RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-2100 ENERGY CASE MANAGEMENT SYSTEM - DECISIONS.

EEOICPA TRANSMITTAL NO.10-08

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-2100 has been revised to update the ECMS coding instruction associated with reconsiderations. Post-reconsideration decision codes now have required reason codes associated with them.

Chapter 2-2100 has been revised to clarify the medical status effective date for consequential illnesses including situation where CBD develops subsequent to an acceptance of beryllium sensitivity or asbestosis develops subsequent to an acceptance of pleural plaques.

Chapter 2-2100 has also been revised to include instruction on the use of the new code for consequential acceptances (CA).

Chapter 2-2100 has also been revised to include the addition of the new MB reopening code specific to reopenings based on SEM database changes. The use of the existing MI reopening code has been revised related to these types of reopenings as well.

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FILING INSTRUCTIONS:

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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
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
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
4. General Decision Coding. (Continued)

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.
4. General Decision Coding. (Continued)

(h) I0W – ‘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) C0W – ‘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
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 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: 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).
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.
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
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
4. General Decision Coding. (Continued)


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.
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.
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
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.
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.
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) I0W – ‘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) C0W – ‘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’
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.
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)*.
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.
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).
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.
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.
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.
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
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.
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.
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 F5 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.
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:
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.
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 and 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.
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:
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.
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.
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.


(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)
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:
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
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) **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.
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) **CAO – ‘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.)
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”.
9. Reconsideration Codes. (Continued)

b. Date to HR. This field is the date the HR is made aware of the reconsideration request.

c. Recon Reg 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.)

If the post-reconsideration final decision partially denies or defers a claimed element on a Part E decision, the secondary decision codes PD and DV should be used along with the reconsideration code, just as they are with primary recommended and final decision codes. Multiple Post-Reconsideration codes (R_) should not be entered for one Part B or Part E decision, unless there is a partial remand. (Note: The post-reconsideration final decision generally parallels the related final decision unless there is a reversal to accept or a remand issued when the case is reconsidered.)

(1) R0 - ‘FAB RECON - ACCEPT’. When the reconsideration is granted and the post-reconsideration final decision is issued 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 ‘R0’ code. The status effective date is the date the post-reconsideration final decision is issued. R0 should only be used if the related final decision that was being reconsidered was an F0.

Upon entering the ‘R0’ code, the CE/HR must select a specific reason code from the “reason cd” field, which is a drop-down box corresponding to the ‘R0’ claim status code.

The reason codes available for the ‘R6’ claim status code are listed below. The reason code should reflect
9. Reconsideration Codes. (Continued)

everything being accepted in the current decision for that Part of the Act.

(a) B – ‘Part B’ – Used to record any accepted Part B component of the decision.

(b) 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.

(c) CAW – ‘Causation and Wage Loss Accepted’ – Used when causation and wage loss are being accepted simultaneously under Part E.

(d) CAI – ‘Causation and Impairment Accepted’ – Used when causation and impairment are being accepted simultaneously under Part E.

(e) 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.

(f) 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.

(g) 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.

(h) CIW – ‘Causation, Impairment, and Wage Loss Accepted’ – Used when causation, impairment, and wage loss are all being accepted in the current Part E decision.

To record any accepted Part E component of the decision, the CE/HR must select one of the following
9. Reconsideration Codes. (Continued)

(2) **R1 - ‘FAB RECON – DENY, EMPLOYMENT NOT COVERED’**.
When the reconsideration is granted and the post-
reconsideration final decision is issued to deny
benefits due to employment that is not covered, the
CE/HR enters the ‘R1’ code. The status effective date
is the date the post-reconsideration final decision
was issued.

(3) **R2 – ‘FAB RECON – DENY, CONDITION NOT RELATED TO
EMPLOYMENT’**. When the reconsideration is granted and
the post-reconsideration final decision is issued to deny
benefits due to the condition not being related
to employment, the CE/HR enters the ‘R2’ code. The
status effective date is the date the post-
reconsideration final decision was issued.

