

RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL
VERSION 3.1:

EEOICPA TRANSMITTAL NO. 19-02

May 16, 2019

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this transmittal to notify staff of the publication of Version 3.1 of the Federal (EEOICPA) Procedure Manual (PM). Version 3.1 (v3.1) replaces Version 3.0 (v3.0), effective the date of publication of this transmittal.

Following are the content edits that make up Federal (EEOICPA) PM v3.1:

- Chapter 6, Processing Mail:
 - Ch. 6.5d was updated for clarity. The language included in v3.0 read:

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

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

- (1) FOIA Requests. FOIA requests allow third parties to request and gain access to existing Federal Government information, as outlined under 5 U.S.C. §552. FOIA requests are highly time sensitive and require careful attention as they involve the disclosure of specific documentation pertaining to the DEEOIC and/or its claimants. Each DEEOIC Office is to have a FOIA coordinator to effectively facilitate the identification and processing of FOIA requests.*

Exhibit 6-2 shows a FOIA Process Flow Chart which identifies the steps to be taken in order to accurately and expeditiously process a FOIA request received in a DEEOIC office.

It has been revised in v3.1 to:

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

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

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

Exhibit 6-2 shows a FOIA Process Flow Chart which identifies the steps to be taken in order to accurately and expeditiously process a FOIA request received in a DEEOIC office.

- Exhibit 6-2, FOIA Process Flow Chart, has been updated
- Chapter 12, Representative Services:
 - Ch. 12.6 has been updated to clarify communication with an employee of a duly appointed representative. The language included in v3.0 read:

6. *Interaction with Representatives. After a claimant properly appoints a representative to handle his or her DEEOIC claim, the CE or FAB staff person contacts the representative by letter (Exhibit 12-3). In the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in the claims process. From that point forward, or until the claimant removes or changes the representative, the CE or FAB staff person will communicate with the designated representative and copy them on all written interactions intended for the claimant.*

It has been revised in v3.1 to:

6. *Interaction with Representatives. After a claimant properly appoints a representative to handle his or her DEEOIC claim, the CE or FAB staff person contacts the representative by letter (Exhibit 12-3). In the letter, the CE acknowledges the appointment and describes the extent to which the representative has an active role in*

the claims process. From that point forward, or until the claimant removes or changes the representative, the CE or FAB staff person will communicate with the designated representative and copy them on all written interactions intended for the claimant. The CE or FAB staff are permitted to communicate with employees of the designated representative, including legal assistants, administrative staff, paralegals, or other individuals in the employment of the representative.

- Chapter 15, Establishing Toxic Substance Exposure and Causation:
 - Exhibit 15-2, Section 4.4 has been modified to eliminate the need to report ICD codes. The language included in v3.0 read:

*4. **Health Effect(s):** List the health effect(s) that are under toxic development along with the diagnosis date and ICD-9 or ICD-10 code as appropriate based on filing date of the diagnosed condition. Since the employee's work processes and work duties remain the same for the identified facility/site and labor category, multiple health effects may be listed and considered within the same section. The CE will clearly specify in #6 which toxins are associated with each corresponding health effect.*

It has been revised in v3.1 to:

*4. **Health Effect(s):** List the diagnosed condition that has a health effect link established by application of SEM or the opinion of a qualified physician. Since the employee's work processes and work duties remain the same for the identified facility/site and labor category, multiple health effects may be listed and considered within the same section. The CE will clearly specify in #6 which toxins are associated with each corresponding health effect.*

- Exhibit 15-4, has been modified to eliminate references to day-by-day exposure.
 - Section 1.b regarding angiosarcoma. The language included in v3.0 read:
 - b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to polyvinyl chloride on a day-by-day basis for at least 250 aggregate work days. This can be determined by an IH assessment.*

It has been revised in v3.1 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to polyvinyl chloride for at least 250 aggregate work days. This can be determined by an IH assessment.

- Section 4.b regarding asbestosis. The language included in v3.0 read:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Section 10.b regarding laryngeal cancer. The language included in v3.0 read:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Section 11.b regarding leukemia. The language included in v3.0 read:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to benzene on a day-by-day basis for at least 250 aggregate work days. This can be determined by an IH assessment.

