



RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE
MANUAL VERSION 4.0:

EEOICPA TRANSMITTAL NO. 20-01

November 14, 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 4.0¹ of the Federal (EEOICPA) Procedure Manual (PM). Version 4.0 (v4.0) replaces Version 3.1 (v3.1), effective the date of publication of this transmittal.

Following are the content edits that make up Federal (EEOICPA) PM v4.0:

- Chapter 1 – Definitions
 - Ch. 1.2ccc has been edited to correct a citation in compliance with 20 CFR § 30.5. The language included in v3.1 read:

ccc. Specified Cancers. The following are specified cancers in accordance with 20 CFR § 30.5(ff):
 - It has been edited in v4.0 to:

ccc. Specified Cancers. The following are specified cancers in accordance with 20 CFR § 30.5(gg):
- Chapter 7 – Case Creation
 - Ch. 7.2 has been edited to comply with 20 CFR § 30.100 and 30.101 regarding the necessity for a claimant signed claim form. The language included in v3.1 read:

2. New Cases. A new case usually consists of a Claim for Benefits, Form EE-1 or EE-2, with the accompanying Form EE-3, Employment History for a Claim Under the EEOICPA. A new case is created based on a signed written communication from the claimant; a claimant's AR, or a person acting on behalf of the claimant (e.g., a relative or guardian). Any one of the following documents is considered a request for benefits:

¹ The contents of this document do not have the force and effect of law and are not meant to bind the public in any way.

- a. *Form EE-1, Employee’s Claim for Benefits;*
- b. *Form EE-2, Survivor’s Claim for Benefits; or*
- c. *Any letter or document containing “words of claim” under the EEOICPA. “Words of claim” means that the individual has communicated in writing his or her intent to seek benefits under the EEOICPA.*

It has been edited in v4.0 to:

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

- a. *Form EE-1, Employee’s Claim for Benefits;*
- b. *Form EE-2, Survivor’s Claim for Benefits; or*
- c. *Any letter or document containing “words of claim” under the EEOICPA. “Words of claim” means that the individual has communicated in writing his or her intent to seek benefits under the EEOICPA.*

- Ch. 7.5 has been edited to comply with 20 CFR § 30.100 and 30.101 and adds guidance regarding processing signed claim forms. The language included in v3.1 read:

5. *Creating Cases in ECS.* *The CCC enters into ECS information reported by the claimant from the incoming claim form, such as personal, medical, employment and any other relevant claim data. Important demographic information from the claim form necessary to create a claim includes the employee/survivor name, SSN, mailing address, phone number, date of birth, sex, etc. The CCC also enters information concerning the nature of the claim to include the medical conditions claimed as work-related, the employment history for the employee, and responses to the receipt of other award or other legal information. Once this information is entered and saved, ECS assigns a unique Case ID Number for the entire case file. In addition, each person who has filed a claim within a case is assigned a unique claimant identification number. If the CCC is processing a claim based on the submission of correspondence that contains words of claim, he or she is to enter as much information as possible to permit ECS to assign a Case and Claimant ID Number. At a minimum, ECS requires the entry of name and mailing address of the claimant (in the case of a survivor, it is necessary to name the employee) to permit the creation of a case. Once the CCC creates a claim under this circumstance, the matter is referred to the assigned CE to notify the claimant of the need to complete an EE-1 or 2 to allow for claim adjudication. A claimant signature is not necessary on any form or letter with words of claim for case creation to occur; however,*

for claim adjudication a signed EE-1 or EE-2 is required. Without a properly completed form, the claim is administratively closed.

It has been edited in v4.0 to:

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

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

- Ch. 7.9a has been added to provide guidance on resumption of development after withdrawal of a claim:
 - a. *To resume development on a withdrawn claim, the claimant must submit a signed letter to DEEOIC requesting the resumption of the withdrawn claim or submit a new signed EE-1 or EE-2 form for the same illness(es)/death previously under adjudication. DEEOIC will resume development by picking up where development left off at the time the claimant chose to withdraw. Therefore, if a*

recommended decision concerning the claim in question was issued and the case forwarded to FAB, but then the claim was administratively closed while the case was at FAB due to claim withdrawal, a new recommended decision should not be issued.

