



RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE
INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL:
CHAPTER 2-0100, INTRODUCTION; 2-0800, DEVELOPING AND
WEIGHING MEDICAL EVIDENCE; AND 2-1500, CONSEQUENTIAL
CONDITIONS

EEOICPA TRANSMITTAL NO. 16-05

March 2016

EXPLANATION OF MATERIAL TRANSMITTED:

This material is issued as procedural guidance to update, revise and replace the EEOICPA Procedure Manual (PM) Chapters 2-0100, Introduction; 2-0800, Developing and Weighing Medical Evidence; and 2-1500 Consequential Conditions. This version incorporates changes that have arisen since the last publication of Chapters 2-0100, 2-0800, and 2-1500 to include:

- Removes pagination from Chapters 2-0100 and 2-0800.
- Removes all footers subsequent to the Table of Contents from Chapters 2-0100 and 2-0800.
- Ch. 2-0100, updated section 1 on Purpose and Scope to include a brief summary on the structure of Part 2 of the PM.
- Ch. 2-0100, deleted section 2, Structure of Part 2.
- Ch. 2-0100, corrected the Executive Order 13179 signed date from December 29, 2006 to December 7, 2000.
- Ch. 2-0100.4, updated the references materials used by the Claims Examiners.
- Ch. 2-0800.7, revised the language on the use of a death certificate to establish a diagnosis.

- Ch. 2-0800.11, removed reference to Bureau of Labor Statistics, Occupational Outlook Handbook and website link.
- Ch. 2-0800.13, updated to indicate that a copy of the Contract Medical Consultant (CMC) reports will be attached to Recommended Decisions denying claims based on causation.
- Ch. 2-0800, Exhibit 1, updated the Medical Information section to include a list of accepted medical conditions.
- Ch. 2-0800, Exhibit 1, updated the Verification of Review section to allow a designee to sign the referral.
- Ch. 2-0800, Exhibit 2, removed questions on Impairment and instructed to refer to PM Ch. 2-1300.
- Ch. 2-0800, Exhibit 2, removed question "Does the employee's work and exposure history make it at least as likely as not that the exposure to the toxic substances was a significant factor in causing, contributing to or aggravating the employee's medical condition?"
- PM Ch. 2-1500.9, corrected to reflect that a clinical psychologist or psychiatrist meets the definition of being a qualified physician.



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FILING INSTRUCTIONS:

Remove

PM Ch. 2-0100
PM Ch. 2-0800
PM Ch. 2-1500

Insert

PM Ch. 2-0100
PM Ch. 2-0800
PM Ch. 2-1500

File this Transmittal behind Part 2 in the front of the Unified Federal (EEOICPA) Procedure Manual.

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

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SUPERSEDED

1. Purpose and Scope. Part 2 of the Federal (EEOICPA) Procedure Manual (PM) outlines the policies, guidelines and procedures for developing, adjudicating and managing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). Topics included in Part 2 relate to claim intake, eligibility criteria, developing evidence, application of program policy, and issuing decisions.

2. Staff Responsibilities. District Office and Final Adjudication Branch (FAB) staff within the Division of Energy Employees Occupational Illness Compensation (DEEOIC) develop and adjudicate claims, provide courteous and timely responses to requests for information, comply with program policy to reach fair and consistent claim outcomes, initiate compensation payments, and monitor assigned caseloads.

a. Processing Claims. The mission of a DEEOIC Claims Examiner (CE), FAB Hearing representative (HR), and FAB CE is to exercise keen judgment, derived from experience, background, and acquired knowledge, tempered with compassion and common sense. This involves the ability to assess evidence, consider pertinent issues, and make well-rationalized judgments. DEEOIC claims staff are to evaluate each case comprehensively based on the unique characteristics of the information present. Moreover, staff are to apply an objective analysis of the evidence that comports with the legal, regulatory and procedural guidance in guiding claim adjudication. Decisions issued by DEEOIC staff are to include a description of evidence considered; analysis and interpretation of information supporting factual findings; and provide a clear, understandable decision.

3. Reference Materials for Claims Examiners. DEEOIC district and FAB offices have full access to a range of reference materials and programmatic resources that are available through a publically accessible website. In addition, DEEOIC makes locally available other material that assists its staff in adjudicating claims. Reference materials available to staff include:

a. Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, 42 U.S.C. § 7384 *et seq.*

- b. 20 CFR Parts 1 and 30 (Regulations) - Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, issued December 29, 2006.
- c. Executive Order 13179, signed December 7, 2000.
- d. Federal EEOICPA PM.
- e. Bulletins, Circulars and Program Memoranda.
- f. Guides to the Evaluation of Permanent Impairment, 5th Edition, American Medical Association.
- g. ICD9/10 coding manuals or online resources.
- h. NIOSH Regulations on dose reconstruction and probability of causation (42 CFR Parts 81 and 82, Guidelines for Determining the Probability of Causation and Methods for Radiation Dose Reconstruction Under the Employees Occupational Illness Compensation Program Act of 2000; Final Rules).
- i. The Federal Register publications listing covered facilities.
- j. User's Guide for the Interactive RadioEpidemiological Program (NIOSH-IREP).
- k. Interagency contacts or website links
- l. Shared Drive maintained by the NO.
- m. Site Exposure Matrix (SEM).
- n. Energy Compensation System (ECS) user guidance and procedures
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1. Purpose and Scope. Proper development and weighing of medical evidence is essential to the sound adjudication of claims for benefits and to the comprehensive management of Energy Employees Occupational Illness Compensation Program Act (EEOICPA) claims. This chapter discusses the function of a Claims Examiner in developing and evaluating medical evidence and weighing conflicting medical opinions.

2. Sources of Medical Evidence. Most medical reports come from one of these sources:

a. Claimant's health care provider, which includes the attending physician, consulting experts, and medical facilities. The CE may consider treatment records from a clinic operated at an employing facility as medical evidence.

b. Department of Energy (DOE). Medical Monitoring Programs, administered by certain DOE facilities, maintain medical examination records and exposure data on their employees. For example, the DOE Former Worker Medical Screening Program (FWP) began in 1996 and functions to evaluate the effect of the DOE's past operations on the health of former workers at DOE facilities, and to offer medical screening to former workers.

c. Oak Ridge Institute for Science and Education (ORISE) administers the beryllium screening program by providing beryllium-related testing at locations across the country. ORISE offers extensive testing for chronic beryllium disease (CBD) and medical monitoring to individuals testing positive for beryllium sensitivity.

d. Contract Medical Consultant (CMC). Furnishes medical opinions, guidance, and advice based upon review of the case file. Moreover, the physician provides independent and rationalized responses to CE questions regarding various medical issues that may arise during case adjudication, such as causation, impairment, wage-loss, or medical necessity of care.

e. Second Opinion Physicians are physicians contracted by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) to provide a narrative report describing the findings from physical examination of a

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patient and review of diagnostic testing or other medical records.

f. Referee Specialists are physicians of an appropriate specialty, chosen randomly, to examine the employee or a case file and furnish a rationalized medical opinion, to resolve a conflict of medical opinion in a case between the employee's physician and a CMC, Second Opinion Physician, or other medical specialist.

3. Types of Medical Evidence. Medical evidence in EEOICPA cases consists of the following major categories:

a. Treatment records are the most prevalent form of medical evidence. They consist of any record made during the evaluation, diagnosis and treatment of a patient by his or her health care providers. They include:

(1) Attending physician records (e.g., chart notes, reports, etc.) which include records from medical consultants assisting the attending physician.

(2) Records of physicians consulted by the patient for an independent medical opinion.

(3) Evidence of diagnostic testing (e.g., X-ray films, electrocardiogram (EKG) tracing, etc.) and the reports of medical providers interpreting the tests. For the purposes of interpreting tests, medical providers include physicians as defined in Section 30.5(dd) of the regulations.

(4) Treatment records from hospitals, hospices, in-home health or residential health care facilities.

b. Medical evaluations may occur for a variety of reasons other than to further the diagnosis and treatment of the patient. The purpose of the examination distinguishes medical evaluations from treatment records. Medical evaluations include:

(1) Evidence from the DOE's FWP (e.g., former worker screening records, pre-employment physicals, termination physicals, etc.)

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- (2) Examinations required under state or federal compensation programs (e.g., evaluations for state workers' compensation (SWC) claims, Social Security disability examination, Veterans' Administration (VA) programs, etc.)
- (3) Medical reports or opinions obtained for litigation under state or federal rules of evidence.
- c. Reports produced in response to a DEEOIC referral to a CMC, Second Opinion physician, or Referee Specialist.
- d. Other types of evidence include:
- (1) Cancer Registry records may be used in some cases to establish a diagnosis of cancer and date of diagnosis.
- (2) Death certificates which contain information about the cause of death or date of diagnosis. (See Section 7 of this chapter for additional information regarding death certificates.)
- (3) Secondary evidence relied upon by a physician in forming an opinion. For example, a doctor may rely upon the information provided by a medical specialist in determining the cause of an illness.
- (4) Affidavits containing facts based on the knowledge of the affiant regarding the date of diagnosis.
4. Contents of a Medical Report. The value of findings and conclusions contained in medical records varies.
- a. Treatment Records.
- (1) A doctor's report of examination usually contains a description of subjective complaints, objective findings, assessment, and a plan for follow up or treatment. The Subjective, Objective, Assessment and Plan format is often shown in the medical records by the letters S, O, A and P. Even where the "SOAP" abbreviation is not used, the records tend to follow this pattern.

(a) The subjective section records information obtained from the patient. It generally contains information about why he or she is seeking treatment, complaints, medical history and current treatment. A subjective section might state, for example, "Patient comes in today to have us look at a lump on his neck that has gotten larger over the last month."

(b) The objective section records the physician's findings based on his or her observation, examination and testing. An objective section might state, for example, "The patient's breathing is labored and his X-ray shows a spot on his left lung." The three general classes of objective findings are:

(i) Laboratory findings such as complete blood count (CBC), tissue biopsy, bone marrow smear or biopsy, beryllium lymphocyte proliferation test (BeLPT), etc.

