



RELEASE – TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL  
VERSION 4.3:

EEOICPA TRANSMITTAL NO. 20-04

September 14, 2020

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this transmittal to notify staff of the publication of Federal (EEOICPA) Procedure Manual (PM) Version 4.3 (v4.3) which replaces v4.2, effective the date of publication of this transmittal.

Following are the content edits that make up PM v4.3:

- **Chapter 2 – The EEOICPA**

- Ch. 2.6 has been updated to reflect the current distribution method for initial case assignments. The language in v4.2 previously read:

6. *Jurisdiction.* This paragraph describes the jurisdiction of the four DEEOIC DOs. The DO that handles a claim is determined by where the employee last worked as a covered employee. A DO acquires jurisdiction if the last covered facility is/was located within the geographical area it serves.

a. *Survivor Claims.* This rule applies to claims from survivors as well as those brought by the employee.

b. *Uranium Workers.* All claims for uranium workers (or their survivors) who may have been awarded benefits under Section 4 or 5 of RECA are within the jurisdiction of the Denver DO.

It has been updated in v4.3 to:

6. *Jurisdiction.* Employee and survivor claims filed with the DEEOIC are assigned to a CE within one of the four district offices on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

- Exhibit 2-1, Jurisdictional Map, that was previously included in v4.2, has been removed from v4.3, as this exhibit was outdated. As such, the remaining exhibits of Chapter 2 has been renumbered accordingly.

- **Chapter 6 – Processing Mail**

- Ch. 6.7i has been updated to remove all references to the Regional Director and to communicate a uniform procedure for reporting PII violations. The language in v4.2 previously read:

- i. *Improper Release of Protected PII. If protected PII is improperly release to an incorrect individual, or documentation sent to the correct individual contains protected PII of another individual that was not redacted, DEEOIC staff must:*
  - (1) *Contact the individual via telephone and registered mail to request the return of the document. The DEEOIC staff member provides a self-addressed, stamped envelope for the return of the material directly to the DEEOIC;*
  - (2) *Immediately notify Appropriate Management (DD, FAB Manager or FAB Branch Chief) who in turn notifies the Regional Director or NO, who complies with established departmental reporting requirements, documenting the type of PII disclosure, the circumstances surrounding the disclosure, how it was discovered, the appropriate actions taken to recover the document in question, and the disposition of the recovery effort; and*
  - (3) *Track each PII recapture request within the Regional or FAB Office.*
    - (a) *If the recapture of the PII documentation is successful, the incident becomes closed with the incident record filed and maintained in OWCP.*
    - (b) *If the third party in possession of the improperly released documentation refuses to return it, the DEEOIC staff member reports the situation through the appropriate management, through the Regional Director (except FAB), to the NO, who will provide guidance.*

It has been updated in v4.3 to:

- i. *Improper Release of Protected PII. If protected PII is improperly released to an incorrect individual, or documentation sent to the correct individual contains protected PII of another individual that was not redacted, DEEOIC staff must notify their supervisor who will follow the standard department protocols for reporting PII violations.*

- Exhibit 6-1, OIS Subjects and Categories, that was previously included in v4.2, has been removed from v4.3, as this Exhibit was outdated. As such, the remaining exhibits of Chapter 6 have been renumbered accordingly.

- **Chapter 7 – Case Creation**

- Ch. 7.4 has been updated to remove references to claims assignments based on jurisdictional locations. The language in v4.2 previously read:

4. *Assignment of Claims to a DO.* The assignment of a claim to a particular DO occurs based on the state where the employee's most recent location of covered employment occurred, as listed on Form EE-3. Each DO is responsible for claims originating from a state for which it has jurisdictional responsibility. Information regarding DO jurisdictional boundaries is located on the DEEOIC main webpage. If the claimant does not submit a Form EE-3 with his claim, the CCC uses the claimant's state of residence to make a DO assignment. Each DO is to provide the CCC with an up to date case create digit assignment list so that upon creation, the CCC directs the claim to appropriate CE. When CE digit assignments change, the DD or a designee is to email the updated list to zzOWCP-DEEOIC-Centralized Case Create Group.

It has been updated in v4.3 to:

4. *Assignment of Claims to a DO.* The assignment of a claim to a particular DO occurs on a rotational basis to maintain an equal distribution of work, relative to the experience level of the CE.

- Ch. 7.7a has been updated to remove reference to the Resource Center (RC) verifying employment using ORISE, as this function is now performed by the assigned district office Claims Examiner (CE). The language in v4.2 previously read:

a. *Consideration of Employment.* In addition to considering the claimed medical condition(s), claimed employment is also considered. Part B of the EEOICPA covers employees of the DOE, its contractors and subcontractors, beryllium vendors, AWEs and eligible survivors. Part E offers benefits to DOE contractors, subcontractors and their eligible survivors.