It has been revised in v3.1 to:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to benzene for at least 250 aggregate work days. This can be determined by an IH assessment.

- Section 12.b regarding lung cancer. The language included in v3.0 read:

- b. *Exposure:* The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Section 14.b regarding mesothelioma. The language included in v3.0 read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 30 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 30 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Section 15.b regarding ovarian cancer. The language included in v3.0 read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Section 17.b regarding pleural plaques. The language included in v3.0 read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

It has been revised in v3.1 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos for at least 250 aggregate

work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Chapter 18, Eligibility Criteria for Non-Cancerous Conditions:
 - Ch. 18.6 has been edited for clarity concerning the use of evidence to support a pre-1993 CBD claim. The language included in v3.0 read:

6. Established CBD Before 1993, Part B. The evidence required to establish a claim for established CBD under Part B of the Act is described under 42 U.S.C. §7384l(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested for, diagnosed with, and/or treated for a chronic respiratory disorder.

If the earliest dated document showing that the employee was either treated for or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria should be used. Evidence of a chronic respiratory disorder includes records communicating existence of a long term, prolonged pulmonary disease process. References to acute pulmonary conditions, such as short-term pulmonary distress associated with temporary viral or bacterial infection do not qualify as a chronic respiratory disorder. Pulmonary testing performed in occupational or medical settings, which identify abnormalities, are not appropriate to document a chronic respiratory disorder, unless interpreted as such by a physician. In situations where it is critical that the question of whether historical documentation communicates the existence of a chronic respiratory disorder, the CE is to undertake development to allow for a physician chosen by the claimant to provide clarification, or when the claimant is unable to provide such evidence, seek the input of a CMC.

If the earliest dated document showing a chronic respiratory disorder lists a date after January 1, 1993, the post-1993 CBD criteria should be used. If the employee sought treatment before 1993, but the medical documentation relating to the treating document is dated on or after January 1, 1993, the pre-1993 CBD criteria should be used. In this situation, the medical evidence is to clearly communicate the fact that treatment occurred prior to 1993.

To establish pre-1993 CBD, the medical documentation is to include at least three of the following: characteristic chest radiographic [or computed tomography (CT)] abnormalities; restrictive or obstructive lung physiology testing or diffusing lung capacity defect; lung pathology consistent with CBD (including the results of an abnormal mediastinal lymph node biopsy); a clinical course consistent with a chronic respiratory disorder, or immunologic tests showing beryllium sensitivity (e.g., skin patch test or beryllium blood test preferred).

It has been revised in v3.1 to:

6. Established CBD Before 1993, Part B. *The evidence required to establish a claim for established CBD under Part B of the Act is described under 42 U.S.C. §73841(13). Whether to use the pre- or post-1993 CBD criteria depends upon the totality of the medical evidence, including when the employee was tested positive for, diagnosed with, and/or treated for a chronic respiratory disorder.*

If the earliest dated document showing that the employee was tested positive for, treated for, or diagnosed with a chronic respiratory disorder is dated prior to January 1, 1993, the pre-1993 CBD criteria should be used. Evidence of a chronic respiratory disorder includes records communicating existence of a long term, prolonged pulmonary disease process. References to acute pulmonary conditions, such as short-term pulmonary distress associated with temporary viral or bacterial infection do not qualify as a chronic respiratory disorder. Pulmonary testing performed in occupational or medical settings, which identify abnormalities, are not appropriate to document a chronic respiratory disorder, unless interpreted as such by a physician. In situations where it is critical that the question of whether historical documentation communicates the existence of a chronic respiratory disorder, the CE is to undertake development to allow for a physician chosen by the claimant to provide clarification, or when the claimant is unable to provide such evidence, seek the input of a CMC.

If the earliest dated document showing a chronic respiratory disorder lists a date after January 1, 1993, the post-1993 CBD criteria should be used. If the employee sought treatment before 1993, but the medical documentation relating to the treating document is dated on or after January 1, 1993, the pre-1993 CBD criteria should be used. In this situation, the medical evidence is to clearly communicate the fact that treatment occurred prior to 1993.