(ii) Diagnostic procedures such as X-rays, ultrasound, computerized axial tomography (CAT) scans, magnetic resonance imaging (MRI), electromyogram (EMG) and similar techniques of visualizing or recording physiological conditions. Some objective tests are subject to greater interpretation by the physician.

(iii) Physical findings that are noted by the physician's visual inspection, palpation and manipulation of the body. They include description of demeanor, readings of temperature or pulse, description of respiration, observation of affect, etc.

(c) The assessment section contains the physician's opinions, suspicions and diagnoses. In most cases, the value of a medical report is determined by the quality and detail of the narrative describing the physician's assessment. The scope of the assessment will vary with the type of medical condition and its complexity.

The assessment section may contain statements such as, "The pathology report was reviewed and showed the presence of small cell carcinoma of the lung." or "Based on the patient's rest tremor, balance problems and rigidity of muscles, he has Parkinson's disease."

(d) The plan section describes the treatment plan and prognosis. The physician may, for example, prescribe medication, refer the patient to a specialist, or suggest additional testing.

(2) Reports of tests and procedures should contain the employee's name, date of the test, the objective data obtained, and the signature of the person responsible for conducting the test or procedure. Where appropriate, reports should include a physician's interpretation of laboratory tests or diagnostic procedures.

Tests for which interpretation is necessary include, but are not limited to, pathology reports, BeLPT, X-rays, MRI, CAT scans, Pulmonary Function Tests (PFT), Minnesota Multiphasic Personality Inventories (MMPIs), and the Beck Depression Inventory. In cases where the physician offers insufficient interpretation of medical evidence, the CE must seek clarification either from the source of the report, or a CMC referral, as appropriate. The CE is not to interpret test results, as that is a medical judgment to be made by a medical professional.

(3) Hospital, hospice and clinic records will contain the same type of physicians' records and diagnostic testing as outlined above. Also, the CE should review the admission summary, surgery reports, nursing notes, the discharge summary, autopsy reports, etc.

b. Medical Evaluations. Generally, medical evaluation reports contain the following types of information:

(1) An explanation as to why the physician is conducting an examination of the patient. The report may state, for example, "Mr. Smith is referred by the

Department of Labor (DOL) for an independent medical evaluation regarding his claim for asbestosis."

(2) A description of the information the physician has reviewed and relied upon in reaching his or her conclusions. This often includes a discussion of the course of treatment, which describes past treatment undergone by the patient, and the physician's recommendation for present and future care. References to studies and other medical or scientific data that supports the analysis may also be included.

(3) A description of any examination and tests performed during the evaluation.

(4) The opinion(s) of the evaluating physician with an explanation of the rationale supporting his or her conclusion.

c. DEEOIC Referrals. The CMC, Second Opinion physician, or Referee Specialist reports should contain the same general information as any other medical assessment. In addition, the report should contain a well-reasoned response to questions presented by the CE, including a summary of the evidence and medical references used.

5. Developing Medical Evidence. Although it is ultimately the responsibility of the claimant to submit medical evidence in support of his or her claim, the CE is to assist the claimant in collecting evidence necessary to establish a compensable medical illness. This includes communicating with the claimant to explain deficiencies in case evidence, requesting supportive documentation, and allowing reasonable time for the claimant to provide a response. The CE also assists by taking affirmative action to obtain medical evidence through communications with treating physicians and/or other medical providers. Assistance can also be achieved with the use of Program resources to obtain clarifying medical evidence including the use of a CMC, Second Opinion physician, or Referee Specialist. The development of medical evidence is performed in various aspects of case adjudication: to establish diagnosis, to establish causation, to determine a percentage of impairment in impairment claims, to establish a causal relationship between a covered illness and wage-loss, and to resolve inconsistencies and conflicts in medical opinions.

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a. Physicians and chiropractors. Medical evidence must be from a physician. The definition of a physician includes surgeons, podiatrists, dentists, clinical psychologists, psychiatrists, occupational medicine practitioners, optometrists, and osteopathic practitioners within the scope of their practice as defined by state law. Chiropractors may only be considered physicians in EEOICPA cases for treatment of manual manipulation of the spine to correct a subluxation that is demonstrated to exist by X-ray (usually relevant only in consequential injuries.) However, chiropractic care may be authorized as treatment for an accepted condition. Any such treatment must be prescribed by the authorized treating physician, and the physician must provide rationale as to how the treatment in question relates to the covered condition.

b. Deficient Evidence. During adjudication of a claim, there are many topics that require evaluation of medical evidence including: medical diagnosis, interpretation of diagnostic evidence, causal relationship between illness and occupational toxic substance exposure, permanent partial impairment, effect of illness on historical wages, and medical necessity of care or other service needs. In each of these matters, legal, regulatory, or procedural guidance exists through on-line Programmatic resources (Bulletins, Circulars, EEOICPA Regulations, etc.) to instruct the CE on evaluating the sufficiency of evidence submitted in support of a claim. The CE is to adhere to these guidelines and to direct development in a manner that will best overcome evidence omissions or deficiencies.

c. Telephone Requests. In many situations, a minor deficiency in the medical evidence can be easily overcome with a telephone call to the physician's office to request specific documents. If, however, a phone call does not produce an immediate result (i.e., a fax of the required documentation) the CE should send a written request. If the physician's office indicates that the medical evidence will be mailed, the CE will follow-up with written correspondence memorializing the telephone call and noting the specific documents that are being requested.

(1) The CE must document the call in the Energy Compensation System (ECS).

(2) Statements made by the physician over the telephone do not constitute valid medical evidence.

d. Written Requests. The CE may decide that the best method of collecting the evidence is to submit a written inquiry directly to the physician (with a copy to the claimant). However, the CE has the authority to submit written requests for information to any possible source that may reasonably be able to provide a substantive response to a need for medical documentation. A written request for information is to communicate the identified defect, in a clear and concise fashion, and the various options available for presenting information or documentation that will best overcome the defect.

(1) If records are requested from a treating physician or other sources, the Form EE-1/EE-2 submitted by the claimant serves as a medical release to obtain the requested medical information.

(2) If a reply is not received within 30 days or the response does not resolve the deficiency, the CE considers other options for obtaining the required medical evidence (e.g., a CMC referral, cancer registry or death certificate). Reasonable time extensions may be granted by the CE. It may be helpful to initiate telephone contact with the recipient to gauge the likelihood for response, or to respond to questions or other concerns.

e. Unavailable Medical Records. If the CE obtains information that pertinent medical records have been destroyed or are otherwise unavailable, the CE should attempt to obtain from the physician written confirmation which contains the following information:

- (1) An affirmation that the physician treated the employee for the claimed condition(s).
- (2) A statement that the requested medical records are no longer available.
- (3) A discussion that includes the diagnosis and date of diagnosis.

(4) The physician's signature and the date signed.

6. Weighing Medical Evidence. When the CE receives medical evidence from more than one source, he or she must evaluate the relative value, or merit, of each piece of medical evidence. This is particularly important in cases where there is a conflict between the medical evidence received from a CMC and a treating physician. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken. The CE should also understand how to assign weight to the medical evidence received.

a. How to Evaluate Evidence. In evaluating the merits of medical reports, the CE evaluates the probative value of the report and assigns greater value to:

(1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information. Generally, a physician who has physically examined a patient, is knowledgeable of his or her medical history, and has based the opinion on an accurate factual basis, has weight over a physician conducting a file review. For example, a physician who opines that his patient's lung cancer is related to exposure to diesel engine exhaust has less probative value if the opinion demonstrates no knowledge of the frequency or levels of exposure to diesel engine exhaust.

(2) An opinion based on a definitive test(s) and includes the physician's findings. Some medical conditions can be established by objective testing. A positive pathology report from a physician is sufficient evidence of the diagnosis of cancer. However, a physician's opinion that a patient has cancer is of little probative value if the pathology report shows no malignancy. A physician's report of a positive beryllium lymphocyte proliferation test or lung lavage cells showing abnormal findings is sufficient evidence of the diagnosis of beryllium sensitivity.

It is important for the CE to undertake appropriate steps to work with a treating physician in the

collection of evidence, before referring the case to a CMC.

(3) A well-rationalized opinion over one that is unsupported by affirmative evidence. The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached, including appropriate citations or studies. An opinion that is well-rationalized provides a convincing argument for a stated conclusion that is supported by the physician's reasonably justified analysis of relevant evidence. For example, an opinion which is supported by the interpretation of diagnostic evidence and relevant medical or scientific literature is well-rationalized. Conversely, an opinion which states a conclusion without explaining the interpretation of evidence and reasoning that led to the conclusion is not well-rationalized.

(4) The opinion of an expert over the opinion of a general practitioner or an expert in an unrelated field. For example, if a general practitioner has a patient with rest tremors, balance problems, and muscle rigidity, a diagnosis of alcohol abuse with dehydration may seem reasonable. However, if a conflicting report is received from a Board-Certified neurologist diagnosing Parkinson's disease based on the same symptoms, it would carry greater weight because a neurologist is an expert on neurological disorders. This is particularly true for an illness like Parkinson's disease that cannot be confirmed by an objective laboratory test. Conclusive statements of an expert without any underlying justification, other than affirmation of the physician's expertise, are not to be viewed as carrying significant probative value.

(5) An unequivocal opinion over one that is vague or speculative. A physician offering a clear, unequivocal opinion on a medical matter is to be viewed as more probative compared to an opinion that waivers or hesitates in its presentation or, contains vague and speculative language. An opinion which contains verbiage such as "possibly could have" or

"may have been" or provides a guess or estimation indicates speculation on the part of the physician.

7. Using Death Certificate to Establish Diagnosis. Prior to considering the use of a death certificate to establish a diagnosis, the following actions must be undertaken:

a. Claimant Advised. The CE must advise the claimant, in writing, of the medical evidence necessary to establish a diagnosis and grant him or her the opportunity to submit available medical records (See PM Ch. 2-0300.6 Advising the Claimant of Deficient Evidence). The letter sent to the claimant is to include a statement describing the need to obtain medical evidence of a diagnosed condition. Medical evidence with the potential to identify a diagnosed illness include any hospital admission/discharge reports or reports describing an illness; inconclusive diagnostic testing results, or other medical records alluding to the existence of a potential illness. The function of this development is to ensure that the CE receives all available medical records for consideration.

b. Diagnosis listed on death certificate. Once development is completed and it is unlikely any other affirmative medical evidence is available for review, a CE may use a death certificate acknowledged by a physician or recognized by a state medical authority to establish a diagnosed illness.

