the date of the hearing.

(14) Date RWR - This field is completed only for reviews of the written record (RWR), using the date the RWR is completed/the date of the final decision.

(15) Location and State - These fields are completed only for oral hearing requests, using the city where the hearing is to take place. The state where the hearing is to occur can then be selected from the drop-down menu associated with the state field.

(16) Appeal Status and Appeal Status Date - The CE/HR selects the current status of the objection process (such as "Hearing Convened" or "Appeal Request Untimely") along with completing the date of the current status in the appeal status date field.

(17) Notes - This is an optional field where any notes regarding the objections can be listed. For example, if the received date for an appeal appears untimely because the appeal receipt date is more than 60 days after the recommended decision, but the postmark date is within 60 days, the timely postmark date would be mentioned in the notes section.

(18) Final Decision - This field is completed when the final decision is issued. On cases where objections have been filed and an oral hearing or RWR was performed, the Final Decision Code is entered through the appeals screen. To enter the final decision code in these circumstances, the CE/HR selects the button next to the final decision field on the appeals screen and enters the appropriate final decision code (see Paragraph 7 below).

7. FAB Decision Codes. The FAB CE/HR must ensure that all coding throughout the claim file is correct when a FAB decision is issued. If FAB must enter missing codes on behalf of the DO/CE2 Unit, the FAB CE/HR must select the appropriate office's "dist office cd" on the claim status code (update) screen to reflect the office that actually took the action. The FAB CE/HR must ensure that the status effective date of any added or updated codes have the correct status effective date.

When issuing final decisions, the appropriate final decision code (see list below) is entered into ECMS. The status effective date of the code will be the date the final decision was issued.

Currently there are two systems for ECMS separately tracking Part B and Part E activity. The final decision coding is entered with a decision code/reason code combination that relates to the 'Part B' portion in ECMS B, and a decision code/reason code combination that relates to the 'Part E' portion in ECMS E. This is necessary to ensure accurate statistics about what decisions were made in relation to the 'Part B' and 'Part E' portions of the case. For example, if a decision is issued that accepts Part B and denies Part E, it would not be coded as a partial accept/partial deny in both systems. It would be coded as an acceptance in ECMS B and a denial in ECMS E.

Under Part E, "causation" for employee claimants means that the claimed covered illness was caused by exposure to a toxic substance at a covered Part E facility or site. "Causation" for a survivor claimant means that exposure to a toxic substance at a covered Part E facility or site was a significant factor in aggravating, contributing to, or causing the death of the employee.

a. F0 - 'Final Accept'. When the CE/HR renders a final decision on an approved claim for benefits, where there are no other pending elements on the claim (including additional medical conditions, wage loss, or impairment), the CE/HR enters the 'F0' code. The status effective date is the date of the final decision.

Upon entering the 'F0' code, the CE/HR must select a specific reason code from the "reason cd" field, which is a drop-down box corresponding to the 'F0' claim status code.

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## 7. FAB Decision Codes. (Continued)

To record any accepted Part B component of the decision, the CE/HR must select reason code 'B' [Part B] for entry in ECMS B.

To record any accepted Part E component of the decision, the CE/HR must select one of the following reason codes from the drop-down menu to record all of the claimed elements being accepted in the current decision. These reason codes are to be entered exclusively in ECMS E:

- (1) CAU - 'Causation Accepted' - Used when causation is established under Part E, which results in medical benefits for an employee or death benefit for an eligible survivor.
- (2) CAW - 'Causation and Wage Loss Accepted' - Used when causation and wage loss are being accepted simultaneously under Part E.
- (3) CAI - 'Causation and Impairment Accepted' - Used when causation and impairment are being accepted simultaneously under Part E.
- (4) IMP - 'Impairment Only Accepted (Causation Previously Accepted)' - Used when causation was established on a previous decision and impairment is all that is being accepted in this decision under Part E.
- (5) WAG - 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all that is being accepted in this decision under Part E.
- (6) IMW - 'Impairment and Wage Loss Accepted' - Used when causation was established in a previous decision and the current decision accepts for wage loss and impairment.
- (7) CIW - 'Causation, Impairment, and Wage Loss Accepted' - Used when causation, impairment, and wage loss are all being accepted in the current Part E decision.

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7. FAB Decision Codes. (Continued)

b. G1 - 'Final Partial Accept/Partial Develop/Defer'. When the CE/HR renders a final decision where part of the claim is going to be approved for benefits, while another part of the claim needs further development/deferral (including additional medical conditions, wage loss, or impairment), the CE/HR enters the 'G1' code. The status effective date is the date of the final decision.

This code allows for benefits to be administered while development continues. Status code 'G1' is used with reason code 'B' [Part B] in ECMS B for final decisions that describe a partial acceptance for one claimed condition under Part B and partial development/deferral for one or more other conditions under B.

For Part E cases only, the CE/HR must select the appropriate reason code from the drop-down menu for input into ECMS E. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

(1) CAU - 'Accept Causation' - Used when causation for a claimed condition is accepted for benefits and additional development of another claimed element is required.

(2) CAW - 'Accept Causation and Wage Loss' - Used when causation and claimed wage loss are being accepted and additional development of another claimed element is required.

(3) CAI - 'Accept Causation and Impairment' - Used when causation and claimed impairment are being accepted and additional development of another claimed element is required.

(4) IMP - 'Accept Impairment' - Used when causation has previously been accepted, claimed impairment alone is being accepted, and the additional development of another claimed element is required.

(5) WAG - 'Accept Wage Loss' - Used when causation has previously been accepted, claimed wage loss alone

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7. FAB Decision Codes. (Continued)

is being accepted, and the additional development of another claimed element is required.

(6) IMW - 'Accept Impairment and Wage Loss' - Used when causation was previously accepted, impairment and wage loss are both claimed, a decision is being issued that accepts both impairment and wage loss for benefits, and the additional development of another claimed element is required.

(7) CIW - 'Accept Causation, Impairment, and Wage Loss' - Used when causation is accepted along with both claimed impairment and wage loss, and the additional development of another claimed element is required (e.g., a cancer claim is pending dose reconstruction at NIOSH).