*For claims filed at the RC, the RC verifies employment through the Oak Ridge Institute for Science and Education (ORISE) and/or clarifies the nature of claimed employment.*

It has been updated in v4.3 to:

a. *Consideration of Employment.* In addition to considering the claimed medical condition(s), claimed employment is also considered. Part B of the EEOICPA covers employees of the DOE, its contractors and subcontractors, beryllium

*vendors, AWEs and eligible survivors. Part E offers benefits to DOE contractors, subcontractors and their eligible survivors.*

*Upon receipt of a claim filed at the RC, the District Office CE will perform all necessary actions to verify claimed employment, including review of the Oak Ridge Institute for Science and Education (ORISE) database information.*

- **Chapter 9 – Transfers and Loans**

- Ch. 9.3c has been updated to remove language related to case transfers based on the last place of covered employment. The language in v4.2 previously read:

*c. DOs may transfer case files to other jurisdictions permanently, based upon the employee's last verified covered employment. Alternatively, management decisions may lead to changes in case allocations amongst the district or FAB offices.*

It has been updated in v4.3 to:

*c. DOs may transfer case files to other jurisdictions permanently, based on management decisions regarding case allocations amongst the district or FAB offices.*

- **Chapter 10 – Resource Centers**

- Chapter 10 has been replaced in its entirety to update the functions of the Resource Center and their role in occupational history development.
- Exhibit 10-1, Occupational History Interview, has been updated.
- Exhibit 10-2, RECA Occupational History Interview, that was previously included in v4.2, has been removed from v4.3, as this Exhibit was outdated.
- Accordingly, what was Exhibit 10-3, Interview Confirmation Letter, in v4.2, has been updated and renumbered as Exhibit 10-2 in v4.3.

- **Chapter 11 – Initial Development**

- Ch. 11.9 has been added to include a description of the Correspondence Creation and Tracking System (CCAT) and an overview of the forms and letters contained therein. The new section contained in v4.3 reads:

*9. Correspondence Creation and Tracking System (CCAT.) CCAT is an internal form and correspondence generator within ECS that is used to generate certain standardized forms and correspondence letters. The system populates various fields with information already contained within ECS, such as names and addresses, while allowing*

*the user to input other claim-specific information. In addition, CCAT also contains samples of these forms and letters.*

*a. Below, in alphabetical order, are the forms and letters currently available in CCAT:*

- (1) Alternative Filing Acknowledgement Letter*
- (2) AR Acknowledgement Letter*
- (3) Change of Address Acknowledgement Letter*
- (4) Claim Acknowledgement Letter*
- (5) DEEOIC Case Transfer Sheet*
- (6) DME Authorization Letter*
- (7) EE-8 and EN-8 Smoking History Questionnaire*
- (8) EE-9 and EN-9 Race/Ethnicity Questionnaire*
- (9) EE-10 and EN-10 Claim for Additional Wage-Loss and/or Impairment Benefits under the EEOICPA*
- (10) EE-11A and EN-11A Form (Impairment)*
- (11) EE-16 and EN-16 Form*
- (12) Hearing Request Acknowledgement Letter*
- (13) Hearing Transcript Letter*
- (14) HHC Authorization Letter*
- (15) Home Hospice Authorization Letter*
- (16) Letter to DOJ for RECA Award Confirmation*

- (17) *Lump Sum Payment Acknowledgement Letter*
- (18) *Medical Travel Reimbursement Authorization Letter*
- (19) *Not Claiming Impairment and/or Wage-Loss Letter*
- (20) *Physician Letter*
- (21) *Rehabilitative Service Authorization Letter*
- (22) *Residential Care Facility Authorization Letter*
- (23) *Review of Written Record Acknowledgement Letter*
- (24) *Untimely Hearing Request Letter*

- In conjunction with the above change, the following exhibits that were previously included in v4.2 and are now available through CCAT, have been removed from v4.3, and the remaining exhibits of the affected chapters have been renumbered accordingly:

- Exhibit 7-1: Sample Acknowledgement Letter
- Exhibit 12-3: Notification to Representative
- Exhibit 19-1: Letter to DOJ for RECA Award Confirmation
- Exhibit 19-2: Alternate Letter to DOJ for RECA Award Confirmation
- Exhibit 20-2: Sample Alternative Filing Letter
- Exhibit 21-2: Not Claiming Impairment Letter
- Exhibit 22-2: Not Claiming Wage-Loss Letter
- Exhibit 25-1: Sample Acknowledgment Letter, Review of Witten Record
- Exhibit 25-2: Sample Acknowledgement Letter, Hearing
- Exhibit 29-3: Sample Ancillary Medical Services Authorization Letter
- Exhibit 29-4: Sample Authorization Letter
- Exhibit 29-7: Sample Travel Authorization Letter

- **Chapter 14 – Establishing Special Exposure Cohort Status**

- Chapter 14.6 has been updated to reflect additional guidance for calculating workday requirements in instances where evidence supports an onsite presence at a designated Special Exposure Cohort (SEC) facility for 24 hours. The language in v4.2 previously read:

6. Workday Requirement. Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC worksites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are some cases where the employee worked for less than a year, and additional guidance is required to calculate the 250 workdays.

- a. *A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.*
- b. *When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workdays any infrequent periods of non-presence or non-work, like sick leave, strikes, layoffs or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC worksite for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.*
- c. *The period of 250 workdays starts with the worker's first day of employment at the SEC worksite. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC worksites.*
- d. *Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension, dues, union local records, etc.), the following table may be used for conversion.*

*250 days = 50 five-day weeks, or*

*42 six-day weeks, or*

*12 months (five-day weeks), or*

*10 months (six-day weeks), or*

*2,000 hours*

*One month = 21 days (if evidence indicates six-day weeks, 25 days)*

- e. *Where records of an employee's earnings are available, such as a W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows. Divide the annual wages*

*earned at the SEC worksite by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual employment. As such, this method should only be used when all primary employment data is lacking.*

- f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the NO Policy Unit may be required.*

It has been updated in v4.3 to:

*6. Workday Requirement. Eligibility under the SEC provision typically requires 250 workdays of eligible employment at one or more SEC worksites. In most cases, the determination of 250 workdays of employment is straightforward. However, there are some cases where the employee worked for less than a year, and additional guidance is required to calculate the 250 workdays.*

- a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another (8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.
  - (1) If evidence exists establishing an employee's onsite presence at a designated SEC facility for 24 hours, including time spent working or living at the facility, the employee will be credited for 3 work shifts (i.e. 3 workdays) towards the 250-work day requirement. In such instances, the 250-work day requirement will be satisfied if the evidence establishes the employee's onsite residential presence at a designated SEC facility for 83 days, which a CE may consider as the equivalent of 250 workdays.**
- b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workdays any infrequent periods of non-presence or non-work, like holidays, sick leave, strikes, layoffs, or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC worksite for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.*
- c. The period of 250 workdays starts with the worker's first day of employment at the SEC worksite. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC worksites.*

d. *Where the number of days is not apparent in the employee's primary employment record, e.g., from the employer or union (records for pension, dues, union local records, etc.), the following table may be used for conversion.*

*250 days = 50 five-day weeks, or*

*42 six-day weeks, or*

*12 months (five-day weeks), or*

*10 months (six-day weeks), or*

*2,000 hours*

*24 hours per day of residential onsite presence for 83 days*

*One month = 21 days (if evidence indicates six-day weeks, 25 days)*

e. *Where records of an employee's earnings are available, such as W-2 Forms or Social Security earnings records, but the periods of employment are not, estimate the 250 workdays as follows: Divide the annual wages earned at the SEC worksite by the employee's hourly rate to determine the number of hours worked. If the number is greater than 2,000 hours, it meets the 250 workday requirement. The problem with converting dollar amounts to workdays is that they may be rough estimates of actual employment. As such, this method should only be used when all primary employment data is lacking.*

f. *There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the NO Policy Unit may be required.*

- Exhibit 14-1, List of SEC Designated Classes, has been updated to include the following EEOICPA Circulars:
  - Circular 20-01: West Valley Demonstration Project SEC (01/01/69 – 12/31/73)
  - Circular 20-02: Y-12 Plant SEC (01/01/77 – 07/31/79)
- Exhibit 14-2, SEC Class Screening Worksheet, which was previously included in v4.2, has been removed from v4.3. As such, the remaining exhibits of Chapter 14 have been renumbered accordingly.

- **Chapter 15 – Establishing Toxic Substance Exposure and Causation**

- Exhibit 15-4: Exposure and Causation Presumptions with Development Guidance for Certain Conditions, has been updated.