Nothing in this section should be interpreted as limiting the use of a death certificate for other purposes, such as evidence of the cause of death under Part E.

8. Using Affidavits to Establish Date of Diagnosis. While an affidavit cannot be used to establish a medical diagnosis, it can be used to establish a date of diagnosis after the CE has made a reasonable effort to establish the date of diagnosis from the medical records. CE actions should include the following:

a. Advice to Claimant. The claimant must be advised, in writing, that medical evidence (i.e., pathology report, autopsy report, physician's reports) should be submitted to establish a date of diagnosis.

c. Additional Medical Development. If the claimant and the CE cannot obtain medical evidence to establish the date

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of diagnosis, the CE must notify the claimant of the need to submit copies of affidavits from those in a position to know the former worker's condition during the illness. For example, a home health nurse or relative who provided care to the employee may provide an affidavit.

d. Death Certificate. If reliable affidavits are not received, then the CE may use the date of diagnosis (if shown) or date of death from the death certificate. The CE should not guess at a diagnosis date based on a death certificate's "approximate interval between onset and death" as the date of onset is not necessarily the date of diagnosis.

e. Medical Review. If an affidavit reveals evidence of a medical condition, but no physician's diagnosis is contained in the file, the case may be forwarded to a CMC for review and confirmation of a diagnosis.

9. Reviews by a CMC. DEEOIC uses the services of a contractor to coordinate referrals of cases to qualified medical specialists. A CMC is a contracted physician who conducts a review of case records to render opinions on medical questions. Medical opinions from a CMC are essential to the resolution of claims due to ambiguous causation, lack of medical evidence, unique exposures or other medical questions. The function of a CMC is to provide clarity to claims situations in the absence of pertinent or relevant medical evidence from other sources that support the claim. The function of a CMC is not to validate probative input by the claimant's chosen treating physician. The description of appropriate reasons for CMC referral includes the following:

a. Diagnosis. Clarification and confirmation of diagnosis.

b. Causation. Assessment of exposure and medical documentation for the purpose of rendering an opinion on causation.

c. Impairment. Percentage of permanent impairment to the whole person as a result of an accepted illness or illnesses.

d. Onset Date. Onset and period of illness relating to

reported wage-loss.

e. Consequential Injuries. Determination of consequential illness/injury due to accepted illness or treatment of that illness.

f. Treatment. Medical necessity of medical care, durable medical equipment or home/auto modification.

g. Clarification. Interpretation of medical reports, test results or other medical evidence.

h. Conflict. Resolve conflict of medical opinions.

10. Deciding on Need for a CMC Referral. The decision to refer a case to a CMC for review is at the discretion of the assigned CE. An obvious defect in case evidence must exist, including the absence of affirmative medical evidence or other diagnostic evidence, for which a medical opinion is necessary. A CMC referral may also be necessary for review of impairment or wage-loss issues. The CE should not view a medical referral as an automatic requirement for each claim, but an option available in situations where no other reasonable option exists to obtain a resolution to an outstanding medical question.

a. Review Not Necessary. The following are examples of when a CMC referral may not be necessary:

(1) The CE determines that other action, such as requesting additional records from the claimant or treating physician, may be more appropriate. In most cases, the CE does not need to refer a claim to a CMC when a treating physician has provided a substantive, well-rationalized opinion in response to a claim question. Moreover, the CE should view the existence of a treating physician as the primary source of medical evidence before consideration of a CMC referral. Accordingly, the CE should typically give the treating physician the first opportunity to review medical evidence from the file, such as a SOAF and other documents, for the purpose of responding to claim questions. If the treating physician does not provide substantive responses to claim questions, the CE may consider the claim in posture for a CMC review.

(2) The claim evidence renders a CMC opinion unnecessary, such as instances where a presumption of causation exists, or the circumstances of case development does not necessitate a medical opinion, such as when there is no evidence of exposure to a toxic substance or no plausible scientific association between a toxin and a diagnosed illness.

b. Appropriateness of Review. The following are some examples of when a CMC referral may be required:

(1) The CE is unable to conclude whether pre-1993 medical evidence is sufficient to diagnose CBD.

(2) Medical tests are submitted which do not provide clear diagnosis or interpretation (e.g., a BeLPT that does not clearly state that the test is positive or negative).

(3) It is unclear whether a medical condition, unlisted on a death certificate, was a significant factor in causing, contributing to or aggravating an employee's death. For example, an employee dies of a heart condition, but the covered condition is asbestosis.

(4) It is unclear whether the confirmed exposure to a toxic substance is linked to the illness claimed by the employee.

(5) A treating physician has offered a speculative, or vague opinion, or one that is not substantiated by reasonable medical rationale, and the CE has undertaken reasonable steps identifying the defects to the physician, but he or she has not responded or responded unsatisfactorily.

11. Referral to CMC. It is ultimately the responsibility of the jurisdictional DO to ensure that all the necessary components of a CMC referral are prepared accurately, the content of the referral is appropriate and specific to the issue under determination, and sufficient factual documentation is prepared to allow the CMC a clear understanding of the medical question(s) to be addressed. When guidance requires that email communication be prepared, a copy of the email is to

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scanned/bronzed into the case file in the OWCP Imaging System (OIS).

Interactions between DEEOIC staff and the CMC contractor occur through a secure internet portal, referred to as the Client Portal. All DEEOIC staff are to reference the "Client Portal User Guide" for additional information about using the Client Portal and referring cases to CMCs. Coordination of information between DEEOIC staff and the CMC contractor, including transmission of referral packages, is the responsibility of designated staff (i.e., Medical Scheduler). The CE, however, initiates the CMC referral process.

a. Preparation of referral email. The CE sends an email to the Medical Scheduler indicating that a CMC review is required, and requesting referral to the CMC contractor. The body of the email should contain:

- (1) Claimant name.
- (2) Claim number.
- (3) Type of review requested.
- (4) Medical Specialty requested. The "Client Portal User Guide" contains a list of medical specialty types

available for claims review. It is crucial that the CE selects the most appropriate preferred medical specialty to perform the review. The CE considers the following in determining the preferred medical specialty.

(a) Causation questions are best handled by occupational medicine specialists. Occupational medicine specialists can also evaluate the diagnosis and treatment of occupational lung conditions; such as asbestosis, silicosis, CBD, pneumoconiosis, and chronic obstructive pulmonary disease (COPD).

(b) Diagnosis or treatment questions are best handled by medical specialists for the condition or procedure under evaluation. Selecting generalist/internal medicine/family practice is appropriate if the condition involves a medical

specialty not listed in the "Client Portal User Guide."

(c) Impairment questions are best performed by specialists with experience in treating the particular organ system affected by the accepted work-related illness.

b. Scanning. The CE creates an electronic image of the following items as a single PDF file, and attaches the file to the referral email. A copy of the completed Statement of Accepted Facts (SOAF) is to be scanned/bronzed to the case file in OIS.

(1) A SOAF (See Exhibit 1 for example) is a narrative summary of the factual framework of the case record. The SOAF logically conveys factual findings that have been decided by the CE upon examination of the case record, or application of Programmatic resources, such as the Site Exposure Matrices (SEM). The CE makes factual findings derived from a reasonable interpretation of evidence contained in the case record, and not from undocumented sources.

Factual findings presented in the SOAF are to be clearly stated. Simple words and direct statements

reduce the potential for ambiguity or misinterpretation. The CE is to avoid using legal terms and Program jargon. Moreover, the CE must ensure that factual findings are presented in a logical order, and grouped chronologically within subject-specific sections relating to medical, employment, exposure, etc. The SOAF is to include the following information:

(a) Identifying demographics, including the employee's name, case file number and relevant personal information (e.g., employee's date of birth, date of employee's death, etc).

(b) Description of any accepted conditions or other diagnosed medical conditions. Medical information in the case file that is not relevant to the referral need not be reiterated in the SOAF.

(c) Detailed description of the employee's employment history. This includes information about where the employee worked, dates of employment, and his or her job title and duties, if relevant to the referral. The CE will review Form EE-3 to assess the employee's claimed employment; however, in preparing the SOAF, the CE should only include employment that has been verified by the DEEOIC and determined to be covered employment (See PM Ch. 2-0500, Establishing Covered Employment).

The CE refers to the OHQ for more detailed descriptions of work processes and must be diligent to identify all relevant employment data that has been determined to be factually established from the case evidence. This is particularly true in referral situations involving causation, as there is a need to clearly understand job descriptions, duties performed, working conditions, etc.

(d) For causation determinations, identification of the occupational toxic substance exposures encountered by the employee. The CE makes findings of toxic substance exposure based on a careful analysis of case evidence, and reference to Program resources such as researching the SEM, or seeking guidance from the Industrial Hygienists (IH) or Toxicologists (TOX) when appropriate (See PM Ch. 2-0700, Establishing Toxic Substance Exposure). Toxic substance exposures, reasonably established by available evidence, and shown to have a potential health effect to the diagnosed condition, are listed in the SOAF. When possible, the CE is also to provide relevant information on the nature, extent and duration of such exposures.

Quantification might include levels of exposure, concentrations of asbestos fibers in the air, levels of noxious substances, the (approximate) number of times exposed, etc. The CE is to avoid the use of terms such as light, heavy, undue, severe, and abnormal because they are subject to

great differences of interpretation. In certain situations, where the CE must provide an explanation as to how certain exposure findings are achieved, he or she is to document such analysis in the case file with a memorandum to the file.

(e) The CE should include a brief history of the significant events that have transpired in the case (i.e., date of filing of Part B and/or Part E, date submitted to the National Institute for Occupational Safety and Health (NIOSH) for dose reconstruction, date of denial/acceptance, etc.) if determined to be relevant to the referral.