The portion(s) of the claim being held in abeyance for additional development or because the decision cannot be issued at this time (possibly because of a partial waiver) are identified by the secondary decision status code 'DV' [Partial Develop] and corresponding reason code as set out in Paragraph 4 above.

c. F1 - 'Final Deny - Employee Not Covered'. When the CE/HR renders a final decision to deny benefits due to employment that is not covered, the CE/HR enters the 'F1' code. The status effective date is the date the final decision was issued.

d. G2 - 'Final Partial Accept/Partial Deny/Partial Develop/Defer'. When the CE/HR renders a final decision where part of the claim is going to be approved for benefits, while another part of the claim is going to be denied, and yet another part of the claim requires further development or is being deferred, the FAB CE/HR enters the 'G2' code. The status effective date is the date of the final decision.

This code allows for benefits to be administered while development continues. Status code 'G2' is used with reason code 'B' [Part B] in ECMS B for final decisions that describe a partial acceptance for one claimed condition

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7. FAB Decision Codes. (Continued)

under Part B and partial denial and partial development for one or more other conditions under Part B.

For Part E cases, the CE/HR must select the appropriate reason code from the drop-down menu. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

(1) CAU - 'Accept Causation' - Used when causation for a claimed condition is accepted for benefits and a portion of the claim is being denied and a portion of the claim requires additional development.

(2) CAW - 'Accept Causation and Wage Loss' - Used when causation and wage loss are being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.

(3) CAI - 'Accept Causation and Impairment' - Used when causation and impairment are being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.

(4) IMP - 'Accept Impairment' - Used when causation has been previously accepted, impairment alone is being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.

(5) WAG - 'Accept Wage Loss' - Used when causation has been previously accepted, wage loss alone is being accepted, a portion of the claim is being denied, and a portion of the claim requires additional development.

(6) IMW - 'Accept Impairment and Wage Loss' - Used when causation has been previously accepted, a decision is being issued that accepts both impairment and wage loss, a portion of the claim is being denied, and a portion of the claim requires additional development.

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7. FAB Decision Codes. (Continued)

(7) CIW - 'Accept Causation, Impairment, and Wage Loss' - Used when causation is accepted along with both impairment and wage loss, a portion of the claim is being denied, and a portion of the claim requires additional development (e.g., a cancer claim is undergoing dose reconstruction at NIOSH).

The portion(s) of the claim being held in abeyance for additional development or because the decision cannot be issued at this time (possibly because of a partial waiver) is identified by the secondary decision code 'DV' [Partial Develop] and corresponding reason codes set out in Paragraph 4 that are only available in ECMS E. The portion(s) of the claim denied are identified by the secondary decision status codes 'PD' [Partial Denial].

e. F3 - 'Final Deny - Survivor Not Eligible'. When the CE/HR renders a final decision to deny benefits because the claimed survivor is not eligible, the CE/HR enters the 'F3' code. The status effective date is the date of the final decision.

f. F4 - 'Final Deny - Condition Not Covered'. (B only) When the CE/HR renders a final decision to deny Part B benefits because the condition is not covered under Part B, the FAB CE/HR enters a 'F4' code in ECMS B. The status effective date is equal to the date of the Final Decision.

g. F5 - 'Final Deny - Cancer Not Work Related (PoC)'. When the CE/HR renders a final decision to deny benefits because the PoC result from NIOSH is less than 50%, the CE/HR enters the 'F5' code. This means if more than one condition is being denied, but at least one of them is a cancer case that went to NIOSH, the D5 primary decision code must be selected. This code is also to be used in cases of CLL-cancer only, wherein the PoC is presumed to be zero. The status effective date is the date of the final decision. This code is used for BOTH Part B and Part E cancer denials based upon a PoC of less than 50%.

Upon entry of the 'F5' code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'F5' claim status code.

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## 7. FAB Decision Codes. (Continued)

The reason codes available for the 'D5' claim status code are listed below.

The only reason code allowable for ECMS B is 'B' [Part B].

Note 1: In ECMS E, the 'F5' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/HR enters the 'F5' code with a reason code denoting what is being denied. The CE/HR then enters the 'DV' status code and appropriate associated reason code listed in paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

Note 2: If there is also a finding in the Part E decision to deny one or more claimed conditions because medical evidence was not provided to support diagnosis of the claimed condition, in addition to the cancer(s) specifically included in the NIOSH PoC determination (described by using the 'F5' code), it is appropriate to enter, in tandem with the 'F5' entry, status code 'PD' [Partial Deny] with 'IN' reason code to describe/record the additional denial. Essentially, the coding would be deny/partial deny. This captures one or more conditions were denied because causation could not be established and at least one other condition had insufficient medical to establish the diagnosis of the claimed illness. Additional elements being denied, such as impairment, wage loss, and other causation denials can be captured in the reason code for 'F5', unless specifically requested in relation to the condition(s) being denied under 'PD'.

For example, if prostate cancer and wage loss are denied for lack of causation (PoC and toxic exposure) and asbestosis is denied because medical evidence was not provided, the Part E case would be coded 'F5'-'CAW' and 'PD'-'IN'.

The reason codes associated with the F5 code are:

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7. FAB Decision Codes. (Continued)

(1) B - 'Part B' (B only) - Used when cancer is claimed under Part B, but is being denied based on the NIOSH PoC.

(2) CAU - 'Causation' (E only) - Used when cancer is claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development).

(3) WAG - 'Wage Loss' (E only) - Used in the rare circumstance when a wage loss claim is received and adjudicated after a cancer denial.

(4) CAW - 'Causation and Wage Loss' (E only) - Used when cancer and wage loss are claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development) and wage loss must also be denied.

(5) IMO - 'Impairment - 0%' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial. The impairment rating may not have been completed because causation was not established or if one was provided with a 0% impairment rating.

(6) IMN - 'Impairment - Not Ratable' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and the claim for impairment is for a non-ratable condition, such as certain psychiatric conditions.

(7) IMR - 'Impairment - Resolved' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(8) IOW - 'Impairment (0%) and Wage Loss' (E only) - Used when wage loss and impairment related to a previously denied cancer are both being denied. The claim for impairment is denied because it has a 0% rating or because an impairment rating was not completed due to lack of causation.

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7. FAB Decision Codes. (Continued)

(9) INW - 'Impairment (Not Ratable) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied related to a previously denied cancer are both being denied. The claim for impairment is denied because the condition being claimed is not ratable for impairment, such as certain psychiatric conditions.