(4) **R3 – ‘FAB RECON – DENY, SURVIVOR NOT ELIGIBLE’**.
When the reconsideration is granted and the post-
reconsideration final decision is issued to deny
benefits due to the survivor not being eligible, the
CE/HR enters the ‘R3’ code. The status effective date
is the date the post-reconsideration final decision
was issued.

(5) **R4 – ‘FAB RECON – DENY, CONDITION NOT COVERED’**.
(B only) When the reconsideration is granted and the
post-reconsideration final decision is issued to deny
benefits due to the condition not being covered under
Part B, the CE/HR enters the ‘R4’ code. The status
effective date is the date the post-reconsideration
final decision was issued.

(6) **R5 – ‘FAB RECON – DENY, CANCER NOT WORK-
RELATED,POC’**. When the reconsideration is granted and the
post-reconsideration final decision is issued to deny
benefits because the PoC result from NIOSH is
less than 50%, the CE/HR enters the ‘R5’ code. If
more than one condition is being denied in the current
decision, but at least one of them is a cancer case
that went to NIOSH, the F5 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 the post-
reconsideration final decision is issued. This code
9. Reconsideration Codes. (Continued)

is used for BOTH Part B and Part E cancer denials if the above criteria for POC < 50% is met.

Upon entry of the ‘R5’ code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the ‘R5’ claim status code.

The reason codes available for the ‘R5’ claim status code are listed below.

(a) B – ‘Part B’ (B only) - Used when cancer is claimed under Part B, but is being denied based on the NIOSH PoC.

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

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

(d) 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.

(e) 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.

(f) 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.
9. Reconsideration Codes. (Continued)

(g) **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.

(h) **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.

(i) **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.

(j) **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.

(k) **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.
(l) 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.

(m) 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.

(n) 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.

(o) 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.

(p) 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.

(7) R6 – ‘FAB RECON - REVERSED TO ACCEPT’. When the reconsideration is granted and the post-reconsideration final decision is issued to approve benefits despite the recommended decision to deny, the CE/HR enters the ‘R6’ code. The status effective date

9. Reconsideration Codes. (Continued)
is the date the post-reconsideration final decision is issued.

Upon entering the ‘R6’ code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the ‘R6’ claim status code.

The reason codes available for the ‘R6’ claim status code are listed below. The reason code should reflect everything being accepted in the current decision for that Part of the Act.

(a) B - ‘Part B’ - Used to record any accepted Part B component of the decision.

(b) 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.

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

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

(e) 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.

(f) 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.

(g) 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.

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

(8) R7 – ‘FAB RECON – REMANDED’. When the reconsideration is granted and the post-reconsideration final decision is issued to remand a decision of the DO/CE2 Unit, the CE/HR enters the ‘R7’ code. The status effective date is the date the post-reconsideration remand is issued. 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 DOL error (either FAB or DO) that could have been avoided or an unavoidable reason that was not a DOL 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 ‘R7’ 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 ‘R7’ goes into ECMS B and E, but could have different reason codes in each.

Do not enter multiple ‘R7’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.

DOL Error – Any remand that the FAB considers to be have been avoidable by the DO/CE2 Unit:
9. Reconsideration Codes. (Continued)

(a) ERM – ‘Error - Medical (Dx, Disease, Causation, DMC related)’ – This reason code is selected if the remand is based on an error in 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 DOL error that is not predominately medical, employment, or survivorship in nature.

No DOL Error – Any remand that FAB considers to have been unavoidable by the DOL:

(a) DEA – ‘No DO Error – Death of Claimant’ – This reason code is selected when the FAB becomes aware of the claimant’s death prior to the end of the reconsideration period.

(b) RTN – ‘No DO Error – Recommended Decision Returned by Post Office’ – This reason code is selected when the decision is returned by the post office and a new address cannot be obtained for re-issuance of the decision.

(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.
9. Reconsideration 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 a post-reconsideration decision that is a partial remand, it is appropriate to use additional R_ codes and secondary decision codes to capture any partial acceptance, denial, or deferral that is happening along with the reconsideration remand. The R7 code should be the code that is entered through the reconsideration screen and linked to the final decision. Any additional secondary codes or R_ codes related to the post-reconsideration decision will have the same status effective date as the decision.