- Chapter 12 – Representative Services

- Ch. 12.4 has been edited to comply with 20 CFR. § 30.600 regarding obtaining claimant signed claim forms. The language included in v3.1 read:

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

It has been edited in v4.0 to:

4. AR's Role. The AR's role in the claims process depends on the scope of the authority that the claimant grants him or her. Unless the claimant's authorization specifies otherwise, a properly appointed AR has the authority, to the same extent as the claimant, to present or seek evidence, make factual or legal arguments, or seek medical authorization, interact with DEEOIC staff, and obtain information from the case file. Any notice or other communication from the DEEOIC that relays a requirement for claim adjudication is considered satisfied, if the DEEOIC sends it to a properly designated AR. The DEEOIC considers any communication sent to an AR the same as communication to the claimant. In most situations, the CE or FAB staff person is to relay information or other communications directly to the AR, with a copy going to the claimant. Where claimant contact information is unavailable, the CE or FAB staff person communicates solely with the AR. However, the CE or FAB staff person may choose to contact the claimant directly, if an AR is unresponsive, provides unclear guidance or direction, or a contradiction exists between information received from an AR versus the claimant. In any situation, the claimant is the final arbiter of any matter involving his or her claim. An

appointed AR, who does not possess legal authority through a POA or court document to act on behalf of a claimant, does not have the authority to sign for a claimant in initiating a claim or sign an EN-20 Payment Form for the claimant.

- Exhibit 12-2, Powers of Attorney Memo for SOL Review has been replaced with an updated version.
- Chapter 14 – Establishing Special Exposure Cohort Status
 - Ch. 14.7c has been edited to clarify that leukocytosis and thrombocytosis are not a diagnosis of cancer. The language included in v3.1 read:

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

It has been edited in v4.0 to:

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

- Chapter 15 – Establishing Toxic Substance Exposure and Causation
 - Ch. 15.11d has been edited to provide instructions on how an Industrial Hygienist (IH) engages directly with a claimant in collecting exposure data for informing a toxic substance profile. The language included in v3.1 read:

d. *IH assessment and opinion. The IH reviews the issue framed by the CE and determines whether more information from the case file is required to answer the question, or if the entire case file is needed. This is reserved for the most complex cases and is at the discretion of the IH. The IH role is to anticipate, recognize, and evaluate hazardous conditions in occupational environments, and to opine based upon his/her specialized knowledge. The IH strives to answer the question based upon the information outlined by the CE.*

(1) *IH Memorandum. The IH renders an expert opinion in the form of a memorandum that addresses the issue as specifically as possible. The IH's reply addresses the specific question(s) posed by the CE in the IH Referral, and employs specialized training to make findings based upon the evidence of file and clearly rationalized science.*

It has been edited in v4.0 to:

d. *IH assessment and opinion. The IH reviews the issue framed by the CE and determines whether more information from the case file is required to answer the question, or if the entire case file is needed. This is reserved for the most complex cases and is at the discretion of the IH. The IH role is to anticipate, recognize, and evaluate hazardous conditions in occupational environments, and to opine based upon his/her specialized knowledge. The IH strives to answer the question based upon the information outlined by the CE.*

During the evaluation of the CE's IH referral, DEEOIC IH (federal or contractor) staff may determine if it is necessary to obtain clarification from a claimant regarding the circumstance of an employee's work that brought the employee into contact with a particular toxic substance. This could include clarifying the employee's specific occupational roles and responsibilities; proximity to work processes or particular materials; frequency of activity occurrence; knowledge of work with particular materials; or clarifying information provided in referral case evidence. Under this circumstance, the IH will email the designated federal IH Team Lead advising of the need for clarifying information and requesting a telephone call with the claimant. Within the email the IH will identify the claim file number, explain the specific information requested and the justification for the request. Upon review, the federal IH Team Lead will then coordinate with the assigned CE to have a telephone call with the claimant and a federal IH staff person to address the request for information. Upon completion of the call, in addition to the usual ECS call summary, the CE will prepare a Memo to File describing the outcome of additional development, including a detailed narrative of any conversation held with the claimant. Once complete, the CE will forward the memo to the requesting IH for consideration in preparation of the IH referral response.