(2) List of Questions for the CMC to address. (See Exhibit 2 for example). The questions put to the CMC must relate to a particular informational need that a physician is to address. The questions to a CMC should clearly communicate the information required. To this end, the questions should be straightforward and objectively stated. Avoid questions that are overly broad, or contain numerous subcomponents. In addition, questions that are leading or biased to a particular outcome are not appropriate. The CE is to limit the questions to the CMC to the relevant information necessary to address the particular claim for which a decision is required. A copy of the list of questions is to be scanned/bronzed to the case file in OIS.

(a) For referrals under Part B, questions should be specific to a statutory requirement for any of the compensable occupational illnesses. Questions must be specific to a medical determination, rather than an adjudicatory standard.

For example, in a pre-1993 CBD claim, a specific medical question is, "Does any X-ray show characteristic abnormalities consistent with CBD?" rather than, "Do the medical records support an acceptance of CBD under our Program requirements?"

(b) For referrals under Part E, questions should

identify the standard of proof required. For example, the CE asks, "Is it at least as likely as not that asbestos was a significant factor in causing, contributing to or aggravating the employee's diagnosed illness?"

In some instances, there may be two unrelated conditions that the CE determines require a review by two separate specialists. The CE will need to prepare one SOAF and specify the two specialists required for review. The CE will prepare separate questions for each specialist to address.

(3) Medical Records relevant to the issues for which the CMC is to render an opinion are to be imaged into a PDF formatted to the file and attached to the CMC referral email. For cases where an impairment rating is being sought, the CE may image the most pertinent or recent (two or three years old) medical records. For Second Opinion, Referee Specialist examination, or other case reviews, comprehensive medical records may need to be imaged. In some instances, the CE or designated staff person may need to divide the electronic images into several files to allow for electronic submission. The designated staff person should label each file clearly to allow for chronological or other categorical identification.

12. Role of Medical Scheduler in CMC Referrals. Each District Director (DD) designates a Medical Scheduler who processes and tracks CMC referrals. The Medical Scheduler is also responsible for coordinating communication between DO staff and the CMC contractor. When guidance requires that email communication be prepared, a copy of the email is to be printed and placed in the case file. Upon receipt of a CMC referral submission from a CE, the Medical Scheduler is to take the following actions:

a. Review of Referral. Conducts a thorough review of the referral package to ensure all required documentation is present, questions to the CMC are clear, and imaged records are legible. The SOAF should also be inspected to ensure that relevant factual findings have been reached that will allow for a comprehensive and reliable CMC analysis. Upon inspection, any referral package that is deemed to be incomplete or defective is returned to the CE for

corrective action. The Medical Scheduler is to return the referral package to the originating CE with a memo describing the problem to be addressed before a referral can be initiated.

b. Submission of Referral. Once the Medical Scheduler has determined that a referral is complete and ready for submission to the CMC contractor, he or she is to log onto the CMC contractor's internet portal, and follow the steps in the "Client Portal User Guide" for creating a claimant referral. Using the referral tab on the Client Portal, the Medical Scheduler inputs the claimant's information as needed, and uploads all relevant electronic documents to complete the transaction.

c. Confirmation. Upon receipt of submission confirmation from the CMC contractor, the Medical Scheduler is to notify the originating CE via email that the referral is complete.

d. Processing for Payment. When the Medical Scheduler receives confirmation from the CE that the report is complete and accurate (see Section 13 of this Chapter), the Medical Scheduler compares the referral sheet to the billing form submitted by the contractor to validate that the charged amount corresponds to the service request. The Medical Scheduler must ensure that the billing codes/units identified on the OWCP-1500 correspond appropriately to what the CE requested be performed by the contractor. The Medical Scheduler must be aware of the following when reviewing billing for CMC reports completed through the contractor process:

(1) For cases with multiple questions regarding the same or related conditions requiring the services of one specialist, (e.g., occupational medicine) one billable charge is permitted.

(2) For cases with one or more unrelated conditions, requiring the services of a single specialist, (e.g., pulmonary or occupational medicine) one billable charge is permitted.

(3) For cases with unrelated conditions requiring the services of multiple specialists, (e.g., oncology, pulmonary, dermatology) separate charges are

appropriate for each referral to a different specialist.

e. If the OWCP-1500 is correct, the Medical Scheduler prints the OWCP-1500 and stamps the document "Prompt Pay" in black ink, with a signature and date in black ink, in the top right hand corner of the OWCP-1500. The "Prompt Pay" date (date received in the district office (DO) plus 7 days) must be entered in block 11 of the OWCP-1500. The Medical Scheduler scans the stamped document, titles the bill using the last four digits of the employee's Social Security Number (SSN) and the employee's last name (e.g., 1234Smith).

The Medical Scheduler does not attach the CMC report or other documents to the bill. The Medical Scheduler then submits the approved OWCP-1500 to the Contracting Officer Representative (COR) or alternate COR designee via email at the email group "DEEOIC-CMC-INVOICES." The COR coordinates, communicates, and ensures cooperation among the contractor and associated Government personnel, for the purpose of anticipating and resolving difficulties, and ensuring satisfactory completion of contracts. For efficiency and management purposes, payable bills should be collected throughout each business day and electronically transmitted by batch in one email at the end of each work day. The Medical Scheduler should include in the body of the email a list of the bills that should be included as attachments to ensure that the COR or alternate COR designee receives an accurate listing of bills. The case file should contain a copy of the OWCP-1500 and the original medical report.

f. The Medical Scheduler will enter the following dates in ECS to ensure prompt payment of all physician referral bills : 1) Status Effective Date (enter the date listed in block 24A of the OWCP-1500); and 2) Eligibility End Date (enter the date of the physician's response, i.e., the date of the report).

g. Once the COR or alternate COR designee receives the batch, the bills are to be certified by the designated COR by placing a signature stamp on each invoice. The office Administrative Assistant will then mail the bills to the Bill Pay Agent (BPA) for processing and payment.

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- h. If a problem with the billing is identified, the Medical Scheduler communicates the issue with the contractor and copies the COR and alternate COR designee via e-mail.
- i. Problems with Reports. The Medical Scheduler notifies the District Director of any problems dealing with the CMC contractor.
13. Post Referral to CMC. Upon submission of a referral to the CMC contractor, the contractor will then assign a particular CMC to respond. The CMC selection is the function of the CMC contractor, and DEEOIC has no input in the selection of the physician chosen to review the case, other than the preferred specialty of the physician. Once assigned, the CMC is to assess all submitted documentation, and prepare a comprehensive and responsive medical narrative to the questions posed by the referring CE. The CMC then submits his or her report back to the contractor. The contractor then undertakes a quality control review to ensure that the report is complete, rationalized, and fully responsive to the questions posed by the CE. Upon clearance for release, the CMC contractor will then post the completed report along with a completed Form OWCP-1500 on the Client Portal.

To access the reports, the Medical Scheduler or designated staff logs into the Client Portal using the steps listed in the "Client Portal User Guide" and accesses the status for the relevant claim. The Medical Scheduler or designated staff downloads the CMC report and completed Form OWCP-1500 from the Client Portal.

- a. Completed Reports. Once the medical report is downloaded, the CE reviews it for accuracy and completeness. The review should include the CMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the CMC's rationale showing how his or her opinion is supported by the evidence in the file.

- (1) If the medical report is accurate, appropriate and complete, the CE sends approval to the Medical Scheduler, via email, to authorize payment of the medical bill no later than the next business day. The CE indicates in the text of the email that the review

completed by the CMC is acceptable. The email is scanned/bronzed to the case file in OIS.

(2) If the medical report is incomplete or incorrect, or not properly responsive to the questions posed, the CE notifies the Medical Scheduler, via email, of the issues with the medical report. The email is scanned/bronzed to the case file in OIS. The District Director or designated staff will return the medical report to the contractor and request the contractor provide an additional report to correct the situation. The CMC shall provide the additional report within (14) days of receipt of the request without additional charge. The District Director will notify the contractor in writing of the request for the additional report. A copy of the notification should be scanned/bronzed to the case file in OIS.

To ensure prompt payment of all physician referral bills to the BPA, (i.e., CMC, Second Opinion, Referee Specialist bills) the Medical Scheduler or designated staff records the referral and receipt of the medical report/billing in ECS.

- b. Request for Report. If the claimant requests a copy of the CMC's report, the CE provides a copy of the report with a cover letter, which includes the following disclaimer paragraph:

Attached is a copy of the medical report that you requested. Please be advised that {Enter the CMC's name} is a medical consultant for the Department of Labor. The Department of Labor will make the final decision in this claim. Please do not contact {Enter the CMC's name} regarding this report. If you have additional evidence to submit in support of your claim or if you have any questions or concerns regarding this report, please contact me at {Enter the DO's toll-free number}.

Staff may redact the CMC's personal address, personal telephone number, and personal email address, but must give the CMC's business telephone number, business address, and business email information.

A copy of the CMC's IH/Toxicologist report will be sent with all Recommended Decisions denying a claim based on causation.

c. Contract Compliance. Upon the identification of any systematic deficiencies or other problematic situations involving the CMC referral process, immediate action is to be taken to advise the District Director or a designee and the National Office COR. This would include situations involving consistently poor or low quality CMC reports, timeliness problems, or unresponsiveness to questions.

14. Second Opinion Examinations. A Second Opinion examination is a type of medical referral arranged by the DEEOIC that requires the employee to undergo a physical examination. The results of that examination, along with the physician's review of pertinent medical documentation, facilitate the production of a narrative medical report describing the physician's independent medical opinion in response to questions raised by the assigned CE.

To schedule Second Opinion examinations, the DEEOIC utilizes the CMC contractor with access to a database of physicians capable of performing in-person physical examinations by geographical location. Much like the CMC referral process, the decision to initiate a Second Opinion examination and the appropriate specialist falls to the CE assigned to the claim, but selection of the physician is the sole responsibility of the scheduling contractor.

a. Role of the CE. The CE is responsible for deciding when a Second Opinion examination is necessary in lieu of obtaining information from other sources, such as inquiry to a treating physician or CMC referral. A Second Opinion examination should be reserved for situations for which an actual physical examination of the patient will assist with the resolution of an outstanding claim, such as those involving issues of medical necessity or in situations where claimants have difficulty obtaining information necessary for completion of an impairment rating.

b. Referral for Second Opinion Examination. As discussed in Section 11 of this Chapter, interactions between the DEEOIC staff, the CMC, and physicians selected for Second

Opinion examinations occur through the Client Portal. The Medical Scheduler or designated staff is responsible for the coordination of information between DEEOIC staff and the contractor, including transmission of referral packages. The CE initiates the process for obtaining a

Second Opinion examination and ensures all necessary referral and medical documentation is sent to the Medical Scheduler or designated staff. Arranging for a Second Opinion examination follows the same basic referral steps listed as when making a CMC referral.