(a) Partial Accept/Partial Remand – ‘R0’ + reason code to show what is accepted and ‘R7’ + remand reason code.

(b) Partial Reverse to Accept/Partial Remand – Enter ‘R6’ + reason code to show what is accepted and ‘R7’ + remand reason code.

(c) Partial Deny/Partial Remand – Enter denial code (‘R1’, ‘R2’, ‘R3’, ‘R4’, ‘R5’, or ‘R9’) + reason code showing what is denied and ‘R7’ + remand reason code.

(d) Partial Accept/Partial Deny/Partial Remand for Part B – Enter ‘R8’ (FAB Recon Accept in Part/Deny in Part) + reason code ‘B’, followed by ‘R7’ + remand reason code in ECMS B.

(e) Partial Accept/Partial Deny/Partial Remand for Part E – Enter ‘R8’ (FAB Recon Accept in Part/Deny in Part) + reason code that shows what is accepted, ‘PD’ + reason code to show what is denied, and ‘R7’ + remand reason code in ECMS E.
(f) Partial Accept/Partial Deny/Partial Develop/
Partial Remand for Part B – Enter ‘R8’ (FAB Recon
Accept in Part/Deny in Part) + reason code ‘B’
and ‘R7’ + remand reason in ECMS B. There is no
recon code equivalent to ‘G2’ (partial
accept/partial deny/partial develop), so we cover
as many elements to the decision as we can within
the coding scheme. The claimed medical
conditions that have been deferred will be
notated with an ‘R’ status on the medical
condition screen, which will reflect they have
not yet been adjudicated.

(g) Partial Accept/Partial Deny/Partial
Develop/Partial Remand in Part E – Enter ‘R8’ (FAB
Recon Accept in Part/Deny in Part) + reason code
to show what is accepted, ‘PD’ + reason code to
show what is denied, ‘DV’ + reason code to show
what is deferred, and ‘R7’ + remand reason code in
ECMS E.

(h) Partial Accept/Partial Develop/ Partial
Remand for Part B – There is no recon code
equivalent to ‘G1’ (FAB Accept in Part/Develop in
Part), so the acceptance code R0 (FAB Recon
Accept) + reason code ‘B’ and ‘R7’ + remand
reason code is entered in ECMS B. The claimed
medical conditions that have been deferred will
be notated with an ‘R’ status on the medical
condition screen, which will reflect they have
not yet been adjudicated.

(i) Partial Accept/Partial Develop/ Partial
Remand for Part E – There is no recon code
equivalent to ‘G1’ (FAB Accept in Part/Develop in
Part), so enter the acceptance code R0 (FAB Recon
Accept) + reason code showing what is accepted,
‘DV’ + reason code to show what is deferred, and
‘R7’ + remand reason code in ECMS E.

(9) R8 – ‘FAB RECON - ACCEPT IN PART/DENY IN PART’. When
the reconsideration is granted and the post-
reconsideration final decision is issued where part of
the claim is approved for benefits, while another part
of the claim is denied, the CE/HR enters the ‘R8’
9. Reconsideration Codes. (Continued)

code. The status effective date is the date the post-reconsideration final decision is issued.

Upon entering the ‘R8’ code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the ‘R8’ claim status code.

The reason codes available for the ‘R8’ claim status code are listed below. The reason code should reflect everything being accepted in the current decision for that Part of the Act.

(a) B – ‘Part B’ – Used to record any accepted Part B component of the decision.

(b) 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.

(c) CAW – ‘Causation and Wage Loss Accepted’ – Used when causation and wage loss are being accepted simultaneously under Part E.

(d) CAI – ‘Causation and Impairment Accepted’ – Used when causation and impairment are being accepted simultaneously under Part E.

(e) 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.

(f) 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.

(g) 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.
9. Reconsideration Codes. (Continued)

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

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.

If the post-reconsideration final decision is to accept in part, deny in part, and defer in part, the portion(s) of the claim being denied in the decision is identified by the secondary decision status code ‘PD’ [Partial Deny] and the portion of the claim being deferred is identified by the secondary decision status code ‘DV’ with the corresponding reason code set out in Paragraph 4 above.