(1) *IH Memorandum. The IH renders an expert opinion in the form of a memorandum that addresses the issue as specifically as possible. The IH's*

reply addresses the specific question(s) posed by the CE in the IH Referral. The IH is to employ his or her subject matter expertise to make reasonable findings regarding exposure based upon the unique features of the case under review. The IH is to consider any information obtained from the claimant in a verbal exchange that occurred because the IH requested clarification.

- Exhibit 15-4.3 has been edited to extend the temporal duration for the presumption of asbestos exposure for certain labor categories, to remove language requiring high levels of asbestos exposure, and to add the labor category of Uranium Miner/Miller. The language included in v3.1 read:

3. **Asbestos (exposure presumption)**: *The program recognizes that asbestos is a toxic material that was present in all Department of Energy (DOE) facility locations. The CE may accept the following presumptions regarding asbestos exposure.*

a. *Asbestos exposure through 1986, specific end date used is December 31, 1986.*

(1) The following labor categories are considered to have had significant exposure to asbestos at high levels based on their associated job tasks.

- *Automotive mechanic; Vehicle mechanic; Vehicle maintenance mechanic*
- *Boilermaker*
- *Carpenter; Drywaller; Plasterer*
- *Demolition technician; Laborer*
- *Electrical mechanic; Electrician; Floor covering worker*
- *Furnace & saw operator; Furnace builder; Furnace operator; Furnace puller; Furnace technician; Furnace tender; Furnace unloader*
- *Glazier; Glass installer; Glazer*
- *Grinder operator; Mason (concrete grinding); Tool grinder; Maintenance mechanic (general grinding); Welder (general grinding); Machinist (machine grinding)*
- *Insulation worker; Insulation trade worker; Insulator*
- *Ironworker; Ironworker-rigger*
- *Maintenance mechanic; Electrician; Insulator;*
- *Mason; Brick & tile mason; Concrete and terrazzo worker; Bricklayer, Tilesetter*
- *Millwright*
- *Heavy equipment operator; Operating Engineer*
- *Painter*
- *Pipefitter, Plumber steamfitter; Plumber/pipefitter; Plumbing & pipefitting mechanic; Plumbing technician, Steamfitter*
- *Roofer*

- *Sheet metal mechanic; Sheet metal fabricator/installer*
- *Welder; Welder burner; Welder mechanic*

(2) All other labor categories are assumed to have had some level of exposure to asbestos. However, that level of exposure is determined by guidance from an IH or full IH assessment. The IH will determine if the level of exposure was significant (high, moderate, or low) or not significant (incidental-occurring in passing only).

It has been edited in v4.0 to:

3. Asbestos (exposure presumption): *The program recognizes that asbestos is a toxic material that was present in all Department of Energy (DOE) facility locations. The CE may accept the following presumptions regarding asbestos exposure, when applicable to the medical condition under adjudication.*

a. Asbestos exposure through December 31, 1995.

(1) The CE is to consider the following labor categories to have had significant exposure to asbestos based on their job tasks.

- *Automotive mechanic; Vehicle Mechanic; Vehicle maintenance mechanic*
- *Boilermaker*
- *Carpenter; Drywall; Plaster*
- *Demolition technician, Laborer*
- *Electrical mechanic; Electrician; Floor covering workers*
- *Furnace & saw operator; Furnace builder; Furnace operator, Furnace puller; Furnace technician; Furnace tender; Furnace unloader*
- *Glazier, Glass installer, Glazer*
- *Grinder Operator; Mason (concrete grinding); Tool grinder, Maintenance mechanic (general grinding); Welder (general grinding); Machinist (machine grinding)*
- *Insulation worker; Insulation trader worker; Insulator*
- *Ironworker, Ironworker-rigger*
- *Maintenance mechanic; Electrician; Insulator*
- *Mason; Brick & tile mason; Concrete and terrazzo worker; Bricklayer; Tilesetter*
- *Millwright*
- *Heavy equipment operator; Operating Engineer*
- *Painter*
- *Pipefitter; Plumber steamfitter; Plumber/pipefitter; Plumbing & pipefitting mechanic; Plumbing technician; Steamfitter*
- *Roofer*
- *Sheet metal mechanic; Sheet metal fabricator/installer*