(1) Preparation of referral email. The CE sends an email to the Medical Scheduler indicating that a Second Opinion examination is needed, and requesting referral to the CMC contractor. The body of the email should contain:

- a. Claimant name.
- b. Claim number.
- c. Second Opinion review request.
- d. Medical Specialty requested. Refer to Section 11.a(4) of this chapter for further discussion of medical specialty.
- e. Previous physicians involved in the case.
- f. SOAF (Exhibit 1).
- g. List of Questions for the Second Opinion physician to address. (Exhibit 2)
- h. Medical Records.
- i. Cover Letter to the claimant. (Exhibit 4)

A copy of the referral email is scanned/bronzed to the case file in OIS.

(2) Role of the Medical Scheduler. The Medical Scheduler follows the steps listed in Sections 11 and 12 of this chapter to transmit the Second Opinion examination request to the CMC contractor and perform

follow-up actions. As is the case with the CMC referral process, the identification of any systematic deficiencies or other problematic situations involving the Second Opinion examination referral process, should be brought to the attention of the DD.

Once the contractor has selected a physician to perform the Second Opinion examination, the contractor will notify the claimant, in writing, of the specialist's name, address and telephone number, and date and time of the appointment. The contractor will also send the claimant a copy of the cover letter (See Exhibit 4 for example). The contractor will follow-up with the claimant to ensure that the claimant attended the appointment.

In the event the claimant requests to reschedule the Second Opinion examination, the CE will determine whether the appointment should be changed, as outlined in Section 16 of this chapter. If the claimant does not attend the Second Opinion examination, the CE may suspend action on any open claims and administratively close the case until such time as the employee agrees to and attends the examination as outlined in Section 16.

15. Referee Specialist Examinations. A conflict of medical opinion can arise between a physician selected by a claimant, and that of a CMC or Second Opinion physician. In most instances, the CE's careful weighing of the medical evidence should permit the resolution of the conflict. However, where the weight of medical evidence is equal between the opinion of the treating doctor and that of the CMC or Second Opinion physician, a Referee Specialist opinion is necessary. The CE obtains a Referee Specialist opinion by requesting a third, impartial physician review the competing opinions presented. The assigned physician then evaluates both sides of the competing argument, and makes the deciding conclusion.

a. Value of Referee's Opinion. The probative value of a Referee's opinion, if sufficiently rationalized and derived from careful examination of evidence from the competing physicians, is granted special weight. This means that once the Referee has fully considered the argument presented by both sides engaged in a conflict in medical opinion, and reached a rationalized conclusion regarding the matter, the CE is to consider the opinion of the Referee as the conclusive answer to the issue to be resolved.

b. File review or physical examination. A Referee Specialist examination will consist of either a review of the case record or an actual physical examination of the employee. If a conflict exists between the medical opinion of the employee's treating physician and the medical opinion of a CMC, a Referee referral file review is needed. However, if a conflict exists between the medical opinion of employee's treating physician and the medical opinion of the Second Opinion physician, a Referee referral physical examination should be scheduled.

c. Assignment of the Referee. The CE will utilize the same basic referral process for referral to a Referee examiner as is used for a Second Opinion, except for some notable differences.

(1) In the referring email to the Medical Scheduler, the CE is to denote the type of review as a Referee Specialist examination. A copy of the email is to be scanned/bronzed to the case file in OIS.

(2) The CE's questions to the Referee Specialist are to be sufficiently detailed and narrow to resolve the conflict of medical evidence. The questions should not introduce new or unique topics for the physician to address. The purpose of the Referee Specialist examination is limited to that which is necessary to resolve an existing conflict of medical opinion.

16. Failure to Undergo Second Opinion or Referee Specialist Examination. The employee assigned to undergo either a Second Opinion or Referee Specialist examination is obligated to attend the examination. Moreover, the CE is responsible for evaluating any request to change the date or time of an appointment to determine if sufficient reasons exist to allow for such a change. The employee and/or claimant will not be authorized to change a scheduled Second Opinion or Referee Specialist examination without providing a substantive and documented cause. The determination of whether an appointment should be changed is at the discretion of the CE who is responsible for initiating the referral. Generally, appointment changes should only be permitted in emergency situations, or when the employee has given a sufficiently convincing rationale for a need to

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change the appointment. Appointment changes that are necessary merely for the general convenience of the employee are usually not permitted. Once authorization for an appointment change is granted, the CE, through the Medical Scheduler, must notify the designated contractor.

Once a Second Opinion or Referee Specialist examination has been scheduled, it is expected that the employee attend. Failure to attend a scheduled examination may result in suspension of action on any open claims and administrative closure until such time as the employee agrees to and attends the necessary examination.

- a. Follow-up Action. If the employee was examined, the CE should expect a report within 21 days. This guideline also applies if a case is referred for a file review.
- b. Failure to Appear. If the physician's office reports that the employee did not appear for his or her scheduled appointment, the employee and any representative should be contacted by a documented phone call or in writing to request an explanation. If a reasonable explanation is provided, the CE re-schedules the examination, through the CMC Contractor.

If the employee does not respond to the CE's request for an explanation or if an explanation is provided and the CE determines good cause is not established, or if the employee fails to appear for the re-scheduled examination without good cause, the CE issues a letter advising the employee and representative that the issue to be resolved (i.e., adjudication of a consequential injury, request for surgery, medical supply, etc.) cannot be further adjudicated until the medical examination is completed. The CE suspends any further action to adjudicate the outstanding issue and administratively closes the claim. Development may resume if the employee agrees to undergo a medical examination and undergoes it.

- c. Disruptions at the Medical Examination. If a medical examination cannot be completed due to disruptions caused by someone accompanying the employee, the medical examination must be rescheduled with a different qualified physician. The employee will not be entitled to have anyone else present at this subsequent examination unless

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the CE determines that exceptional circumstances exist, for example, if a hearing impaired employee requires a sign language interpreter.

SUPERSEDED

Statement of Accepted Facts (SOAF)

1. Employee Information

- a. Name:
- b. Case File Number:
- c. Date of Birth:
- d. Date of Death:
 - i. If deceased, list Cause(s) of Death from Death Certificate

2. Medical Information

- a. Has an Occupational Health Questionnaire (OHQ) been completed? (Provide date)
- b. Diagnosed Condition(s): (Provide date of diagnosis for each, if possible; if diagnosed condition is skin cancer, provide body location)
- c. List any accepted conditions (if applicable).
- d. Other medical information/conditions available for review by referral personnel (if appropriate): (Provide dates of Former Worker Protection (FWPP) Interview, authorized home health care periods, etc.)

3. Employment Information - If Relevant - (Provide a detailed description of the employee's verified and covered employment history – include where employee worked, date(s) of employment, job title(s), job duty(ies))

4. Occupational Toxic Exposure - If Relevant - (Provide the occupational toxic substance exposures encountered by the employee and shown to have a potential health effect to the diagnosed condition; provide relevant information on the nature, extent and duration of such exposures)

5. Claim History – If Relevant - (Provide significant events such as date of filing of Part B and/or Part E, date submitted to NIOSH for dose reconstruction, Probability of Causation %, date of denial/acceptance, date of remanded claim, etc.)

6. Other Information - (Include any other information that may be useful to those conducting the referral evaluation)

7. Claims Examiner Information

- a. Submitting District Office:
- b. Claims Manager:
- c. Unit designation:
- d. Telephone Number:
- e. E-mail address:
- f. Date of referral:

8. Verification of Review – (Should be signed by District Office Director, or designee, indicating that the referral information has been reviewed and meets minimum criteria for submittal)

Sample Questions for Physician

Questions:

CE: Choose from options below or add your own

1. Impairment: Refer to PM Ch. 2-1300, Impairment Ratings for questions and instructions for CMC's conducting impairment evaluations.
2. Impairment: If it is not possible to complete an impairment rating based on the medical evidence we provided, please advise us what medical records and/or testing is required to complete the rating.
3. Diagnosis: In your opinion, do the medical records support a diagnosis of a medical condition? If so, please provide the first date of diagnosis, diagnosis, and the ICD code.
4. Causation: If a medical condition was diagnosed, in your opinion is it at least as likely as not that exposure to toxic substances during the course of employment at covered facility was a significant factor in aggravating, contributing to, or causing the employee's medical condition?
5. Causation: If so, please provide the earliest date of diagnosis(es) and ICD code of the condition you believe is related. Please provide the rationale and objective findings to support your conclusion that the condition(s) are related to exposure in the workplace.