(10) IRW - 'Impairment (Resolved) and Wage Loss' (E only) - Used when wage loss and impairment are both being denied related to a previously denied cancer. The claim for impairment is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(11) COW - Causation, Impairment (0%), and Wage Loss' (E only) - Used when claims for causation, impairment, and wage loss are denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

(12) CNW - 'Causation, Impairment (Not Ratable), and Wage Loss' (E only) - Used when a claim is made for causation, wage loss, and impairment, all of which are being denied simultaneously. The impairment claim is being denied because it is for a non-ratable condition.

(13) CRW - 'Causation, Impairment (Resolved), and Wage Loss' (E only). Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment claim is denied because the impairment was resolved (i.e., does not exist anymore) prior to issuance of the decision.

(14) CA0 - 'Causation and Impairment (0%)' (E only) - Used when causation and 0% impairment are being denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

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7. FAB Decision Codes. (Continued)

(15) CAN - 'Causation and Impairment (not ratable)' (E only) - Used when causation and an impairment for a non-ratable condition, such as certain psychiatric conditions, are being denied simultaneously.

(16) CAR - 'Causation and Impairment (Resolved)' (E only) - Used when causation and impairment that is resolved (i.e., does not exist anymore) prior to the issuance of the decision are being denied simultaneously.

h. F6 - 'Final Accept - Reversal From Denial.' When the CE/HR renders a final decision to approve benefits despite the recommended decision to deny, the CE/HR enters the 'F6' code. The status effective date is the date of the final decision.

This code should also be used if the recommended decision is a partial accept/partial deny and the denial portion is reversed.

Upon entering the 'F6' code, the CE/HR must select a specific reason code from the "reason cd" field, which is a drop-down box corresponding to the 'F0' claim status code.

To record any accepted Part B component of the decision, the CE/HR must select reason code 'B' [Part B] for entry in ECMS B.

If a Part B final decision reversed at least a portion of a recommended decision to deny, while the other Part B elements are accepted, the CE/HR must use an additional primary final decision code to capture the denial. The CE/HR must enter the 'F6' code with reason code 'B' and another applicable final decision for the element that is being denied.

To record any accepted Part E component of the decision, the CE/HR must select one of the following reason codes from the drop-down menu to record all of the claimed elements being accepted in the current decision. These reason codes are to be entered exclusively in ECMS E:

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7. FAB Decision Codes. (Continued)

(1) CAU - 'Causation Accepted' - Used when causation is established under Part E, which results in medical benefits for an employee or death benefit for an eligible survivor.

(2) CAW - 'Causation and Wage Loss Accepted' - Used when causation and wage loss are being accepted simultaneously under Part E.

(3) CAI - 'Causation and Impairment Accepted' - Used when causation and impairment are being accepted simultaneously under Part E.

(4) IMP - 'Impairment Only Accepted (Causation Previously Accepted)' - Used when causation was established on a previous decision and impairment is all that is being accepted in this decision under Part E.

(5) WAG - 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all that is being accepted in this decision under Part E.

(6) IMW - 'Impairment and Wage Loss Accepted' - Used when causation was established in a previous decision and the current decision accepts for wage loss and impairment.

(7) CIW - 'Causation, Impairment, and Wage Loss Accepted' - Used when causation, impairment, and wage loss are all being accepted in the current Part E decision.

If a Part E final decision reversed at least a portion of a recommended decision to deny to a final decision to accept, while other Part E elements are still being denied and/or deferred, the CE/HR must use the secondary decision codes 'PD' and/or 'DV' along with the 'F6' code. The reason code associated with the 'F6' will show what elements are being accepted, including what was reversed. The reason codes associated with the 'PD' and/or 'DV' code(s) will reflect what is still being denied and/or deferred, respectively.

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## 7. FAB Decision Codes. (Continued)

If a Part B final decision reversed at least a portion of a recommended decision to deny to a final decision to accept, while other Part B elements are still being denied and/or deferred, the CE/HR must use a primary decision code along with the 'F6' code with reason code 'B'. The primary decision code will reflect what is still being denied and/or deferred.

i. F7 - 'FAB Remanded'. This code is entered when FAB remands a decision of the DO/CE2 Unit. Upon issuance of the remand order, the CE/HR must enter the claim status code 'F7' in the Claim Status History. The status effective date is equal to the date of the remand order. The CE/HR must also select the appropriate reason code from the drop-down menu that best describes the reason the case is being remanded.

The reason code reflects whether the remand is based on a DO/CE2 Unit error that could have been avoided or an unavoidable reason that was not a DO/CE2 Unit error. The reason codes (listed below) give more detail to the reason for the remand ("other" is the catch-all if no other reason codes fit.)

The FAB CE/HR codes 'F7' into the appropriate system (ECMS B for a B only remand, ECMS E for an E only remand, and both for a Part B/E remand. If the Part B and E decisions are remanded, an 'F7' goes into ECMS B and E, but could have different reason codes in each.

Do not enter multiple 'F7's and reason codes per system to capture multiple types of errors, instead select the reason code that captures the most egregious error (per part type) or "other" if none really fit. If there are multiple reasons for a remand, some avoidable and some unavoidable, select the avoidable reason code.

(1) DO/CE2 Unit Error - Any remand that the FAB considers to be have been avoidable by the DO/CE2 Unit:

(a) ERM - 'Error - Medical (Dx, Disease, Causation, DMC related)' - This reason code is selected if the remand is based on an error in

7. FAB Decision Codes. (Continued)

the medical development or conclusions, such as incorrect causation determinations, DMC referrals, and diagnoses.

(b) ERE Error - 'Employment (Dates/Time Pd, Exposure, SEM Use)' - This reason code is selected if the remand is based on an error in the employment development or conclusions, such as incorrect employment dates/facilities, exposures, or SEM usage.

(c) ERS Error - 'Survivorship' - This reason code is selected if the remand is based on an error in the survivorship development or conclusions.

(d) ERO Error - 'Other (Error - Not Med, Emp, or Survivorship)' - This reason code is selected if the remand is based on a DO/CE2 Unit error that is not predominately medical, employment, or survivorship in nature.

(2) No DO/CE2 Unit Error - Any remand that FAB considers to have been unavoidable by the DO/CE2 Unit:

(a) DEA - 'No DO Error - Death of Claimant' - This reason code is selected when the FAB becomes aware of the claimant's death while the case is pending a final decision.