- *Welder; Welder burner; Welder mechanic*
- *Uranium Miner/Miller*

b. For employment that does not qualify for the standard in “a.”, the CE will assume the employee to have had some level of exposure to asbestos. However, the CE is to refer the case to an IH to determine the level, extent, nature and frequency of exposure; including whether the exposure was significant (high, moderate, or low) or not significant (incidental – occurring in passing only).

- Chapter 16 – Developing and Weighing Medical Evidence

- Ch.16.3a(3) has been edited to correct a citation reference relating to 20 CFR § 30.5. The language included in v3.1 read:

(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.

It has been edited in v4.0 to:

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

- Ch. 16.5a(1) has been added to add distinction on how DEEOIC is to define a diagnosed condition vs. symptom:

(1) Establishment of a diagnosis requires that a physician interpret available clinical and diagnostic evidence to identify a disease or disorder. Alternatively, signs and symptoms are abnormalities that a physician may use to form a judgment of medical diagnosis. A claimed illness filed by a claimant that medical evidence establishes as a finding, sign or symptom is not necessarily a diagnosed condition. In those instances where unclear evidence exists whether the CE should categorize the claimed condition as a medical diagnosis or not, the CE is to seek clarification from the claimant’s physician or a CMC.

- Ch. 16.9a-c has been edited to correct an error in the outline format. The language included in v3.1 read:

a. Diagnosis. Clarification and confirmation of diagnosis.

c. 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.*

It has been corrected in v4.0 to:

- 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 a covered illness or illnesses.*

- Chapter 18: Eligibility Criteria for Non-Cancerous Conditions

- Ch. 18.13 has been edited to clarify the appropriate use of SEM in cases of fibrotic lung diagnoses. The language included in v3.1 read:

13. Pneumoconiosis, Part E. Pneumoconiosis is the deposition of particulate matter, such as coal dust, asbestos, and silica in the lungs. Pneumoconiosis is oftentimes a broad categorization physician's use for various subtypes of pulmonary disease. For example, asbestosis is a type of pneumoconiosis, as is silicosis. It is not appropriate for a CE to make assumptions that a diagnosis of pneumoconiosis is equivalent to any number of its subtypes without seeking clarification from a physician. Pneumoconiosis is a Part E covered illness only. A physician's diagnosis of pneumoconiosis can be supported by clinical evidence from the physician, along with other affirmative diagnostic evidence including:

It has been edited in v4.0 to:

13. Pneumoconiosis, Part E. Pneumoconiosis is caused by the deposition of particulate matter, such as coal dust, asbestos, and silica in the lungs. Pneumoconiosis is oftentimes a broad categorization physicians use for various subtypes of pulmonary disease. For example, asbestosis is a type of pneumoconiosis, as is silicosis. The CE is to treat pneumoconiosis, pulmonary fibrosis and interstitial lung disease as being equivalents for purposes of claims adjudication. For SEM searches, the appropriate search term for each of these is "pneumoconiosis, other." It is not appropriate for a CE to make assumptions beyond these that a diagnosis of pneumoconiosis is equivalent to any number of its subtypes without seeking clarification from a physician. Pneumoconiosis is a Part E covered illness only. A physician's diagnosis of pneumoconiosis can be supported by clinical evidence from the physician, along with other affirmative diagnostic evidence including:

- Chapter 22 – Wage-Loss Determinations

- Ch. 22.6a has been updated to comply with guidance found in Ch. 22.12. The language included in v3.1 read:

- a. *Wage-Loss Letter and Response Form (Form EE-11B/EN-11B): Form EE-11B lists the criteria to establish wage-loss. The form includes an explanation regarding earnings records for the twelve quarters prior to the first quarter of claimed wage-loss and contains a solicitation for earning records. Form EE-11B includes a statement that earnings records will be requested from the SSA. However, since SSA no longer requires the claimant's signature on Form SSA-581 to submit earnings records, the CE is no longer required to include Form SSA-581 (See paragraph 10a) with Form EE-11B. Form EE-11B also includes a request for additional employment evidence that supports the claimed wage-loss, along with medical evidence supporting a causal relationship between the covered illness and the wage-loss claimed. The form contains an instruction for the claimant to submit Form EN-11B (Wage-Loss Benefits Response Form) if he/she is claiming wage-loss, and to identify the condition(s) for which he/she is claiming wage-loss, and provide the date (trigger month and year) of claimed wage-loss.*

It has been edited in v4.0 to:

- a. *Wage-Loss Letter and Response Form (Form EE-11B/EN-11B): Form EE-11B lists the criteria to establish wage-loss. The form includes an explanation regarding earnings records for the twelve quarters prior to the first quarter of wage-loss and contains a solicitation for earning records. Form EE-11B includes a statement that earnings records will be requested from the SSA. However, since SSA no longer requires the claimant's signature on Form SSA-581 to submit earnings records, the CE is no longer required to include Form SSA-581 (See paragraph 10a) with Form EE-11B. Form EE-11B also includes a request for additional employment evidence that supports the wage-loss, along with medical evidence supporting a causal relationship between the covered illness and the wage-loss. The form contains an instruction for the claimant to submit Form EN-11B (Wage-Loss Benefits Response Form) if he/she is claiming wage-loss, and to provide the date (trigger month and year) the employee first experienced wage-loss.*
- Chapter 23 – Consequential Conditions
 - Ch. 23.3 has been edited to comply with 20 CFR § 30.100 and 30.101 regarding the necessity of obtaining claimant signed claim forms. The language included in v3.1 read:

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.

It has been edited in v4.0 to:

3. *Claims for Consequential Conditions.* *The claimant must file a claim for all consequential condition(s) in writing and may use any method of written notification, so long as the claimant signs the submission. However, while documents containing written words of claim for a consequential condition(s) are acceptable, the CE is to obtain a completed and claimant signed Form EE-1/2 associated with the consequential claim before issuing a decision. A signed claim form is also required for all metastatic cancers. Ideally, the claimant should concurrently send a written statement identifying the specific nature of the consequential condition claimed, along with a signed EE-1/2. A signed EE-1/2 is required, because it provides notice to the claimant of his or her responsibilities in filing for benefits under the Act.*

- Chapter 25 – FAB Review Process

- Ch. 25.7d(7) has been added to provide guidance on the resumption of development after the withdrawal of a claim:

(7) *Resumption of FAB review after claim withdrawal. A claimant may choose to withdraw a claim prior to the issuance of a final decision. If FAB had scheduled a hearing, a withdrawal of the claim will also constitute a withdrawal of the request for a hearing. Under this circumstance, should the claimant seek to resume adjudication of the claim, a hearing will not occur and instead the FAB will undertake a review of the written record at the conclusion of any balance of the 60 day period remaining for the claimant to submit evidence for consideration. If the claimant did not file an objection prior to a withdrawal of a claim, and the claimant later seeks to resume adjudication of the claim, the claimant retains their right to object and/or request a hearing for any remaining balance of the 60-day period for filing objections that existed prior to the claim withdrawal.*

- Chapter 26 – FAB Decisions

- EEOICPA Bulletin No. 19-04 has been incorporated by updating the Exhibit 26-2, Medical Benefits Letter

- Chapter 28 – Medical Bill Process

- Ch. 28.2b has been updated to clarify the role of the Medical Benefits Examiner (MBE). The language included in v3.1 read:

b. *Medical Benefits Examiner. The MBE is a specialized CE responsible for reviewing, developing, and approving or denying claims for in-home health care.*