- Exhibit 15-4.1b, regarding Angiosarcoma, has been amended. The language in v4.2 previously read:

*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.*

It has been updated in v4.3 to:

*b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant polyvinyl chloride exposure. This can be determined by an IH assessment.*

- Exhibit 15-4.4b, regarding Asbestosis, has been amended. The language in v4.2 previously read:

*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.*

It has been updated in v4.3 to:

*b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant asbestos exposure. This can be determined by existing asbestos exposure presumptions or an IH assessment.*

- Exhibit 15-4.6c, regarding Bladder Cancer, has been amended. The language in v4.2 previously read:

*c. Causation: For employees with demonstrated regular, routine exposure at significant levels (as opined by an Industrial Hygienist) to one of these substances for a full, consecutive working year, causation is presumed.*

It has been updated in v4.3 to:

*c. Causation: For those employees who were employed consecutively for a full working year in a position that would have involved significant exposure to one of the toxins identified in (b)(1-5) (as opined by an Industrial Hygienist), causation is presumed.*

- Exhibit 15-4.7b(1), regarding Chronic Obstructive Pulmonary Disease, has been amended. The language in v4.2 previously read:

(1) *The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1986.*

It has been updated in v4.3 to:

(1) *The employee was employed in any of the labor categories that are listed in Exhibit 15-4.3a(1) for an aggregate of 20 years prior to and including December 31, 1995.*

- Exhibit 15-4.9b, regarding Kidney Cancer, has been amended. The language in v4.2 previously read:

b. *Exposure: An employee who was employed for 5 or more consecutive years prior to 1990 and had significant exposure to trichloroethylene (TCE). This can be determined by an IH assessment or without the review of an IH if the employee meets all of the following employment criteria (exposure presumption):*

It has been updated in v4.3 to:

b. *Exposure: An employee must have been employed for 5 or more consecutive years prior to 1990 in a position that would have had significant trichloroethylene (TCE) exposure. This can be determined by an IH assessment or without the review of an IH if the employee meets all of the following employment criteria (exposure presumption):*

- Exhibit 15-4.10b, regarding Laryngeal Cancer, has been amended. The language in v4.2 previously read:

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.*

It has been updated in v4.3 to:

b. *Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant asbestos exposure. This can be determined by existing asbestos exposure presumptions or an IH assessment.*

- Exhibit 15-4.11b, regarding Leukemia, has been amended. The language in v4.2 previously read:

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.

It has been updated in v4.3 to:

b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant benzene exposure. This can be determined by an IH assessment.

- Exhibit 15-4.12b, regarding Lung Cancer, has been amended. The language in v4.2 previously read:

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.

It has been updated in v4.3 to:

b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant asbestos exposure. This can be determined by existing asbestos exposure presumptions or an IH assessment.

- Exhibit 15-4.15b, regarding Non-Hodgkin's Lymphoma, has been amended. The language in v4.2 previously read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure with lindane (1,2,3,4,5,6-Hexachlorocyclohexane) for at least 56 days.

or

The employee was employed in a job that would have brought the employee into contact with significant exposure with pentachlorophenol for at least 2 years.

It has been updated in v4.3 to:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure with lindane (1,2,3,4,5,6-Hexachlorocyclohexane) for at least 56 days.

or

*The employee was employed for an aggregate of 2 years in a position that would have had significant pentachlorophenol exposure.*

- Exhibit 15-4.16b, regarding Ovarian Cancer, has been amended. The language in v4.2 previously read:

*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*

It has been updated in v4.3 to:

*b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant asbestos exposure. This can be determined by existing asbestos exposure presumptions or an IH assessment.*

- Exhibit 15-4.18b, regarding Pleural Plaques, has been amended. The language in v4.2 previously read:

*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.*

It has been updated in v4.3 to:

*b. Exposure: The employee must have been employed for an aggregate of 250 days in a position that would have had significant asbestos exposure. This can be determined by existing asbestos exposure presumptions or an IH assessment.*

- **Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions**

- Ch. 18.19 has been edited to comply with the removal of Exhibit 18-1. The language in v4.2 previously read:

*19. Other Conditions. Like asbestosis and the lung ailment COPD, there are a host of other non-cancerous conditions potentially covered under Part E that are not covered under Part B. With the wide variety of conditions claimed under Part E, this chapter cannot address diagnostic requirements of all possible conditions. However, the matrices in Exhibit 18-1 have been created to provide information relating to the assessment of the following conditions: kidney disease; occupational asthma; toxic neuropathy; and chronic toxic encephalopathy. Ultimately, the CE uses his or her best judgment in reviewing and evaluating the probative value of the medical evidence.*

It has been updated in v4.3 to:

19. *Other Conditions. With the wide variety of conditions claimed under Part E, this chapter cannot address all common diagnostic or clinical characteristics for every particular diagnosis. Ultimately, the CE uses his or her best judgment in weighing the probative value of available medical evidence to ascertain a diagnosis. The establishment of a diagnosis requires that a qualified physician apply sound medical reasoning to interpret available clinical or diagnostic evidence to identify a disease or disorder. In those instances where the CE cannot establish that the weight of medical evidence supports a diagnosis, the CE is to seek clarification from the claimant's treating physician. If the CE is unable to obtain clarification from the treating physician or in instances where the claimant is not currently under the care of a physician, the CE may seek clarification of a medical diagnosis from a CMC.*

- Exhibit 18-1: Matrix for Confirming Sufficient Evidence of Non-Cancerous Covered Illness, has been deleted based on input from the Advisory Board on Toxic Substances and Worker Health.

- **Chapter 19 – Eligibility Requirements for Certain Uranium Workers**

- Ch. 19.3a and Ch. 19.3b, pertaining to RECA claims being solely adjudicated by the Denver District Office, have been removed.

- **Chapter 20 – Establishing Survivorship**

- Chapter 20.12b has been amended to clarify that a survivor electing to receive Part E monetary benefits which an employee would have been eligible to receive will have to have those monetary benefits coordinated if the employee received benefits as part of a State Workers' Compensation (SWC) claim. The language in v4.2 previously read:

- b. *Death Due to Non-Covered Illness, Part E. If a covered Part E employee dies after filing a claim but before the claimed payment is received, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received, had he/she not died prior to payment, rather than survivor benefits. It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment benefits for the election option to be available to the survivor(s). As long as the employee filed a Part E claim, claims for wage-loss and impairment benefits are presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any subsequent amount of monetary benefits claimed by the survivor.*

It has been updated in v4.3 to:

- b. *Death Due to Non-Covered Illness, Part E.* If a covered Part E employee dies after filing a claim, but before the monetary benefits are paid, and if the employee's death was caused solely by a non-covered illness, the survivor(s) has the option to elect to receive the payment that the covered Part E employee would have received had he/she not died prior to payment. This would be in lieu of the survivor lump-sum compensation payable under Part E.

*It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment benefits for the election option to be available to the survivor(s). As long as the employee filed a Part E claim, claims for wage-loss and impairment benefits are presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any remaining balance of Part E lump-sum compensation available to a survivor under Part E should they make an election.*

*Once a survivor makes an election to receive a payment that the covered Part E employee would have received, the survivor is treated the same as the employee in determining whether the payment is subject to state workers' compensation (SWC) coordination. For example, if the employee received SWC benefits for asbestosis and the survivor elected to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the amount payable to the survivor with the amount of those SWC benefits. (See PM Chapter 32, Coordinating State Workers' Compensation Benefits).*

- **Chapter 22 – Wage-Loss Determinations**

- Exhibit 22-4, SSA Contact Numbers, which was previously included in v4.2, has been removed from v4.3, as it is duplicative with Exhibit 13-1. As such, the remaining exhibits of Chapter 22 have been renumbered accordingly.

- **Chapter 24 – Recommended Decisions**

- Ch. 24.7a has been edited for clarity. The language in v4.2 previously read:

- a. *Written Decision.* The written decision is comprised of an Introduction, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.

- (1) *Introduction.* This portion of a RD succinctly summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E.

It has been updated in v4.3 to:

a. *Written Decision. The written decision is comprised of an introductory statement, a Statement of the Case, Explanation of Findings, and Conclusions of Law. Exhibit 24-1 and Exhibit 24-2 provide sample RDs.*

(1) *Introductory Statement. This is a statement written following the title “Recommended Decision” that summarizes what benefit entitlement is being recommended for acceptance, denial or deferral. Distinction is made between benefits addressed under Part B vs. Part E.*

- Exhibit 24-1 has been modified to align with the text of Ch. 24.7; specifically, the header “Notice of Recommended Decision” has been changed to “Recommended Decision.
- Exhibit 24-2 has been modified to align with the text of Ch. 24.7; specifically, the header “Notice of Recommended Decision” has been changed to “Recommended Decision.
- Exhibit 24-3, Notice of Recommended Decision, has been updated to include new language to clarify reporting requirements for recommended acceptances.