To establish pre-1993 CBD, the medical documentation is to include at least three of the following: characteristic chest radiographic [or computed tomography (CT)] abnormalities; restrictive or obstructive lung physiology testing or diffusing lung capacity defect; lung pathology consistent with CBD (including the results of an abnormal mediastinal lymph node biopsy); a clinical course consistent with a chronic respiratory disorder, or immunologic tests showing beryllium sensitivity (e.g., skin patch test or beryllium blood test preferred). Once it is established that the employee had a chronic respiratory disorder prior to 1993, the CE is not limited to the use of medical reports dated prior to 1993 to meet three of the five criteria.

- Ch. 18.12(a)(2) has been edited for clarity. The language included in v3.0 read:
 - (2) *Present for an aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an atomic weapon (Part B claims only).*

It has been revised in v3.1 to:

- (2) *Present for an aggregate of at least 250 work days during the mining of tunnels at a DOE facility located in Nevada or Alaska for tests or experiments related to an*

atomic weapon (Part B claims only). This tunnel work occurred through October 1992, at which time the unilateral moratorium on nuclear weapons testing went into effect.

- Chapter 21, Impairment Ratings:

- Ch. 21.13 has been revised with updated guidance on calculating increased impairment awards with tort offset/SWC coordination. The language included in v3.0 read:

13. How to Calculate Increased Impairment Award with Tort Offset/SWC Coordination. For increased impairment claim involving tort offset and/or SWC coordination, the calculation must be based on the current impairment rating/award and not on the net increased impairment award.

For example, John Doe had previously been awarded impairment for asbestosis and skin cancer for 26%. The current combined impairment rating is 40%, which comprised of 33% due to asbestosis and 10% due to skin cancer. Using the current impairment rating, follow the calculation in Section 12c to determine the relative percentage of impairment for each organ or body function and Section 12d to determine the dollar amount attributable for each organ or body function. The dollar amount attributable to each organ or body function must be based on the current impairment award of 40% or \$100,000.00 and not on the net increase of 14% (40% - 26% = 14%) or \$35,000.00. As such, the increased impairment calculation is as follows:

For asbestosis – Multiply 76.74% (the percentage attributable to asbestosis based on the current impairment rating) by the current impairment award of \$100,000.00 to determine that \$76,740.00 is the dollar amount attributable to asbestosis.

For skin cancer – Multiply 23.26% (the percentage of current impairment rating attributable to skin cancer) by \$100,000.00 to determine that \$23,260.00 is the dollar amount attributable to skin cancer.

Since the CE calculates the increased impairment award based on the current impairment rating and not on the net increase, any previous award(s) of impairment and any SWC coordination/tort offset for that organ or body function must be subtracted from the current impairment award.

Example: In the previous impairment decision issued to John Doe, the CE concluded that a surplus of \$1,854.50 remained for asbestosis after coordination of SWC benefits for asbestosis in the amount of \$50,000.00. The total impairment award was \$16,854.50 from the skin portion of the combined impairment award. Since the previous impairment decision, the CE concluded that John Doe received an additional SWC coordination for asbestosis in the amount of \$10,000.00 for a total coordination amount of \$60,000.00.

To calculate the new impairment award, subtract the total coordination amount of \$60,000.00 for asbestosis from the new dollar amount attributable to asbestosis (\$76,740.00) which equals to \$16,740.00 payable for asbestosis. From the new dollar

amount attributable to skin cancer of \$23,260.00, subtract the previous award of \$16,854.50, which equals to \$6,405.50. The CE adds the dollar amounts for each organ or body function to determine that the increased impairment award is \$23,145.50 (\$16,740.00 + \$6,405.50 = \$23,145.50) with no outstanding surplus.

In any unique or challenging circumstance involving how best to apply SWC coordination or tort offset to a payable impairment, the CE consults with the NO Policy Branch.

It has been revised in v3.1 to:

13. How to Calculate Increased Impairment Award with Tort Offset/SWC Coordination. For an increased impairment claim involving tort offset and/or SWC coordination, the calculation must be based on the current impairment rating/award and not on the net increased impairment award.