It has been edited in v4.0 to:

- b. Medical Benefit or Claims Examiner – CE/MBE staff are responsible for reviewing, developing, and deciding whether to authorize the payment of services, appliances, supplies, modifications or travel expenses necessary to cure, give relief, or reduce the degree or period of illness.*
- Ch. 28.2c has been deleted due to the edit added at Ch. 28.2b. Accordingly, the remaining section Ch. 28.2 has been renumbered.
- All references throughout Ch. 28 to Claims Examiner (CE) have been changed to CE/MBE.
- Ch. 28.13d has been edited to reflect a change in the timeframe allowed for a response to a request for reconsideration. The language included in v3.1 read:
 - d. Within 30 days of receiving the request for reconsideration, the MBPU prepares a response to the medical provider outlining DEEOIC’s decision to either:*

It has been edited in v4.0 to:

- d. Within 15 days of receiving the request for reconsideration, the MBPU prepares a response to the medical provider outlining DEEOIC’s decision to either:*
- Chapter 29 – Ancillary Medical Services and Related Expenses
 - All references throughout Ch. 29 to CE have been changed to CE/MBE.
 - Ch. 29.2d has been modified to provide updated development guidance regarding the medical necessity of prescribed ancillary services or equipment; and provide clarity regarding the 30 day medical development authorization period, including two development letters in 15 day increments. The language included in v3.1 read:
 - d. Upon receipt of an authorization request, not accompanied by appropriate medical evidence, the CE begins development.*
 - (1) The CE/MBE sends a development letter to the claimant advising that he or she has received a request, but without the required supporting documentation. The CE/MBE’s development letter to the claimant must include a clear description of the medical documentation needed to support the request, and grant the claimant 30 calendar days to provide the information. The CE/MBE also notifies the claimant that a lack of response or submission of insufficient evidence will result in a denial of the request. (Exhibit 29-1 provides a sample development letter for ancillary medical services. Exhibit 29-2 is a sample development letter for DME / Oxygen therapy and related medical supplies.) The CE/MBE*

updates the correspondence section of ECS to record the issuance of the development letter, once mailed.

- (2) *If the CE receives the appropriate medical evidence within the 30- day development period, the CE prepares an authorization letter to the claimant (Exhibit 29-3 provides a sample authorization letter for ancillary medical services; Exhibit 29-4 is a sample authorization letter pertaining to DME/Oxygen Therapy and related supplies).*
- (3) *In situations where the treating physician does not respond or does not provide clarifying medical rationale to support the request, the CE may refer the matter to a CMC for review.*

It has been edited in v4.0 to:

- d. *Upon receipt of an authorization request, not accompanied by appropriate medical evidence, the CE/MBE begins development.*
 - (1) *The CE sends a development letter to the claimant advising that he or she has received a request, but without the required supporting documentation. The CE's development letter to the claimant must include a clear description of the medical documentation needed to support the request, and grant the claimant 15 calendar days to provide the evidence. If the requested evidence is not received within the 15 day period provided, the CE sends a second development letter, providing an additional 15 days to receive the requested evidence. The CE also notifies the claimant that a lack of response or submission of insufficient evidence will result in a denial of the request. (Exhibit 29-1 provides a sample development letter for ancillary medical services. Exhibit 29-2 is a sample development letter for DME / Oxygen therapy and related medical supplies.) The CE updates the correspondence section of ECS to record the issuance of the development letter, once mailed.*
 - (2) *A CE/MBE may utilize the services of DEEOIC Nurse Consultants in assessing the rationale of the prescribing physician in justifying the medical necessity of prescribed ancillary services or DME. In any instance where a DEEOIC Nurse Consultant identifies a concern with the LMN from a claimant's physician, the CE/MBE must permit the claimant's physician the opportunity to provide clarification. In those situations where the claimant's physician does not provide clarifying rationale to address a deficiency in the evidence within 15 days, the CE/MBE may refer the matter to a CMC for review.*
- Exhibit 29-1 has been edited to reflect the above change in development periods from 30 to 15 days.