• **Chapter 26 – FAB Decisions**

- The final paragraph of Ch. 26.3a has been updated to clarify the requirement that two EN-20s are to be included with each final decision acceptance. The language in v4.2 previously read:

*An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 26-2); and/or (2) an Acceptance of Payment form (EN-20), which is required before payment can be issued.*

It has been updated in v4.3 to:

*An acceptance may include two other components: (1) a medical benefits letter explaining entitlement to medical benefits for an accepted condition (Exhibit 26-2); and/or (2) two Acceptance of Payment forms (EN-20), one of which must be properly completed and returned before payment can be issued.*

- Ch. 26.5c has been edited to remove outdated reference to Co-Located Unit. The language in v4.2 previously read:

c. *Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained by the Co-Located Unit within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure*

*of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.*

It has been updated in v4.3 to:

- c. *Claimant Cannot be Located. When a RD is returned by the Postal Service and a current address for the claimant cannot be obtained within a reasonable period of time, the FAB administratively closes the claim and returns the case file to the DO. In situations involving multiple claimants, the FAB issues a FD to the remaining survivors, denoting the administrative closure of the claimant whose address could not be determined, and outlining that the share of compensation of the claimant whose claim has been administratively closed will be held in abeyance.*
- Exhibit 26-2, Medical Benefits Letter, has been updated to include language regarding the U.S. Department of Treasury's direct deposit program, and the inclusion of SF 1199A, Direct Deposit Sign-Up Form.

- **Chapter 28 – Medical Bill Process**

- Ch. 28.13 has been amended to reflect existing practices related to the OWCP fee schedule review process. The language in v4.2 previously read:

*13. Fee Schedule Appeal Process. As part of the medical bill review process, program regulations provide for the appeal of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service.) In order to maintain consistency, record responses, and track fee schedule appeals, the following procedures have been developed to further delineate this process.*

- a. *When the BPA receives a fee appeal request letter, the BPA stores an electronic copy of the appeal letter in the XTCM Image Retrieval system, linked to the remittance voucher if submitted by the provider, and sends an email to the MBPU for review.*
- b. *For each fee schedule appeal letter received, the MBPU creates a record, and maintains it in a tracking system (spreadsheet or database) created for this purpose.*
- c. *The MBPU POC reviews the fee appeal request to determine if the provider has met any of the conditions below which justify a reevaluation of the amount paid. These three conditions, as found in 20 C.F.R. 30.712, are:*

- (1) *The service or procedure was incorrectly identified by the original code; or,*
  - (2) *The presence of a severe or concomitant medical condition made treatment especially difficult; or,*
  - (3) *The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)*
- 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:*
- (1) *Approve an additional payment amount: In this instance, the MBPU generates a draft letter for DD signature, informing the provider of the approval for additional payment. Where an additional amount is found to be payable based on unusual provider qualifications, the DD determines whether future bills for the same or similar service from that provider should be exempt from the fee schedule. The MBPU also prepares a memorandum for the case file stating the findings and the basis for the approval of the additional amount, or;*
  - (2) *Deny any additional payment: In this instance the MBPU prepares a draft letter-decision for DD signature, advising that additional payment is denied, based upon the provider's inability to establish one of the conditions listed above in Item c (1)(2)(3). Where additional payment is denied, the letter decision must contain a notice of the provider's right to further review, similar to the following:*

*If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and must be addressed to the Regional Director, District \_\_\_\_\_, Office of Workers' Compensation Programs, U.S. Department of Labor, [Insert appropriate Regional Office address and Zip Code.]*
- e. *The draft approval or denial letters are prepared by the MBPU, for the signature of the DD whose office has control of the claim file(s) being addressed in the decision(s). The MBPU sends the draft letter (via email) to the DD for review, signature, and mailing. The DD places a copy of the*

*signed letter in the case file and also returns (via email) a scanned copy of the signed letter, to be retained by the PSM.*

- f. The MBPU continues to track the status of any fee schedule appeal case, and maintains an electronic copy of all correspondence. This includes a copy of the draft letter and a scanned copy of the signed letter mailed by the DD.*
- g. If a denial is subsequently appealed to the RD, the RD must consult with the PSM to obtain copies of relevant bills and documents, and to discuss the appeal. The PSM also provides the RD with a copy of the denial letter signed by the DD. This can be handled via email.*
- h. After consultation with the PSM, the RD prepares a written response to the provider within 60 days of receipt of the request for review. Where additional payment is denied at the regional level, the letter decision from the RD advises the provider that the decision is final and is not subject to further administrative review. The RD forwards a scanned copy of the signed letter decision to the PSM. The PSM also retains that response as part of the appeal record.*
- i. The final outcome of each appeal letter is recorded in the MBPU tracking system to indicate:
  - (1) Additional payment made.*
  - (2) DD Denial letter.*
  - (3) RD Appeal letter.*
  - (4) Time limit (30 days) has expired for appeal to RD.*
  - (5) The final disposition date for each appeal letter.**