Claims Examiner _____

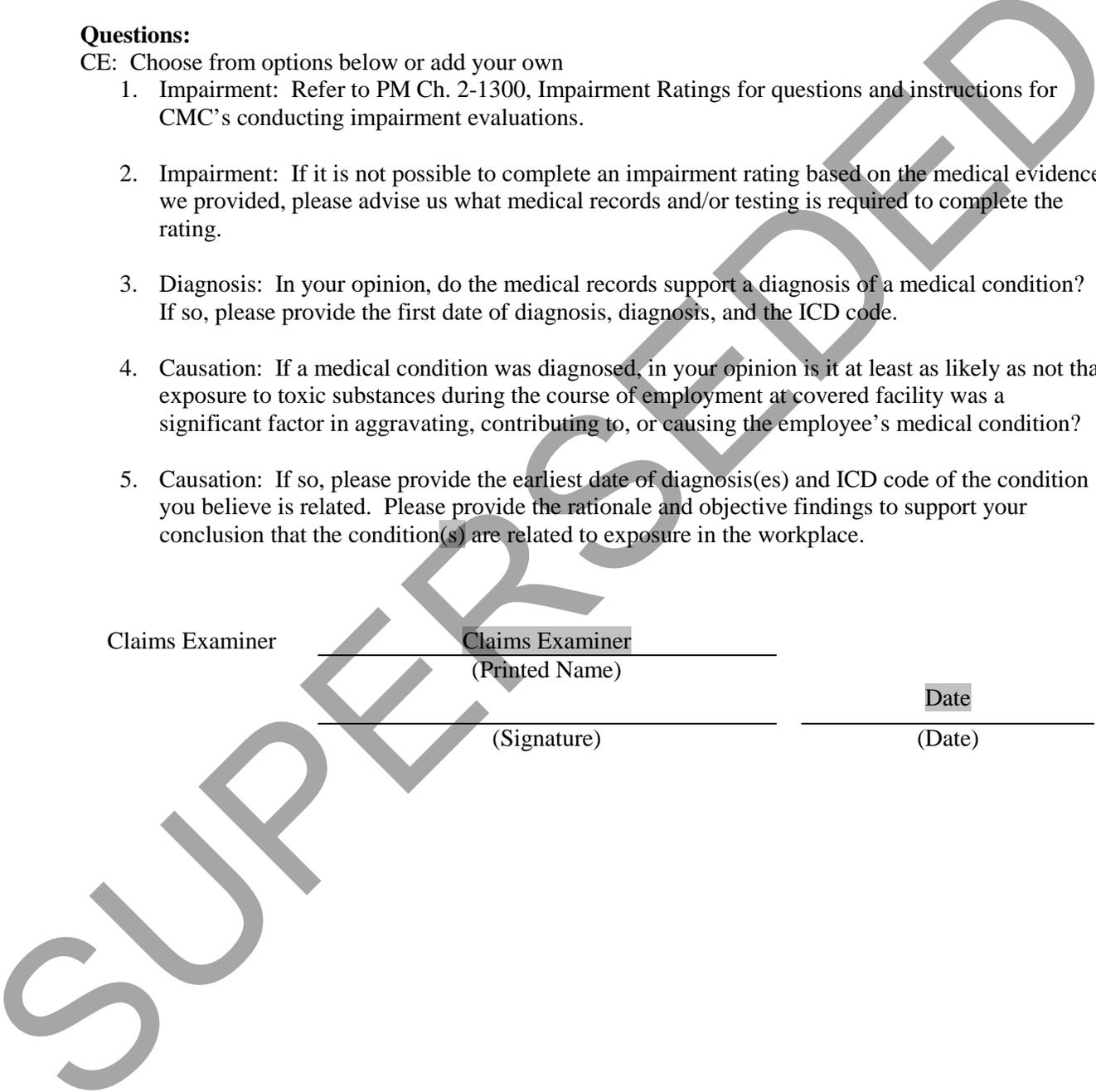
Claims Examiner _____

(Printed Name)

_____ Date

(Signature)

(Date)



ICD Codes and Corresponding Procedure Codes

V49.8FR001
FR002
FR003**File Reviews**File Review
Supplemental File Review
Clarification of Diagnosis, Treatment,
Tests**V49.8**

FR004

Impairment Ratings

Impairment Evaluation

V68.89

WL001

Wage Loss

Assessing Ability to Work/Wage-Loss

V68.2

SEP02

FR002
Cancel**Second Medical Opinions**Second Medical Opinion (includes
physical exam and file review)
Supplemental File Review
Appointment Cancellation**V65.8**

REFER

REF01

**Referee Referrals (Physical Exam
or Written Exam)**Physical examination which includes file
review
File review only

Sample Letter to Claimant Regarding Second Opinion/Referee PhysicianDEEOIC Case ID: (Case ID #)
Employee Name: (Employee Name)(Claimant Name)
(Street Address)
(City, State, Zip)

Dear (Mr/Ms Claimant):

This letter is in reference to your claim under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Under our regulations, the Division of Energy Employees Occupational Illness Compensation (DEEOIC) has the authority to refer an employee for a physical examination by a second opinion physician when it considers such a referral to be reasonably necessary.

Because it considers such a referral to be reasonably necessary for the proper adjudication of your claim, DEEOIC has arranged for you to be examined by a second opinion physician. Please review the attached letter for the time, date, and location of your scheduled appointment. DEEOIC will pay the out-of-pocket costs you incur in connection with the examination or any diagnostic testing. Travel costs to attend the examination are reimbursable upon submission of Form OWCP-957 (Attached).

DEEOIC recommends that you call the physician's office ahead of time to confirm your appointment. Providing the physician with your name, case ID #, and contact information, when you call, will help ensure that the process works as smoothly as possible.

Rescheduling the appointment is strongly discouraged and you should only do so in emergencies. Altering an appointment schedule can hinder our ability to take substantive action on your claim and promptly deliver services to you. If you are unavoidably prevented from keeping your appointment, you must immediately call your assigned claims examiner at the district office at Your Phone #. DEEOIC will evaluate any request to reschedule your appointment to determine whether you have submitted proof of one or more legitimate reasons to change the appointment.

If you do not attend the scheduled appointment, or cannot establish good cause for your failure to appear, DEEOIC will suspend claim adjudication and administratively close your claim. Reopening of the claim record will not occur until you agree to and attend a DEEOIC scheduled medical examination.

DEEOIC strongly encourages physicians to limit persons in attendance during the actual examination to one or two individuals. This would include a family member or designated authorized representative, and/or a health care professional, such as a RN/LPN, or CNA/HHA who is currently providing care to the patient. Ultimately, it is the examining physician's decision as to who can be present during the examination.

If you have a disability (a substantially limiting physical or mental impairment), please contact our office/claims examiner for information about the kinds of help available, such as communication assistance (alternate formats or sign language interpretation), accommodations and modifications.

Should someone accompanying you disrupt the scheduled medical examination, DEEOIC will reschedule the exam with a different qualified physician. You will not be entitled to have that individual accompany you during the subsequent examination unless DEEOIC determines that exceptional circumstances exist.

We appreciate your cooperation in this matter. If you have any questions regarding the scheduled examination, please contact me at the address listed above or call Your Phone #.

Sincerely,

(YOUR NAME)

Enc: OWCP-957
Copy of Authorization Letter

SUPERSEDED

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1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE) role when developing claims for consequential conditions. It also discusses the types of injuries, illnesses, impairments, or diseases that may be considered as consequential conditions.

a. OWCP Imaging System (OIS). Anyone undertaking development action with regard to a claim for consequential conditions is to ensure that documents generated or received during the evaluation process for consequential conditions are properly bronzed/scanned into the OIS. This guidance applies to any of the procedures described throughout this chapter.

2. Defining a Consequential Condition. The effect of an accepted occupational illness under Part B and/or covered illness under Part E in causing, contributing to or aggravating an injury, illness, impairment, or disease is considered a consequential condition. A CE is to accept as compensable any claimed consequential condition(s) that is documented properly by substantive, well-rationalized medical evidence. Consequential conditions can arise for any reason established as being medically linked to a previously accepted work-related illness. In some instances, a "chain of causation" can result in a series of injuries, illnesses, impairments, or diseases, which are a direct consequence of an accepted work-related illness. When medical evidence is present to establish such a scenario, the resulting consequential condition(s) in the causal chain are all compensable under the EEOICPA. The acceptance of a consequential condition(s) results in medical coverage for that condition(s) under Part B and/or Part E as appropriate. Additionally, under Part E, any diagnosed illness, injury, impairment, or disease shown by medical evidence to be a consequence of a covered Part E condition may affect the calculation of an impairment rating and/or wage-loss.

3. Claims for Consequential Conditions. The claimant must file a claim for all consequential condition(s) in writing and may use any method of written notification. However, while documents containing written words of claim for a consequential condition(s) are acceptable to begin the adjudication process, the CE is to obtain a completed and signed Form EE-1/2 associated with the consequential claim before issuing a decision. A signed claim form is also required for all metastatic cancers. Ideally, the claimant should concurrently send a written statement identifying the specific nature of the consequential condition claimed, along with a signed EE-1/2. A

signed EE-1/2 is required because it provides notice to the claimant of his or her responsibilities in filing for benefits under the Act.

a. For each distinct medical condition claimed as a consequence of a previously accepted condition, the CE undertakes a careful examination of the evidence presented in support of the claim. If the evidence demonstrates the existence of a diagnosed consequential illness and the CE decides that the medical justification is sufficient to link reasonably the condition to a previously accepted condition, he or she proceeds with issuing a letter decision of acceptance (refer to 10a on acceptances). In those claims situations where insufficient evidence exists, after development, to establish a consequential claim, the CE issues a recommended decision of denial.

There may be instances where a claimant files words of claim or an EE-1/2 for a condition but it is not clear whether the claimant's intent was to file the condition as resulting from toxic substance exposure or as a consequential condition. In most cases, the condition will be processed as a primary diagnosed condition resulting from toxic substance exposure. However, if the medical or factual information provided with the words of claim or the EE-1/2 alludes to the fact that the condition may be a consequence of a previously approved condition, the CE is to contact the claimant to obtain clarification on whether he or she wants the claim to be processed as a primary condition or as a consequential condition. Once the CE obtains clarification, he or she documents the claimant's intent in ECS and begins appropriate development for that condition.

In those cases where only words of claim was filed, the CE requests that the claimant submit a completed and signed EE-1/2 clearly indicating that the condition is consequential, prior to issuing any decision. (Note: if a completed and signed EE-1/2 was already submitted and the CE just needed to seek clarification of the claimant's intent, a new updated EE-1/2 is not needed).

(1) For any consequential condition(s) where the CE has requested a completed and signed Form EE-1/2, the CE allows a period of 30 days for the claimant to submit the required documentation. After 30 days, the CE administratively closes the claim if the claimant has not submitted a signed

EE-1/2 claim form. The CE is to mail a notice to the claimant(s) that no further action will occur on the claim for that medical condition until receipt of a completed and signed claim form.

b. In some situations, the CE may find evidence contained in a case record that suggests that an unclaimed medical condition is consequential to an accepted condition. If there is sufficient reason to discern that the evidence of record communicates the existence of a likely consequential condition, the CE is to contact the claimant to ascertain whether he or she wants to claim that condition as consequential to a previously accepted illness. If the claimant states that he or she wants to file a claim for that condition, the CE instructs the claimant to submit a completed and signed EE-1/2 form. The mere fact that the CE identifies an unclaimed condition in the medical evidence is not sufficient reason to seek a new claim. Evidence has to be present in the case record to lead the CE to a reasonable conclusion that the condition is consequential to an approved primary condition.

c. Where a claimant previously filed Form EE-1/2 for a condition due to toxic substance exposure that was denied, but later claims that the denied condition is consequential to an accepted condition, the claimant is to file a new Form EE-1/2 claiming the condition as a consequential illness. In this scenario, the CE treats it as new claim filed under the EEOICPA. As this is a new claim filed under the EEOICPA, a Director's Order vacating the prior denial of the same condition based on toxic substance exposure is unnecessary.