- Exhibit 29-2 has been edited to reflect the above change in development periods from 30 to 15 days.
- Ch. 29.4b has been modified to provide clear guidance regarding the evidence a physician may choose to use in support of a prescription for Oxygen Therapy or DME.

The language included in v3.1 read:

- b. *Upon receipt of the request for rental or purchase of Oxygen Therapy DME and/or Oxygen Medical Supplies, the CE evaluates the medical evidence to determine if there is sufficient justification to authorize the request as medically necessary for the treatment or care of an accepted condition. In addition to the guidelines already described in Section 2(g), the claimant must include the following:*
 - (1) *Diagnostic testing that supports the physician's reasons for prescribing Oxygen Therapy DME or Oxygen Medical Supplies, and identifies clear, objective pulmonary deficits including results from an ABG and/or resting/exercise spirometry test, and/or nocturnal oximetry studies. The results are to identify the conditions under which the test(s)/studies were performed; (i.e.; during exercise, at rest, or during sleep). The test(s) are to be performed by a qualified medical professional, and originate from a qualified source such as a laboratory, diagnostic testing facility, hospital, physician's office or clinic.*

It has been edited in v4.0 to:

- b. *Upon receipt of the request for rental or purchase of Oxygen Therapy DME and/or Oxygen Medical Supplies, the CE/MBE evaluates the medical evidence to determine if there is sufficient justification to authorize the request as medically necessary for the treatment or care of an accepted condition.*
 - (1) *As noted earlier in this chapter, the CE/MBE must obtain a LMN from a claimant's physician that provides a written explanation regarding the justification for any prescribed ancillary services or equipment. For Oxygen Therapy DME or Oxygen Medical Supplies, the prescribing physician must describe the diagnostic or clinical evidence that supports the medical necessity for the prescribed care in treating the accepted pulmonary condition.*

- Chapter 30 – Home and Residential Health Care

- Ch. 30.7b has been updated to provide clarity regarding 30 day development periods, including two development letters in 15 day increments. The language included in v3.1 read:

- b. *Incomplete or defective evidence. If, upon review of the case evidence, the MBE finds that any of the basic criteria, above, are missing, or there is a documented defect in the medical evidence that conflicts with the care prescribed in the LMN the MBE is to initiate development.*

It has been edited in v4.0 to:

- b. *Incomplete or defective evidence. If, upon review of the case evidence, the MBE finds that any of the basic criteria, above, are missing, or there is a documented defect in the medical evidence that conflicts with the care prescribed in the LMN the MBE is to initiate development. The duration allocated by the MBE for the submission of necessary evidence to support a HRHC claim is 30 days. For an initial request for evidence, the MBE is to grant a period of 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the 15 day period provided, the MBE sends a second development letter, providing an additional 15 days to submit the requested documentation.*
- o Ch. 30.13 has been added to provide guidance to HRHC providers on their role and responsibility in providing travel assistance to covered employees receiving home health care.

13. Medical Travel Occurring During Authorized Periods of HRHC. DEEOIC permits HRHC providers to travel with a claimant to and from medical appointments when medically necessary for the treatment or care of an accepted work-related illness. DEEOIC considers this type of travel assistance as included within the scope of authorized HRHC service hours and not a separate or additional transportation service. DEEOIC will reimburse travel mileage to either the HRHC provider or the claimant, depending on whose vehicle is used for the travel. Aside from mileage and HRHC service hours spent assisting with travel, no other ancillary costs associated with conducting travel covered under this section is reimbursable. As with any other billable medical service, HRHC providers are to document properly any service time spent assisting with medically necessary travel. Travel under this guidance will not require pre-approval by a Medical Benefit Examiner for travel under 200 miles round-trip or less than three qualifying trips per week. DEEOIC provides guidance relating to extended travel authorization in Chapter 29 – Ancillary Medical Services and Related Expenses. For HRHC travel with the claimant for more than three trips in a week period, a pre-authorization request must be submitted to DEEOIC along with medical justification for such travel.