It has been updated in v4.3 to:

*13. Fee Schedule Review Process. As part of the medical bill review process, program regulations provide for the reconsideration of fee schedule reductions (charges by a provider that have been reduced in accordance with the OWCP fee schedule for that specific service). A provider whose charge OWCP partially pays under the fee schedule has 30 days to request reconsideration of the fee determination.*

- a. Fee reconsideration circumstances. A medical provider may contest a payment under the OWCP fee schedule under the following circumstances:*

- (1) *The service or procedure was incorrectly identified by the original code; or,*
  - (2) *The presence of a severe or concomitant medical condition made treatment especially difficult; or,*
  - (3) *The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)*
- b. *A provider is to submit a fee schedule reconsideration involving a DEEOIC claim to the BPA at the medical bill processing mailing address. The fee reconsideration request is to communicate clearly that the provider is contesting a payment under the fee schedule relating to a DEEOIC case file and the applicable fee reconsideration circumstance the provider is pursuing. The provider is to attach any remittance voucher or other accompanying material the provider is using to support the fee reconsideration request.*
- c. *Once received, the BPA will register the fee reconsideration request and forward it to the MBPU. MBPU will coordinate with the DO with jurisdiction over the claim to assess the reconsideration request. Within 30 days of receiving a fee reconsideration, the responsible DD is to issue a written determination on the reconsideration request. The DD's written determination is to state whether or not an additional amount will be allowable as reasonable considering the information submitted in the reconsideration request. If the DD decides to deny the reconsideration request, the DD is to include the following notice within the written decision:*

*If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. Direct any request for additional review to the National Administrator for Field Operations (NAFO). You may submit with the application any additional information you wish the NAFO to consider. Mail your application for additional review to the DEEOIC BPA at the following address:*

*<Insert BPA Mailing Address>*

- d. *If a provider seeks further review of a denied reconsideration request, the DEEOIC BPA will coordinate with the MBPU to direct the request to the NAFO. The NAFO performs the same functions as, and serves as the equivalent of, a Regional Director, which the regulations reference as*

*having to conduct this review. DEEOIC reorganized its regional offices into National Field Operations, so the position of Regional Director no longer exists. The NAFO will seek any information to allow for a comprehensive review of the application, including review of any information supplied by the provider or maintained by DEEOIC regarding the case file. Once the NAFO completes a review of the application and relevant documentation, the NAFO will prepare a written response to the provider within 60 days of the receipt of the request for further review. The decision will communicate whether or not an additional amount is allowable. If the NAFO denies an additional amount, the NAFO's decision to communicate to the provider that the decision is final and is not subject to further administrative review.*

- **Chapter 29 – Ancillary Medical Benefits and Related Services**

- Ch. 29.13 has been updated to provide additional guidance regarding the evaluation of claimant requests for vehicle modification, and removes language pertaining to vehicle purchases. The language in v4.2 previously read:

*13. Vehicle Modifications and Purchases. This section provides clarification with regard to the evidence needed to approve vehicle modifications and purchases, and provides procedural guidance with regard to the process for review, development, and authorization of such requests.*

- a. *Criteria for Modifications. Upon receipt of a LMN describing a medical need for vehicle modification, and if the claimant's medical needs can be met by modifying or adding accessories/equipment to the claimant's present vehicle, the MBE explores that option first, before considering replacement of the existing vehicle. When considering modifications to an existing vehicle, the MBE takes into consideration the type of vehicle currently owned, its age, and condition. Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical.*
- b. *Proposals. If the MBE determines that the claimant's medical needs warrant vehicle modification, the MBE advises the claimant in writing to submit a detailed written proposal containing the following information:*
  - (1) *The year, make, model, and body style of the vehicle to be modified, as well as current mileage, description of general mechanical condition, and any modifications currently needed or anticipated. The same applies regardless of whether the vehicle to be modified is new or used.*
  - (2) *Detailed written estimates from two licensed automobile dealers, or custom alteration facilities, itemizing the proposed vehicle*

*modifications necessary to comply with the treating physician's LMN. Estimates must include a breakdown of all parts, labor, and the respective costs associated with each item. The estimates should also state the amount of time required to perform the modifications.*

*c. Acceptance by the MBE. The MBE has the latitude to approve an estimate that the claimant favors, if the estimates are reasonably similar in scope and cost.*

*(1) Approval or Denial. Upon review of the evidence, the MBE approves or denies the request by sending a letter decision to the claimant advising of the approval, or reason(s) for denial of the request.*

*(2) Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant requesting the additional documentation that is necessary to continue with the review process.*