(b) RTN - 'No DO Error - Recommended Decision Returned by Post Office' - This reason code is selected when the recommended decision is returned by the post office and a new address cannot be obtained to re-issue the recommended decision and issue the final decision to the claimant(s).

(c) CLS - 'No DO Error - Administrative Closure (not claimant death)' - This reason code is selected when the claim must be remanded to the DO/CE2 Unit for an administrative closure for a reason other than death or bad address.

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7. FAB Decision Codes. (Continued)

(d) OTH - 'Error - Other (Error - Not Med, Emp, or Survivorship)' - This code is used for remands that could not be avoided for a reason other than death of claimant, bad address, or administrative closure. An example of 'OTH' errors that are unavoidable are remands based on new evidence, change in law, regulation, policy or procedure, new SECs, and new PEPs.

When issuing partial decisions that include a remand order, codes should be entered in this order:

- (1) Partial Accept/Partial Remand - 'F0' + reason code to show what is accepted, followed by 'F7' + remand reason code.
- (2) Partial Reverse to Accept/Partial Remand - 'F6' + reason code to show what is accepted, followed by 'F7' + remand reason code.
- (3) Partial Deny/Partial Remand - Denial code ('F1', 'F3', 'F4', 'F5', or 'F9') + reason code showing what is denied, followed by 'F7' + remand reason code.
- (4) Partial Accept/Partial Deny/Partial Remand -
  - (a) If the Partial Accept/Partial Deny/Partial Remand is for Part B - code 'F8' (FAB Accept in Part/Deny in Part) + reason code 'B', followed by 'F7' + remand reason code in ECMS B.
  - (b) If the Partial Accept/Partial Deny/Partial Remand is for Part E - code 'F8' (FAB Accept in Part/Deny in Part) + reason code that shows what is accepted, 'PD' + reason code to show what is denied, and 'F7' + remand reason code in ECMS E.
- (5) Partial Accept/Partial Deny/Partial Develop/Partial Remand -
  - (a) If the Partial Accept/Partial Deny/Partial Develop/Partial Remand is for Part B - code 'G2' (FAB Accept in Part/Deny in Part/Develop in Part)

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7. FAB Decision Codes. (Continued)

+ reason code 'B', followed by 'F7' + remand reason in ECMS B.

(b) Partial Accept/Partial Deny/Partial Develop/Partial Remand is for Part E - code 'G2' (FAB Accept in Part/Deny in Part/Develop in Part) + reason code, 'PD' + reason code to show what is denied, 'DV' + reason code to show what is deferred, and 'F7' + remand reason code in ECMS E.

(6) Partial Accept/Partial Develop/Partial Remand -

(a) If the Partial Accept/Partial Develop/Partial Remand is for Part B - code 'G1' (FAB Accept in Part/Develop in Part) + reason code 'B', followed by 'F7' + remand reason code in ECMS B.

(b) If the Partial Accept/Partial Develop/Partial Remand is for Part E - code 'G1' (FAB Accept in Part/Develop in Part) + reason code, 'DV' + reason code to show what is deferred, and 'F7' + remand reason code in ECMS E.

The status effective date for all the primary and secondary decision codes is the date of the final decision.

j. F8 - 'Final Partial Accept/Partial Deny'. When the CE/HR renders a final decision where part of the claim is approved for benefits, while another part of the claim is denied, the CE/HR enters the 'F8' code. The status effective date is equal to the date of the final decision.

For Part B cases, status code 'F8' is used with reason code 'B' [Part B] in ECMS B for final decisions that describe a partial acceptance for one claimed condition under Part B and partial denial for one or more other conditions under B.

For Part E cases, the CE/HR must select the appropriate reason code from the drop-down menu and enter it into Part E ECMS. The reason code for the decision explains only what is being accepted in the current decision. These are the Part E reason codes available in the drop down menu:

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7. FAB Decision Codes. (Continued)

(1) CAU - 'Accept Causation' - Used when causation for a claimed condition is accepted for benefits and a portion of the claim is being denied.

(2) CAW - 'Accept Causation and Wage Loss' - Used when causation and wage loss are being accepted and a portion of the claim is being denied.

(3) CAI - 'Accept Causation and Impairment' - Used when causation and impairment are being accepted and a portion of the claim is being denied.

(4) IMP - 'Accept Impairment' - Used when causation was previously accepted, impairment alone is currently being accepted, and a portion of the claim is being denied.

(5) WAG - 'Accept Wage Loss' - Used when causation was previously accepted, wage loss alone is currently being accepted, and a portion of the claim is being denied.

(6) IMW - 'Accept Impairment and Wage Loss' - Used when causation was previously accepted, impairment and wage loss are both currently being accepted, and a portion of the claim is being denied.

(7) CIW - 'Accept Causation, Impairment, and Wage Loss' - Used when causation is accepted along with impairment and wage loss, and a portion of the claim is being denied (e.g., a cancer claim is pending dose reconstruction at NIOSH).

The portion(s) of the claim being denied in the decision is identified by the secondary decision status code 'PD' [Partial Deny] and corresponding reason code set out in Paragraph 4 above.

k. F9 - 'Final Deny - Medical Information Insufficient To Support Claim/Non-Cancer Causation Denial'. This code is used when the CE/HR renders a final decision to deny benefits because there is insufficient medical evidence to support an acceptance; for any non-cancer causation denials; for when the maximum payable benefit is met; or

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## 7. FAB Decision Codes. (Continued)

for decisions that solely address impairment and/or wage loss claims (whose related conditions were not previously denied under F5). The status effective date is the date of the final decision.

Upon entry of the 'F9' code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'F9' claim status code. The reason codes available for the 'F9' claim status code are listed below. The reason code 'B' [Part B] is only to be used in ECMS B.

Note 1: In ECMS E, the 'F9' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/HR enters the 'F9' code with a reason code denoting what is being denied. The CE/HR then enters the 'DV' status code and appropriate associated reason code listed in Paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

Note 2: If the decision contains findings to deny multiple claimed conditions, and one denial is for insufficient medical evidence to establish the claimed illness and another denial is for inability to establish causation, impairment or wage loss, the CE/HR should enter 'F9' with the reason code describing the causation/impairment/wage loss denial. In tandem with the 'F9' entry, the CE should enter 'PD' [Partial Deny] with reason code 'IN' to record the denial for insufficient medical to establish illness.

(1) B - 'Part B'(B only) - Used when a condition is denied in ECMS B.