- Chapter 31 – Tort Action and Election of Remedies
 - o Ch. 31.5d has been updated to clarify that payments made by asbestos bankruptcy trusts trigger the offset provision of § 7385. The language included in v3.1 read:

- d. *Bankruptcy. If a claimant receives a settlement in a bankruptcy proceeding, such settlement is treated like any other settlement for purposes of the offset. The CE requests the settlement sheet from the claimant's attorney, as outlined above.*

It has been edited in v4.0 to:

- d. *Asbestos Bankruptcy Trust. A claimant's settlement with asbestos bankruptcy trust is treated like any other tort settlement for the purposes of offset determination. The CE obtains copies of all administrative claim forms that have been submitted to an asbestos bankruptcy trust to compare the pertinent exposure and injuries claimed under the abestosis bankruptcy trust with payable EEOICPA benefits for possible tort offset.*
- Ch. 31.9 has been modified to delete language regarding paper file jackets. The language included in v3.1 read:

9. *Required Tort Offset. After receipt of all relevant documents, the CE determines whether an offset is needed. If so, the CE completes the "EEOICPA Part B/E Benefits Offset Worksheet" (Exhibit 31-1). The Worksheet includes detailed instructions for computing the amounts that the CE uses to calculate the amount of any offset. After completing the Worksheet, the CE staples it to the inside left cover of the case file jacket.*

It has been edited in v4.0 to:

9. *Required Tort Offset. After receipt of all relevant documents, the CE determines whether an offset is needed. If so, the CE completes the "EEOICPA Part B/E Benefits Offset Worksheet" (Exhibit 31-1). The Worksheet includes detailed instructions for computing the amounts that the CE uses to calculate the amount of any offset.*

- Chapter 32 – Coordinating State Workers' Compensation Benefits

- Ch. 32.9 has been modified to delete language regarding paper file jackets. The language included in v3.1 read:

9. *Calculate Amount to Coordinate. Once the CE receives the documentation which verifies the amount of SWC benefits the claimant received for the same covered illness, the CE completes the "EEOICPA/SWC Coordination of Benefits Worksheet" (Exhibit 32-2). This Worksheet (and its detailed instructions) is to be used by the CE to make the calculations necessary to determine how much to coordinate a claimant's EEOICPA Part E benefits to reflect benefits received from a SWC program for a covered illness compensable under Part E. After completing the Worksheet, the CE staples it to the inside of the case file jacket.*

It has been edited in v4.0 to:

9. Calculate Amount to Coordinate. Once the CE receives the documentation which verifies the amount of SWC benefits the claimant received for the same covered illness, the CE completes the "EEOICPA/SWC Coordination of Benefits Worksheet" (Exhibit 32-2). This Worksheet (and its detailed instructions) is to be used by the CE to make the calculations necessary to determine how much to coordinate a claimant's EEOICPA Part E benefits to reflect benefits received from a SWC program for a covered illness compensable under Part E.

- Chapter 35 – Overpayment Process

- EEOICPA Bulletin No. 19-05 has been incorporated by updating a mailing address in the following Exhibits:

- Exhibit 35-2, Sample Initial Overpayment Notification Letter - Without Fault
- Exhibit 35-3, Sample Initial Overpayment Notification Letter – At Fault
- Exhibit 35-4, Sample Letter to Non-Claimant Regarding Federal Debt
- Exhibit 35-8, Sample Overpayment Final Decision – Preliminary At Fault Determination Correct
- Exhibit 35-9, Sample Overpayment Final Decision – Without Fault - Waiver Denied
- Exhibit 35-11, Sample Overpayment Final Decision – Waiver Granted (Full or Partial) Based on Violate Equity and Good Conscience

- Chapter 36 – Debt Liquidation

- EEOICPA Bulletin No. 19-05 has been incorporated by updating a mailing address in the following Exhibits:

- Exhibit 36-1, Sample Second Demand Letter
- Exhibit 36-2, Sample Third and Final Demand Letter
- Exhibit 36-4, Sample Repayment Agreement



Rachel P. Leiton
Director, Division of
Energy Employees Occupational Illness Compensation