For example, John Doe had previously been awarded impairment for asbestosis and skin cancer for 26%. The current combined impairment rating is 40%, which is comprised of 33% due to asbestosis and 10% due to skin cancer. Using the current impairment rating, follow the calculation in Section 12c to determine the relative percentage of impairment for each organ or body function and Section 12d to determine the dollar amount attributable for each organ or body function. The dollar amount attributable to each organ or body function must be based on the current impairment award of 40% or \$100,000.00 and not on the net increase of 14% (40% - 26% = 14%) or \$35,000.00. As such, the increased impairment calculation is as follows:

For asbestosis – Multiply 76.74% (the percentage attributable to asbestosis based on the current impairment rating) by the current impairment award of \$100,000.00 to determine that \$76,740.00 is the dollar amount attributable to asbestosis.

For skin cancer – Multiply 23.26% (the percentage of current impairment rating attributable to skin cancer) by \$100,000.00 to determine that \$23,260.00 is the dollar amount attributable to skin cancer.

Since the CE calculates the increased impairment award based on the current impairment rating and not on the net increase, the total of all SWC coordination/tort offset for that organ or body function must be subtracted from the current dollar amount attributable to that organ or body function that is available for SWC coordination/tort offset.

Example: In the previous impairment decision issued to John Doe, the CE concluded that a surplus of \$1,854.50 remained for asbestosis after coordination of SWC benefits for asbestosis in the amount of \$50,000.00. The total impairment award was \$16,854.50 from the skin portion of the combined impairment award. Since the previous impairment decision, the CE concluded that John Doe received an additional SWC coordination for asbestosis in the amount of \$10,000.00 for a total coordination amount of \$60,000.00.

To calculate the dollar amount of the new impairment award, first subtract the total coordination amount of \$60,000.00 for asbestosis (\$50,000.00 calculated at the time of the prior award + the additional amount of \$10,000.00 = \$60,000.00) from the new dollar amount attributable to asbestosis (\$76,740.00), which leaves \$16,740.00. Add the new amount attributable to skin cancer (\$23,260.00) to this figure for asbestosis, and the result is \$40,000.00 (\$23,260.00 + \$16,740.00 = \$40,000.00).

Finally, from this amount of \$40,000.00, subtract the total amount of impairment benefits previously paid (\$16,854.50), and the resulting figure of \$23,145.50 is the amount payable as increased impairment benefits (\$40,000.00 - \$16,854.50 paid on the prior award = \$23,145.50), with no outstanding surplus.

In any unique or challenging circumstance involving how best to apply SWC coordination or tort offset to a payable impairment, the CE consults with the NO Policy Branch.

- Chapter 30, Home and Residential Health Care, is reissued to include a new forms process for making HHC claims and contains new sections outlining the HRHC claims adjudication process. Also updated are sections pertaining to the emergency authorization of HRHC claims, and other administrative procedures.
 - Section 1. New language introducing an expanded chapter on HRHC.
 - Section 2. Definitions provided to explain terms common to the HRHC claim process.
 - Sections 3 and 4. New language introducing two HRHC claim forms, a discussion of the forms process, and an explanation of the claimant's right to make certain decisions pertaining to their HRHC needs.
 - Sections 5. New guidance to the Medical Benefits Examiner (MBE) regarding the evaluation of a Letter of Medical Necessity (LMN) for authorization of HRHC.
 - Section 6 and 7. New guidance outlining development resources available to the MBE and new procedural guidance discussing the development steps necessary to support an authorization for HRHC.
 - Section 8, 9 and 10. New procedural guidance explaining the process for issuing authorizations for medically appropriate HRHC and for issuing recommended decisions for the denial or reduction of authorized HRHC.
 - Section 11. A revised section explaining the process for obtaining an emergency authorization for HRHC.
 - Section 12. Updated instructions to providers regarding documentation required when billing DEEOIC for HRHC authorized services.

- The following Exhibits for Ch. 30 have been updated:
 - Exhibit 30-1, Form EE-17A: Claim for Home Health Care, Nursing Home, or Assisted Living Benefits Under the EEOICPA
 - Exhibit 30-2, Form EE-17B: Physician's Certification of Medical Necessity Under the EEOICPA
 - Exhibit 30-3, Sample Letter to Treating Physician
 - Exhibit 30-4, DEEOIC Home and Residential Health Care Authorized Billing Codes



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