4. Claim Development. When assessing a claim for a consequential condition, medical evidence is required to document clearly the relationship that creates the nexus between a consequential condition and an accepted work related illness. The medical documentation is to contain information identifying the diagnosis of the consequential condition. In addition, the medical evidence is to include a physician's opinion that presents a convincing and well-rationalized conclusion linking the consequential condition to a previously accepted illness. The opinion of the physician regarding a consequential condition is to be sufficiently probative and compelling to allow the CE to assign the weight of medical evidence to the conclusion offered. Physicians offering vague, equivocal, speculative positions on the relationship between a consequential condition

and a work-related illness require additional investigation by the CE. Additional development is also required when a physician offers opinions that the CE considers to be unsupported by any reasonable medical justification.

a. Exhibit 1 provides a sample listing of secondary medical conditions that are known to result from Chronic Beryllium Disease (and treatment), silicosis, prednisone treatment, and other conditions. This list is not all-inclusive but serves as a guide for identifying some commonly known consequential illnesses. While the Exhibit serves as a guide and lists potential secondary illnesses, the CE is to exercise discretion when developing for these conditions. The fact that a condition appears as "secondary" on the Exhibit in no way establishes that the condition truly resulted from the claimant's approved underlying condition. The CE is to ensure that the claimant submits sufficient medical evidence to substantiate the relationship between the underlying condition and the claimed consequential condition.

5. Metastasized Cancer(s). Metastasized cancer(s) is a type of cancer that originates from a primary cancer site but spreads or invades other organ systems. Metastatic cancer has the same name and the same type of cancer cells as the original, or primary, cancer (Under a microscope metastatic cancer cells generally look the same as cells of the original cancer). For example, breast cancer that spreads to the lung and forms a tumor is metastatic breast cancer, not lung cancer. In many situations, there will be evidence in the form of pathology or other diagnostic evidence that identifies a cancer as "metastatic" or "secondary" to a primary cancer type. A CE may accept a claimed metastatic cancer as a consequential condition if the diagnostic or other medical evidence is sufficiently descriptive to identify it as being caused by another primary cancer accepted as work-related. If the evidence is unclear or does not establish a relationship between the cancers, the CE undertakes additional development to include collecting the opinion of a treating physician or an assessment of the record by a Contract Medical Consultant (CMC).

a. The evidence relating to a metastatic cancer is to include the following:

- (1) The diagnosis of each secondary cancer; and
- (2) The date of diagnosis for each secondary cancer(s).

If the medical evidence is inconclusive and the CE is unable to determine if the cancer is a metastasis, the CE seeks clarification from the treating physician and/or a CMC.

b. Examples of Metastasized Cancers. It is widely accepted that certain carcinomas and/or sarcomas metastasize from a primary site. For example:

(1) Carcinomas of the lung, breast, kidney, thyroid, and prostate tend to metastasize to the lungs, bone, and brain.

(2) Carcinomas of the gastrointestinal tract, reproductive system, and abdomen tend to metastasize to the abdominal lymph nodes, liver, and lungs. Later in their course, these carcinomas can metastasize to the brain and other organs.

(3) Sarcomas often first metastasize to the lungs and brain.

(4) Primary malignant tumors of the brain seldom metastasize to other organs, but they can spread to the spinal cord.

6. Conditions Resulting from Medical Treatment. Consequential conditions can arise from treatment modalities imposed on an employee because of an accepted work-related illness. This can include any injury, illness, impairment or disease arising from any form of medical treatment, including effects from prescription medication.

a. Consequential Conditions Resulting from Medical Treatment for Accepted Conditions. As part of a patient's medical treatment or protocol, a patient may undergo treatment and/or other drug therapy that will produce side effects that can be considered as common consequential conditions.

Examples of such conditions are:

(1) Radiation pneumonitis as a result of radiation treatment;

(2) Skin rashes and radiation burns because of radiation treatment;

(3) Osteoporosis (which causes weakening of the bones and injuries such as spontaneous hip fractures) as a result of steroid treatment.

b. Developing evidence for conditions resulting from medical treatment. When the CE receives a claim for a consequential condition caused by medical treatment of the accepted condition (also known as iatrogenic), the CE investigates the submitted documentation to ensure that the medical evidence supports the claim.

(1) Medical evidence is to identify the medical diagnosis of an illness or injury that is due to the treatment of an accepted work-related illness.

(2) A physician opinion or narrative is to be present that discusses the causal relationship between the consequential condition and a treatment modality made necessary because of the accepted condition. The physician's opinion should present a reasonable chronology of the onset of a consequential condition following a treatment regimen. In addition, the physician is to offer a well-rationalized position on the relationship that exists between a newly diagnosed problem and the treatment of an accepted illness. Vague, speculative or unsubstantiated positions taken by a physician require additional development including a review of the situation by a CMC, if necessary.

7. Independent Intervening Causes. Consequential conditions can arise from an injury arising from an action or event that is reasonably linked to the accepted work-related illness. An example would be an injury sustained by the claimant as a result of a slip and fall on his or her way to or from a medical appointment for the accepted work-related illness. Other examples include injuries to the claimant resulting from accidents involving wheelchairs or scooters, improper Durable Medical Equipment (DME) use, medical transport, etc. When assessing claims of this sort, the CE is to collect documentation that describes the circumstances of the injury, along with the medical evidence that diagnoses a medical condition linked to the event.

a. The CE is to obtain a signed written statement from the claimant that describes the circumstances of the event that resulted in an injury. For example, "I tripped down the stairs when exiting the doctor's office and broke my arm." The

claimant's statement is to be sufficiently descriptive to explain the circumstances of the event or accident, along with an explanation as to how it is linked to the accepted work-related illness.

b. A physician opinion or narrative is to be present that discusses the causal relationship between the event or accident that is somehow linked to the accepted work-related illness and the onset of a new diagnosed medical condition. The physician is to explain the sequence of events that led to the consequential condition, along with his or her explanation as to how the event or accident is related to the accepted work-related illness. If the physician is unable to provide a rational explanation, or there are other contradictions in the evidence that lead the CE to question the sufficiency of the claim, additional development should occur, including a review of the situation by a CMC. In situations where the claimant sustains an injury on his or her way to a medical appointment, it may be necessary to confirm the date, time and location of the appointment to assist with determining that the claimant was in fact on his or her way to an appointment related to the accepted condition.

(1) An independent intervening incident caused by, or attributed to, the employee's own conduct. Injuries, illnesses, impairments or diseases suffered as a result of the employee's own actions will not be accepted as consequential conditions. For example, if an employee is involved in an automobile accident on his or her way to a doctor's appointment for treatment of an accepted condition, but it is determined through medical evidence/police report that the claimant was under the influence of drugs or alcohol at the time of the accident, then the results of the accident could not be considered as a consequential illness or injury.

8. Pre-existing Conditions. Pre-existing conditions are conditions that pre-exist the diagnosis date of an accepted work-related condition. If medical evidence supports that the pre-existing condition became aggravated or worsened by the accepted condition, it is considered a consequential condition. To accept a claimed pre-existing condition as a consequential illness, a medical report is required that includes the diagnosis of the pre-existing condition and a well-rationalized explanation of how the condition was worsened or aggravated by the accepted condition. The medical evidence has to support an

increase in the symptoms or disability that would not have otherwise occurred, or treatment that would not have been necessary, but for the accepted condition. An example of a pre-existing condition affected by a covered condition includes Chronic Obstructive Pulmonary Disease (COPD) that aggravates a pre-existing heart disease such as Coronary Artery Disease. The "Eligibility Begin" date is the filing date of the underlying accepted condition.

9. Psychological Conditions. Psychological conditions can arise as a consequence of the accepted illness and/or treatment of that condition. They can also arise with no physiological basis. Depression, anxiety, and/or chemical imbalance are a few examples of psychological conditions that may have no physiological basis. In addition to a specific diagnosis, these conditions may be described as "psychogenic pain disorder," "conversion disorder," or "psychological syndrome." However described, the symptom or pain is quite real to the individual involved although there is no demonstrable physical disorder.

To accept a claimed psychological condition, the claimant must provide diagnostic evidence and a well-rationalized medical opinion from a qualified physician supporting a causal connection between the psychological condition and the covered condition. A qualified physician must be a clinical psychologist or psychiatrist. In situations where clarification on the causal relationship between the psychological condition and an accepted condition cannot be obtained from a qualified physician, the CE forwards the claimant's case file to a CMC or refers the claimant to a qualified second opinion physician for evaluation and opinion concerning causal relationship.

A CE may authorize social worker services for the treatment of a consequential psychological condition when prescribed under the supervision of a qualified physician. However, the physician is to specify the justification for such services, along with the submission of a narrative report that describes the plan of care with regard to the extent and duration of social services.

10. Accepting or Denying the Consequential Condition. The CE is responsible for taking the appropriate steps in developing any claimed consequential condition. This includes notifying the claimant of any deficiencies in the evidence and allowing him or her the opportunity to respond and submit additional evidence.

a. Acceptances. If the consequential condition is going to be accepted, the CE accepts the consequential condition under Parts B and E, if the primary underlying condition is also accepted under both Parts. The CE notifies the claimant in a letter decision. All letter decisions should contain two signature blocks; one for the CE who drafted the letter, and one for his or her supervisor (or another management official designated by the district director), who will certify the sufficiency of the decisional outcome. Exhibit 2 provides a sample decision letter for approvals of consequential conditions.