(10) R9 – ‘FAB RECON - DENY, MEDICAL INSUFFICIENT TO SUPPORT CLAIM’. When the reconsideration is granted and the post-reconsideration final decision is issued 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 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 the post-reconsideration final decision is issued.

Upon entry of the ‘R9’ code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the ‘R9’ claim status code. The reason codes available for the ‘R9’ claim status code are listed below.

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

(b) DMB – ‘Deny Specific Medical Benefits On Accepted Condition’ (B and/or E) - Used when a specific medical benefit is being denied on an
9. Reconsideration Codes. (Continued)

accepted condition in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

(c) 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.)

(d) 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.

(e) 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.

(f) CAU – ‘Causation’ (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established.

(g) 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.

(i) 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.

(j) IMN – ‘Impairment – Not Ratable’ (E only) - Used when the claim for impairment is being
9. Reconsideration Codes. (Continued)

denied because the claimed impairment is non-ratable, such as certain psychiatric conditions.

(k) 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.

(l) I0W - ‘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.

(m) 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.

(n) 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.

(o) C0W - 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.

(p) 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
9. Reconsideration Codes. (Continued)

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

(q) 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.

(r) 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.

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

(t) 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.

(u) 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.

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
10. Closure Codes. (Continued)

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.

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 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).
10. Closure Codes. (Continued)

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:

- **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.

- **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.]
10. Closure Codes. (Continued)

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, 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
10. Closure Codes. (Continued)

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’ (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.
10. Closure Codes. (Continued)

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 (or consequential acceptance letter if the newly claimed condition turns out to be a consequential illness). 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.
11. New Claims for New Medical Conditions. (Continued)

(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 filing date of the Beryllium Sensitivity.

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 filing date of the pleural plaques.

(b) For all other non-consequential medical conditions, regardless of the diagnosis date, the medical status effective date is the new claim filing date for any conditions eventually accepted, prior to issuance of the final decision.

(c) For consequential conditions, the medical status effective date is equal to the filing date for the primary condition.

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.
11. New Claims for New Medical Conditions. (Continued)

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 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.
12. Director’s Orders. (Continued)

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.)

‘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.

This code can also be entered by the CE, senior, or supervisor when a memo is drafted to the DD/ADD requesting a case be reopened, possibly because of SEM database changes or new residual contamination information.

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
12. Director’s Orders. (Continued)

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 ‘MO’ 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 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.
12. Director’s Orders. (Continued)

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.

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
12. **Director’s Orders. (Continued)**

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.

l. **‘MB’ – Reopening Based on Change to SEM Database.** This code is used when the DD, Director, or anyone else delegated reopening authority, reopens a case based on updated information to the SEM database. The status effective date is the date of the Director’s Order vacating the final decision and granting the reopening.

Note: If a decision awarding medical benefits is vacated, the ‘A’ medical condition status must be set back to ‘R’ and the condition “unlinked” from the final decision, until a new decision is rendered. This will require coordination with Energy Tech Support, but must be done to stop medical bills from being paid on ineligible claims.

13. **‘CA’ – Consequential Acceptances.** When a consequential illness is being accepted, the medical condition status must be updated to an ‘A’ (Accepted) status on the medical condition screen. When the consequential acceptance letter is issued, the CE enters the ‘CA’ (Consequential Acceptance) code in the claim status history with a status effective date equal to the acceptance letter’s date of issuance. When the CA code is entered, the CE will be prompted to link the accepted condition to the consequential acceptance in ECMS.

When the CE enters the CA code, the system will also force the entry of one of the following reason codes:

a. **‘ACP’ – Additional Conditions Pending.** If there is at least one additional condition
12. Director’s Orders. (Continued)

(regular or consequential) that requires a decision (either a new CA code or new Recommended & Final Decision), the CE selects the ‘ACP’ reason code.

b. ‘CCR’ – Consequential Conditions Resolved. If there are no other medical conditions (regular or consequential) currently pending a decision (either a new CA code or new Recommended & Final Decision), the CE selects the ‘CCR’ reason code. This will essentially close out any newly claimed conditions entered with an ‘RD’ (Resume Development) code.