(2) DMB - 'Deny Specific Medical Benefits On Accepted Condition' (B and/or E) - Used when a specific medical benefit is being denied on an accepted condition in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

(3) RMB - 'Reduce Medical Benefits On Accepted Condition' (B and/or E) - Used when a medical benefit

7. FAB Decision Codes. (Continued)

on a previously paid item for a covered condition is reduced in a formal decision (not just a letter).  
(See EEOICPA PM 3-0300.)

(4) IN - 'Insufficient Medical To Establish Claimed Illness' (E only) - Used when a covered illness is claimed under Part E but medical evidence is insufficient to establish the illness.

(5) R4C - 'RECA 4 Cancer' (E only) - Used when a Part E cancer case is denied because the claimant had received benefits under RECA Section 4.

(6) CAU - 'Causation' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established.

(7) WAG - 'Wage Loss' (E only) - Used when the claim for wage loss is being denied due to lack of medical evidence to support the claimed period of wage-loss is causally related to the covered illness.

(h) CAW - 'Causation and Wage Loss' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established and claimed wage loss must also be denied.

(9) IMO - 'Impairment - 0%' (E only) - Used when the claim for impairment is being denied because the impairment rating is 0% under the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(10) IMN - 'Impairment - Not Ratable' (E only) - Used when the claim for impairment is being denied because the claimed impairment is non-ratable, such as certain psychiatric conditions.

(11) IMR - 'Impairment - Resolved' (E only) - Used when the claim for impairment is being denied because the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

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7. FAB Decision Codes. (Continued)

(12) IOW - 'Impairment (0%) and Wage Loss (E only) -  
Used when wage loss and impairment are both being  
denied. The claim for impairment is denied because it  
has a 0% rating or because a claim for impairment was  
filed, but the claimant failed to provide the  
necessary medical documentation.

(13) INW - 'Impairment (Not Ratable) and Wage Loss (E  
only) - Used when wage loss and impairment are both  
being denied. The claim for impairment is denied  
because the condition being claimed is not ratable for  
impairment, such as certain psychiatric conditions.

(14) IRW - 'Impairment (Resolved) and Wage Loss (E  
only) - Used when wage loss and impairment are both  
being denied. The claim for impairment is being  
denied because the impairment was resolved (i.e., does  
not exist anymore) prior to the issuance of the  
decision.

(15) COW - Causation, Impairment (0%) and Wage Loss  
(E only) - Used when claims for causation, impairment,  
and wage loss are denied simultaneously. Impairment  
is denied because the impairment rating is 0% or  
because a claim for impairment was filed, but the  
claimant failed to provide the necessary medical  
documentation.

(16) CNW - 'Causation, Impairment (Not Ratable), and  
Wage Loss' (E only) - Used when a claim is made based  
on causation, wage loss, and impairment, all of which  
are being denied. The impairment is being denied  
because it is for a non-ratable condition.

(17) CRW - 'Causation, Impairment (Resolved), and Wage  
Loss' (E only) - Used when claims for causation,  
impairment and wage loss are being denied  
simultaneously. The impairment claim is being denied  
because the impairment was resolved (i.e., does not  
exist anymore) prior to the issuance of the decision.

(18) CA0 - 'Causation and Impairment (0%)' (E only) -  
Used when causation and impairment are being denied  
simultaneously. Impairment is denied because the

7. FAB Decision Codes. (Continued)

impairment rating is 0% or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(19) CAN - 'Causation and Impairment (Not Ratable)' (E only) - Used when causation and an impairment that is not ratable are being denied simultaneously.

(20) CAR - 'Causation and Impairment (Resolved)' (E only) - Used when causation and impairment that is resolved (i.e., does not exist anymore) prior to the issuance of the decision are being denied simultaneously.

(21) MBM - 'Maximum Payable Benefit Met' (E only) - Used when the maximum payable benefit is already met and a formal decision is required for an impairment and/or wage loss claim.

1. F10 - 'Regulatory Final Decision'. The FAB CE/HR enters this claim status code if a case is identified as having a "regulatory/administrative" decision based on the "one year/365-day rule." The claim status date of the code is different depending on whether objections are present, or if it is a Director's Order to reopen for a new final decision and a decision is pending for more than one year:

(1) For cases where no objection was filed, the recommended decision becomes final 365 days from the time the 60-day objection period expires (if no final decision has been issued), that is, 425 days after the recommended decision date.

(2) For cases where an objection was filed, the recommended decision becomes final on the one-year anniversary date that the letter of objection was received (if no final decision has been issued.)

(3) For cases where a Director's Order was issued reopening a case for issuance of a new final decision, the recommended decision becomes final on the one-year anniversary date of the Director's Order (if no new final decision has been issued.)

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7. FAB Decision Codes. (Continued)

All of these cases must be submitted to National Office for reopening. See Paragraph 12 in this chapter for reopening coding instructions.

8. Alternative Filing Codes. When a claimant requests an alternative filing under Part E, the ECMS codes below are used.

(1) XR - 'Alternative Filing Review Requested' - Used when a claimant requests an alternative filing. The status effective date is the postmark date or date stamp the letter is received in the office, whichever is earlier.

(2) XC - 'Alternative Filing Review Completed' - Used when the CE/SrCE sends out a final response to the alternative filing request. The status effective date is the date of the written response. Depending upon the determination reached in the review, two findings are possible: positive and negative.

The CE/SrCE selects the appropriate reason code from the drop-down menu to indicate whether or not a causal link was found to have existed. If the finding of the causal review is positive, the CE/SrCE selects 'P' (Positive). If the finding of the causal review is negative, the CE/SrCE selects 'N' (Negative) to show that no causal link was found to exist.

9. Reconsideration Codes. When a claimant submits a request for reconsideration, it must be appropriately coded on the reconsideration screen (this screen is completed only for the claimant(s) who request reconsideration).

To access the reconsideration screen, the CE/HR presses the "Appeals/Recons" button on the claim screen, highlights a field in the "Reconsiderations" section of the FAB screen, and clicks insert. The following fields are completed as information on the reconsideration becomes available:

a. Claimant Objections. This field is completed using the associated drop-down menu. The CE/HR selects the reason that best describes why the claimant wants reconsideration, e.g., "challenges law" or "non-specific".