The CE should be aware that once he or she accepts a consequential condition by letter decision, any pending claim for that same condition being affiliated with a toxic substance exposure can be administratively closed. For example, when a letter accepting glaucoma as a consequential condition occurs, there is no need to then issue a recommended accept/deny for glaucoma based on toxic substance exposure. The "Eligibility Begin" date for consequential conditions is the filing date of the underlying accepted condition.

b. Denials. If the CE has determined that insufficient medical evidence exists to accept a claim for consequential condition, and the CE provided the claimant the opportunity to submit supportive evidence, he or she issues a recommended decision specifically denying the claim for a consequential illness. The CE does not issue a letter decision denying a consequential condition. A recommended decision issued to deny a consequential condition must contain a clear explanation to the claimant of the deficiencies in the medical evidence, including any interpretation of medical opinion from a physician, that is not considered sufficiently well-rationalized to support the claim.

c. Issuing the Decision. A CE cannot issue a letter decision accepting a consequential condition or a recommended decision denying a consequential condition without a preceding final decision accepting a primary covered condition. In those situations where a case is in posture for the CE to accept a primary covered condition and a potential consequential condition exists, the CE proceeds with the immediate release of a recommended decision for the primary condition. A CE does not delay issuance of a recommended decision accepting a primary covered condition while development occurs for a

consequential condition. However, if the case is in posture for concurrent acceptance of both a primary and a consequential illness, the CE includes both in the recommended decision.

11. Impairment and Wage-Loss. Consequential conditions may cause additional impairment or wage-loss under Part E, but do not result in an additional lump-sum award under Part B.

a. Impairment rating. An impairment rating assesses the functionality of the whole organ or system. The DEEOIC does not apportion impairment by disease (see EEOICPA PM 2-1300 for further discussion of impairment ratings). The effect of this methodology means that an impairment rating encompasses all illnesses causing damage to an organ system, so long as one is an accepted work-related illness. For conditions accepted as consequential, the CE determines if the acceptance of a new consequential illness requires action to initiate an impairment rating under Part E. If the CE is reviewing case evidence to make a decision on an initial claim for impairment, he or she includes all accepted primary or consequential claims in the assessment of impairment.

(1) The acceptance of a consequential illness that involves an organ system previously included in an impairment rating will not trigger a new impairment evaluation if it is less than two years from the date of the final decision awarding impairment benefits.

(2) For situations where a new consequential illness is accepted after an initial impairment rating has occurred, the CE proceeds with a new impairment rating if the consequential condition affects an organ system that was not previously evaluated for impairment. For example, the primary accepted condition is lung cancer. FAB issued a final decision one year ago to award a 50% impairment due to whole person impairment rating to the pulmonary system. A consequential illness is accepted for stomach ulcers as a result of medication required to treat the cancer. The CE may immediately proceed with a new impairment assessment because the consequential illness effects an organ system (digestive) that was not included in the prior impairment assessment.

If the claimant's treating physician or a CMC identifies a consequential illness during an impairment evaluation that is

not included in the SOAF as an accepted condition (regardless of whether or not it is included in the impairment), the CE contacts the claimant and asks if he or she wants to file a claim for the condition (refer to paragraph 3). If the claimant answers in the affirmative, the CE instructs him/her to submit a completed and signed Form EE-1/2. The processing of the impairment claim should not be delayed if the condition is for the same organ/body system.

b. Wage-Loss. With the acceptance of a new consequential illness, the CE has to determine if sufficient evidence is present to undertake development for wage-loss. CEs calculate wage-loss using the first day that the employee lost wages due to the covered illness and/or consequential illness (see EEOICPA PM 2-1400 for further discussion of wage-loss).

In certain instances, the consequential condition may be the initial cause of the employee's wage-loss. For example, a claimant is approved for CBD due to beryllium exposure under Parts B and E. A year later, the claimant files a claim for pulmonary hypertension as a result of CBD. The medical evidence supports this finding and the assigned CE accepts the pulmonary hypertension as a consequential condition to the approved condition of CBD. The CE obtains evidence showing that the employee has had to stop work due to breathing and cardiac difficulties. The claimant is now entitled to wage-loss benefits under Part E for any lost wages due to pulmonary hypertension.

12. State Workers' Compensation (SWC) Claims, Lawsuits and Fraud. For each consequential injury that is to be accepted, the CE may need to obtain a newly signed Form EN-16 SWC/Tort/Fraud affidavit from the claimant. The EN-16 is valid for one year from the date of claimant signature for all future claims related to that consequential condition, including claims for impairment and wage-loss.

Sample Listing of Medical Conditions
with Likely Secondary Disorders

Disorders secondary to Chronic Beryllium Disease (CBD) or its treatment due to steroid use (such as Prednisone)

- Hypoxemia (low oxygen levels at exercise, rest or with sleep)
- Airflow obstruction/wheezing (asthma-like presentation of CBD)
- Right heart failure, Cor pulmonale
- Pulmonary hypertension
- Respiratory infections (Pneumonia, Acute Bronchitis)
- Spontaneous Pneumothorax
- Deconditioning secondary to chronic lung disease
- Joint Aches (this is a symptom)
- Hyperuricemia, Gout
- Hypercalcemia/hypercalciuria
- Granulomatous Hepatitis
- Skin Nodules/Ulceration
- Aggravation of sleep apnea due to hypoxemia of CBD
- Weight gain
- Elevated blood pressure
- Elevated Cholesterol and abnormal lipids
- Liver function abnormalities
- Blood sugar change
- Diabetes
- Eye/vision problems such as cataracts, glaucoma, and visual acuity changes
- Gastrointestinal conditions such as gastric reflux or peptic ulcers
- Psychiatric or psychological conditions such as depression or anxiety
- Skin problems such as thrush or other fungal infections
- Metabolic changes such as folic acid depletion
- Decreased immune response leading to infections and viruses
- Decreased bone density leading to osteoporosis/osteopenia

Disorders secondary to Silicosis

- Hypoxemia
- Right heart failure, Cor pulmonale
- Pulmonary Hypertension
- Deconditioning secondary to chronic lung disease
- Progressive Massive Fibrosis
- Silicotuberculosis

Disorders secondary to prednisone treatment

- Cataracts
- Glaucoma
- Visual acuity changes
- Diabetes Mellitus
- Osteoporosis
- Osteopenia
- Gastric reflux
- Peptic ulcers
- Elevated blood pressure
- Elevated cholesterol
- Abnormal lipid profiles
- Sleep disorders
- Weight gain
- Myopathy, dermal atrophy
- Increased intracranial pressure

Other disorders

- Oral thrush and other fungal infections secondary to inhaled steroids, immunosuppression
- Folic acid depletion secondary to Methotrexate
- Infections due to immunosuppression (bacterial and viral)
- Post-herpetic neuralgia secondary to Herpes Zoster
- Flare due to immunosuppression
- Tinnitus - this condition is typically synonymous with sensorineural hearing loss. Tinnitus can be considered as a separate, stand alone condition or as consequential to sensorineural hearing loss.

U.S. DEPARTMENT OF LABOR

Office of Workers' Compensation Programs
Division of Energy Employees Occupational
Illness Compensation – Jacksonville Office
DOL DEEOIC Central Mail Room
P.O. Box 8306
London, KY 40742-8306
Tel: XXX-XXX-XXXX



Date

Case ID:

Employee:

Name

Address

City, State, Zip Code

Dear XXXXX:

This letter is in reference to your claim to receive medical benefits to treat your Lymphedema as a consequential illness resulting from the treatment for your accepted condition of breast cancer, under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

Medical evidence includes a letter dated January 1, 2015, in which Dr. John Smith stated that you have been diagnosed with breast cancer and had to undergo a radical mastectomy. As such, you developed lymphedema as a result of your radical mastectomy.

Based on Dr. Smith's statement, the medical evidence is sufficient to establish that your lymphedema is a result of treatment for your covered illness, breast cancer and is accepted as a covered consequential illness under Parts B and E of the EEOICPA guidelines. Medical benefits are approved for the treatment of your lymphedema (ICD-9 Code 457.1) retroactive to July 1, 2013, the date of filing for your breast cancer.

Covered medical services are payable in accordance with fee schedules and medical policy of the EEOICPA. The policy includes coverage of medical appointments, hospitalizations, appliances, supplies and drugs that are prescribed by a qualified physician and approved by the EEOICPA.

When you receive medical treatment you should show this letter to the medical provider you wish to designate as your treating physician and any other authorized medical

Exhibit 2

provider who may treat you for your covered illnesses. Most physicians, hospitals, durable medical equipment providers, and other health care providers will bill the EEOICPA directly so that you will not have to pay for medical treatment covered under the Program. To bill directly, providers must be enrolled in the program. For information about enrollment and billing procedures, providers may contact the Program at the address and telephone number listed at the end of this letter.

Note: If the EEOICPA pays less than the billed amount (in accordance with the fee schedule), you are not responsible for payment of the difference to a provider. Providers (and claimants) may submit requests for reconsideration of fee determinations in writing, with accompanying documentation to the address supplied at the end of this letter.

The EEOICPA will reimburse you for the cost of covered services/items that you have personally paid, providing that you submit appropriate documentation to the Program's billing address. However, bills and requests for reimbursement must be sent to EEOICPA within one year after the end of the calendar year in which the service or supply was provided, or within a year after the end of the calendar year in which the condition was accepted, whichever is later.

To request reimbursement of medical expenses associated with treatment of your accepted illnesses you are required to complete and submit the **OWCP-915 form, Claim for Medical Reimbursement**. You should also complete and submit the **OWCP-957, Medical Travel Refund Request** form with appropriate receipts when seeking reimbursement for travel expenses covered under the program. Both OWCP-915 and OWCP-957 forms (copies enclosed for convenience) include instructions for when you should complete these forms and the documentation required to process your request for reimbursement.

All requests for reimbursement of covered treatment related expenses including travel are to be mailed to:

**Division of Energy Employees Occupational
Illness Compensation
P.O. Box 8304
London, KY 40742-8304**

If providers have questions regarding submission or payment of bills, or require any other medical bill program assistance, they may contact a representative at toll free 1-XXX-XXX-XXXX.

Sincerely,

(Name) Date
Claims Examiner

(Name) Date
Supervisor

Enclosures:

SUPERSEDED