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9. Reconsideration Codes. (Continued)

- b. Date to HR. This field is the date the HR is made aware of the reconsideration request.
- c. Recon Req Date. This field is completed with the date the reconsideration request was received in any FAB office only (not the DO, National Office, or a Resource Center).
- d. Hearing Rep. This field is completed with the code/name of the CE/HR assigned to the case.
- e. Recon Status. This field is completed by selecting the status of the reconsideration process, granted or denied, from the drop-down box associated with the recon status field. Then, the date associated with the reconsideration status is entered in the box associated with the recon status date field.

This entry reflects whether the request for reconsideration has been granted or denied, not the case itself. If the reconsideration is granted, it will have a new, post-reconsideration final decision code entered [see item "g" below]. If the reconsideration is denied, the reason will be annotated in the note section [see item "f" below].

- f. Note. This field is used to input any applicable notes regarding the request for reconsideration. For example, if the received date for reconsideration appears untimely because the reconsideration receipt date is more than 30 days after the final decision, but the postmark date is within 30 days, the timely postmark date would be mentioned in the notes section.

A note should be entered when a request for reconsideration is denied, because there is an untimely filing, no new argument or evidence is submitted, or the new argument or evidence does not contradict the conclusions of the final decision.

- g. Post-Recon Final Decision. This field is completed when FAB accepts the request for reconsideration. A reconsideration code is not entered on cases where there is an untimely filing, no new argument or evidence is submitted, or the new argument or evidence does not contradict the conclusions of the final decision. A note

9. Reconsideration Codes. (Continued)

should be entered for those types of reconsideration denials.

When a reconsideration decision is made, the appropriate post-reconsideration final decision code must be entered into this field for all active claimants (even though the reconsideration screen is only completed for the individual(s) who requested the reconsideration). The codes are listed below. The status effective date of the reconsideration code is the date the new final decision is issued. (Do not overwrite the previous final decision code.)

R0	FAB RECON - ACCEPT
R1	FAB RECON - DENY, EMPLOYMENT NOT COVERED
R2	FAB RECON - DENY, CONDITION NOT RELATED TO EMPLOYMENT
R3	FAB RECON - DENY, SURVIVOR NOT ELIGIBLE
R4	FAB RECON - DENY, CONDITION NOT COVERED
R5	FAB RECON - DENY, CANCER NOT WORK-RELATED, POC
R6	FAB RECON - REVERSED TO ACCEPT
R7	FAB RECON - REMANDED
R8	FAB RECON - ACCEPT IN PART/DENY IN PART
R9	FAB RECON - DENY, MEDICAL INSUFFICIENT TO SUPPORT CLAIM

10. Closure Codes. The CE must enter the following ECMS closure codes in the Claim Status History screen as appropriate.

a. C0 - 'Closed-Administrative Error'. This claim status code is used if a claim was created in error. The status effective date is the date of the memo to the file explaining the administrative closure. This code was created for use by the DO prior to the claims delete capability being given to the field. Now that the field has the ability to delete or administratively close the claim, they need to know when to use each option. In situations where the claim has already started to be developed and related actions are coded into ECMS, use the C0 code. If the claim was created in error and discovered prior to any real development, the claim is be deleted. The status effective date is the date of the memo to the file explaining the administrative closure.

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## 10. Closure Codes. (Continued)

b. C1 - 'Closed-Claim Withdrawn by Claimant'. This claim status code is used if the claimant withdraws all unadjudicated claimed conditions in a system. (A claim in which a final decision has been issued cannot be withdrawn.) The CE will send a letter to the claimant, advising of the closure of the claim(s). The 'C1' is coded with a status effective date equal to the date of the letter to the claimant.

If there are multiple claimed conditions that have not yet been adjudicated, and the claimant wants to withdraw only one or some of the conditions, delete the withdrawn condition(s) and input a case note in ECMS and a memo to the file explaining the situation. The 'C1' is not entered in ECMS. However, if there is only adjudication of one illness pending or all the pending conditions are being withdrawn (no other conditions or wage loss or impairment), 'C1' is entered in ECMS. If wage loss or impairment is pending, wait to code 'C1' to ensure the claim remains on reports. Be aware that if 'C1' is used to close remaining claimed conditions after other conditions have been accepted, medical benefits will not be affected. Essentially, 'C1' should only be entered into ECMS B or E if everything on the claim is adjudicated and withdrawn or withdrawn for that Part (B or E).

c. C2 - 'Closed-Administrative Closure'. This claim status code is used if the claimant does not complete and return required forms, and therefore adjudication cannot continue. These include: tort suit or state workers' compensation information, NIOSH smoking history, race and skin questionnaires, and OCAS-1 (only if there is one claimant).

The CE will send a letter to the claimant, advising of the closure of the claim. The 'C2' is coded with a status effective date equal to the date of the letter to the claimant.

The types of administrative closures listed above do not require a reason code. However, there are some specific circumstances that require a reason code be selected from the drop down menu associated with the 'C2' claim status code:

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10. Closure Codes. (Continued)

FS - 'Failure To Sign Claim Form'. When a claimant files a claim telephonically with a Resource Center but then either refuses or fails to sign an actual claim form, the CE enters the 'C2' claim status code with the corresponding 'FS' (Failure to sign claim form) reason code. The status effective date is the date of the memo to the file explaining the administrative closure.

d. C3 - 'Closed-Employee Died'. This claim status code is used when the employee dies. If the death notification (i.e., phone call, letter) is received, and the case is either pre-recommended decision or post-final decision, the CE enters the 'C3' code, with a status effective date of when the Resource Center, DO, or FAB has been notified, whichever is earlier.

If the death notification is received between the recommended and final decision, meaning FAB has yet to issue the final decision, and will in fact remand the case back to the DO due to the death of the claimant, then the 'C3' code should not be entered until the DO receives the remand. The status effective date of code 'C3' will be that of the receipt date of the remand order, which is equivalent to the transfer-in date to the DO in ECMS. This code can be used in adjudicated and unadjudicated claims.

If the first written notification of an employee's death is on a newly-filed Form EE-2 from a survivor, where the date of death is included on the form, the status effective date is that of the date stamp of receipt in the Resource Center, DO, or FAB of the Form EE-2, whichever is earlier. [The date of death should also be entered on the Case screen.]

Bills submitted for unadjudicated and denied cases will be denied for processing and payment. Bills submitted for approved cases will be accepted for processing and possible payment up to the employee's date of death.

e. C8 - 'Closed-Survivor Died Prior to Payment Being Made'. This claim status code is used on a survivor claim if the survivor dies before compensation is paid. If the death notification (i.e., phone call, letter) is received,

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## 10. Closure Codes. (Continued)

and the case is either pre- recommended decision or post-final decision, the CE enters the 'C8' code, with a status effective date of when the Resource Center, DO, or FAB has been notified, whichever is earlier.

If the death notification is received between the recommended and final decision, meaning FAB has yet to issue the final decision, and will in fact remand the case back to the DO due to the death of the claimant, then the 'C8' code should not be entered until the remand is received back at the DO.

The status effective date of the 'C8' code will be that of the receipt date of the remand order, which is equivalent to the transfer in date to the DO in ECMS.

f. C9 - 'Closed-RECA Awaiting DOJ Adjudication'. This claim status code is used if a claim is filed with EEOICPA prior to adjudication by the Department of Justice (DOJ), and the claim is still pending with DOJ. The CE will send a letter to the claimant, advising of the closure of the claim. The 'C9' is coded with a status effective date equal to the date of the letter to the claimant.

Note: Once DOL receives a decision from DOJ that was pending, development is resumed. At that time, the CE codes 'RD' (development resumed) with a status effective date equal to the date-stamp of receipt of the DOJ decision.

g. C10 - 'Partial Claim Closure'. This claim status code is used when the wage loss or impairment portion of the claim is being closed without the issuance of a recommended or final decision. (Other closure codes reflect a closure of the entire claim, but this code closes only the individual impairment or wage loss component.) Once the 'C10' status code is entered, the CE selects the reason code from the drop-down menu that corresponds with the reason the impairment or wage loss claim is being closed.

(1) NM - 'Not at MMI' - When impairment is claimed, but the employee has not reached Maximum Medical Improvement (MMI), the CE enters the 'C10' claim status code with the corresponding reason code 'NM'

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## 10. Closure Codes. (Continued)

(Not at MMI) reason code. The status effective date of the code is the date of the letter to the claimant informing him or her that an impairment rating cannot be made at this time due to the fact that he or she has not reached MMI.

Note: Once medical evidence is received in the DO indicating that the claimant is at MMI, development is resumed and the 'RD' (Development Resumed) code will be entered into ECMS. The status effective date will be the date the DO/CE2 Unit receives such evidence of MMI.

(2) WLW - 'Wage Loss Claim Withdrawn' - Where wage loss had been claimed, but the claimant chooses to withdraw the claim for wage loss in writing, the CE codes the 'C10' claim status code with the 'WLW' (Wage Loss Claim Withdrawn) reason code. The status effective date is the date stamp of receipt in the Resource Center, DO, or FAB, whichever is earlier.

If the claimant decides to file at a later date, enter a new 'WC' code.

(3) ICW - 'Impairment Claim Withdrawn' - Where impairment had been claimed, but the claimant chooses to withdraw the claim for impairment in writing, the CE codes the 'C10' claim status code with the 'ICW' (Impairment Claim Withdrawn) reason code. The status effective date is the date stamp of receipt in the Resource Center, DO, or FAB, whichever is earlier.

If the claimant decides to file at a later date, enter a new 'IC' code.

Note: If claims for wage loss and impairment are withdrawn simultaneously, the CE will enter two 'C10' claims status codes, one with the 'WLW' reason code and the other with the 'ICW' reason code.

11. New Claims for New Medical Conditions. When a case has a final decision, and a current claimant submits a subsequent claim form for a new medical condition, the new claim filing is recorded in ECMS by entry of claim status code 'RD'-(Development Resumed). A new claim form for new covered medical conditions is required once a final decision is issued.

a. Case File at DO. If the case file is at the DO, and a new claim form is received after a final decision has been issued:

(1) The CE enters the new claim in ECMS by entering an 'RD'- Development Resumed in the claim status history screen of ECMS. The status effective date will be the new claim filing date. This is the earliest of the following: postmark date or date stamp of receipt on the claim form, or the initial piece of evidence that instigated the claim in a DO or FAB office, or Resource Center. [The envelope must be kept with the claim form, and put in the case file.]

Once the 'RD' code and status effective date are entered in ECMS, the CE enters the newly claimed medical condition on the Medical Condition screen. The CE reviews the new condition and begins development of the new medical evidence.

(2) Development of the case will continue through new recommended and final decisions. All previously entered ECMS codes in the Claim Status History are still relevant for the case and will apply to the new claim. They do not need to be re-entered following the 'RD' code. However, all new development for the claim must now be entered in ECMS, including all further development claim status history codes.

(3) If the new medical condition becomes an accepted condition, and the CE enters an "A" in the cond status field, then the med status effective date is determined by the following:

(a) If the original claim was for Beryllium Sensitivity, and was accepted, and the new claim is for CBD, the med status effective date of the CBD is the same as the final decision acceptance date of the Beryllium Sensitivity.

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11. New Claims for New Medical Conditions. (Continued)

Similarly, if the original claim was for pleural plaques, and was accepted, and the new claim is for asbestosis, the med status effective date of the asbestosis is the same as the final decision acceptance date of the pleural plaques.

(b) For all other medical conditions, including consequential conditions, regardless of the diagnosis date, the med status effective date is the new claim filing date for any conditions eventually accepted, prior to issuance of the final decision.

b. Case File at FAB. If the case file is at FAB, and a new claim form or medical evidence for a new covered medical condition is received prior to a final decision:

(1) If the case is in posture for acceptance, FAB will enter the new claim in ECMS by entering an 'RD'-Development Resumed in the claim status history screen. The entry of the 'RD' code follows the same process as in the DO/CE2 Unit, with a status effective date equal to the new claim filing date.

Once the 'RD' code is entered into ECMS, the FAB sends a letter to the claimant, addressing the receipt of the new claim form and instructing the claimant that the DO/CE2 Unit will further develop the new condition.

The CE/HR then enters the newly claimed medical condition on the Medical Condition screen. The CE/HR does not begin development of the new medical condition. This is completed by either the CE2 or the CE upon case return to the DO.

(2) If the case is in posture for denial, it is remanded back to the DO/CE2 Unit for development and adjudication of the new claimed condition.

(3) If a new claim form or medical evidence for the same medical condition(s) is received after a final decision, regardless of its current location, and the claimant sends in additional medical evidence for the

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11. New Claims for New Medical Conditions. (Continued)

original medical condition(s) or a new claim form for the same medical condition(s) already adjudicated in the final decision, this is not considered a new claim.

For either of these occurrences, the 'RD' - Development Resumed claim status code is not entered. Development cannot be resumed for any claims after a final decision without either a new claimed medical condition or a Director's Order. New evidence for previously adjudicated medical conditions must be properly reviewed.

12. Director's Orders. At any time after FAB has issued a decision, the Director of the Division of Energy Employees Occupational Illness Compensation (DEEOIC) may reopen a claim and/or vacate FAB's decision.

For certain routine reopenings, signature authority has been delegated to the Policy Branch Chief, the Unit Chief for Policy, Regulations and Procedures (UPRP) or the District Director (DD). This rule applies to all decisions issued by the FAB.

The reopening process, whether it originates with the claimant, the DO/CE2 Unit, the FAB, or under the auspices of the Director's own discretionary authority, requires certain ECMS codes for identification and tracking, as follows:

a. 'MC' - Claimant Requests Reopening. This code is used when the DO or FAB receives a request for reopening directly from the claimant, or an untimely request for reconsideration containing the requisite evidence warranting further review. The DO or the FAB enters the 'MC' code into ECMS. The status effective date is the postmark date, if available, or the date the request is received in the Resource Center, DO, or FAB, whichever is earlier.

For cases with multiple claimants, this code is entered in the claim status history only for the claimant(s) who submitted the request. (This is the only code related to Director's Orders for which this is true. All other codes for Director's Orders are entered for all active claimants.)

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12. Director's Orders. (Continued)

b. 'MI' - District Director (DD) Requests Reopening.

When the DD or FAB manager asks the Director of DEEOIC (or designee) to review a claim for possible reopening, a memo outlining the DD or FAB manager's concerns must be submitted. The DO or FAB will enter the 'MI' code prior to forwarding the file to the National Office (NO). This code is used whether a reopening request is based on a claimant's request or the DD or FAB manager's, except in the case of a FAB remand order sent to NO for a possible Director's Order (i.e., remand challenge). The status effective date is the date of the DD or FAB manager's memo to the Director of DEEOIC.

c. 'M7' - DO Submits FAB Remand for Possible Vacate Order.

When the DD disagrees with a FAB remand order, the DD will prepare a memo outlining his or her concerns and forward the memo and case file to the NO for review by the Director of DEEOIC. The DO will enter the 'M7' code into ECMS prior to sending the case file to NO. The status effective date is the date of the DD's memo to the Director of DEEOIC.

d. 'MQ' - Reopening Request Received in NO. NO staff enter this code. When a reopening request is received in NO from the DO, or the FAB, this code is required to denote receipt of the request and to indicate that the case file is physically present at the NO. The status effective date is the date of receipt of the request for a reopening in the NO.

This code is also entered when the DD disagrees with a FAB remand order and submits a challenge to the remand order to the NO for review by the Director of DEEOIC. In this circumstance, the status effective date of the 'MQ' is the date the NO received the case file.

e. 'MN' - NO Initiates Review for Reopening. NO staff (and DO staff when appropriate) enter this code. When the Director reviews a claim under the Director's own initiative for either administrative purposes, a change in the law, or for reasons within the sole discretion of the Director, the NO staff (or DO staff when authority has been delegated) enter the 'MN' code to denote that the Director has identified the case as one necessitating a review for

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## 12. Director's Orders. (Continued)

possible reopening and/or vacating of a FAB decision. The status effective date is the date the NO received the case file unless there is other specific guidance for this date, such as in new SEC or PEP bulletins.

f. 'MX' - Reopening Request Denied. After the DD, the Director of the DEEOIC, the Policy Branch Chief, or Unit Chief for UPRP has reviewed the request for reopening and has determined that the request must be denied, the 'MX' code is entered to denote the status of the review.

DO staff enters the 'MX' code if the DD is denying the reopening. NO staff enters the 'MX' code if the Director of the DEEOIC, Policy Branch Chief, or Unit Chief for UPRP is denying the reopening. The status effective date is the date of the letter denying the request for reopening.

This code is also used by NO staff for remands that were submitted to the Director of the DEEOIC for review, where the remand is found to be correct. In this circumstance, the status effective date is the date of the memo to the DD explaining that the remand order stands.

g. 'MF' - Claim Reopened, File Returned to FAB. After the Director has determined a claim must be reopened and a new FAB final decision must be issued, NO staff enters the 'MF' code to denote that a reopening has been granted and that the file has been returned to the FAB for a new final decision. This 'MF' code is not used when a remand order has been vacated and requires a new final decision by FAB. The status effective date is the date of the order granting the reopening.

h. 'MD' - Claim Reopened, File Returned to DO. NO staff enter this code into ECMS to denote that the Director of the DEEOIC, Policy Branch Chief, or Unit Chief for UPRP has granted the reopening request and the file is being returned to the DO for further action and the issuance of a new recommended decision. The status effective date of the 'MD' code is the date of the Director's Order vacating the final decision and granting the reopening.

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## 12. Director's Orders. (Continued)

In situations where reopening authority has been delegated to the DDs, the DO will enter the 'MD' code with a status effective date of the date of the Director's Order.

i. 'MV' - FAB Remand Order Vacated, Requires New Final Decision. This code is used when the Director of the DEEOIC has determined that the remand order was improper and must be set aside, and a new final decision must be issued. NO staff enters this code into ECMS when the Director's Order vacating the Remand Order is issued. The status effective date is the date of the order vacating the FAB remand order.

j. 'MZ' - Receipt of Director's Order in DO or FAB. Once the Director's Order and accompanying case file is received from NO in the DO/FAB, the DO/FAB staff will enter the 'MZ' code to denote date of receipt. The status effective date is the date the DO/FAB receives the Director's Order.

This code is required for the return of every requested Director's Order, regardless of whether the order was granted or denied. This code is also to be used where a remand order was submitted to the Director for review and the file was returned with a memo to the DD explaining that the remand order stands or returned with a Director's Order to FAB vacating the remand order.

In cases where the DD reopens the case, there is no need to enter the 'MZ' code.

k. 'MA' - Residual Contamination Reopening. This code is used to denote that a reopening has been granted based on residual contamination. Authority has been delegated to the DDs to handle these types of reopenings, so this code is entered by the DD with a status effective date of the Director's Order vacating the final decision and granting the reopening.