*(3) Inadequate response. If the claimant does not respond to the development letter, or does not provide sufficient documentation to support the request, after considering all relevant evidence, the MBE issues a letter decision informing the claimant of the authorization denial.*

*d. Vehicle Purchase. If the claimant provides a LMN establishing that modifications to his or her currently owned vehicle are not feasible or practical, and that a substitute vehicle is required for the claimant to operate, the MBE reviews the case with a supervisor and the NO FO, and may authorize the purchase of a suitable replacement vehicle. Under these circumstances, credit must be taken for the value of the claimant's existing vehicle. Purchase options include the following:*

*(1) Purchase of a used vehicle, (similar in quality to the claimant's existing vehicle), equipped to accommodate the claimant's disability and transportation needs.*

*(2) Purchase of a used vehicle that is suitable for modification as described above.*

*(3) Purchase of a new vehicle, modified, or suitable for modification, to meet the needs of the claimant, arising from an accepted condition.*

- (4) *Whether a new or used vehicle is purchased, it must be a vehicle of comparable value as the vehicle currently owned and operated by the claimant (i.e.; a vehicle in a price range that closely approximates the level of income and/or standard of living of the claimant). For example, if the claimant owns a mid-priced Chevrolet, Ford, Honda or Toyota; purchase of a Cadillac, Lincoln, or Lexus SUV, would not represent a vehicle of comparable value. Once the baseline cost of a comparable quality vehicle has been established, the claimant may (at his or her option) choose to upgrade the baseline model, by adding additional equipment, with the difference in cost being paid for by the claimant.*
- (5) *After determining the baseline cost of a comparable vehicle, the MBE must take credit for (deduct) the wholesale value of the claimant's existing car when determining the allowance to be paid for a replacement vehicle. The wholesale value of the existing vehicle can be determined through a number of internet websites that make this information available free-of-charge. The MBE should advise the claimant of the source of their information, once the wholesale value of the claimant's current vehicle has been determined.*
- (6) *Sales Tax. State sales tax should be included in the cost of obtaining a replacement vehicle.*
- (7) *Equipment that is medically necessary for the accepted condition should be factory-installed whenever possible.*
- (8) *Maintenance Costs. The MBE authorizes necessary maintenance on the specialized equipment in a modified vehicle, whether installed in a new or used vehicle.*
  - (a) *Replacement cost of the specialized equipment, due to normal wear and tear, may be considered as well. Other parts of the vehicle will be maintained at the owner's expense, even if the vehicle purchase was reimbursed by DEEOIC.*
  - (b) *Replacement of the vehicle, and all authorized equipment, can be considered if the claimant can establish that the age, mileage, and condition of the vehicle warrant such replacement. Any residual value remaining in the vehicle to be replaced would be applied as a credit toward the cost of a replacement vehicle.*

- (9) *Proof of Insurance.* The claimant bears the cost of obtaining automobile insurance and maintaining current vehicular registration in conformance with the laws of the state within which the claimant resides. Claimants are required to carry comprehensive (fire, theft, vandalism) and collision insurance on any vehicle for which DEEOIC has authorized reimbursement, unless the fair market value of the vehicle and its equipment is less than \$2,500. The claimant may select the deductible of the insurance policy but will be responsible for any such deductible should an accident occur.
- (10) *Vehicle No Longer Needed.* If the MBE obtains information that a vehicle purchased by DEEOIC is no longer needed, the MBE will send an email to the DEEOIC Bill Pay Box Mailbox alerting MBPU of the situation. DEEOIC is entitled to recover the fair market value of the purchased vehicle, less any percentage contribution the claimant made to the overall purchase price of the vehicle and its modifications. The MBPU will undertake appropriate action to attempt recovery of any funds collectable through sale of a DEEOIC purchased vehicle no longer needed by a claimant.

It has been updated in v4.3 to:

13. *Vehicle Modifications.* DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their vehicle to accommodate the effect(s) of an accepted, work-related medical condition, as they relate to the use of that vehicle for purposes of medical transportation. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of those vehicle modification costs that are determined to be medically necessary and reasonable in cost. For the purposes of claim processing under the DEEOIC, a medically necessary vehicle modification means a mechanical alteration or addition to a vehicle, owned and operated by the claimant, necessary for purposes of medical transportation.

- a. *Vehicle Modification Claim Submissions.* For the MBE to assess a claim for vehicle modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.
- (1) *Letter of Medical Necessity (LMN).* The claimant must provide a LMN from a qualified physician who has conducted a face-to-face examination with the patient, prescribing vehicle modifications to address the effect of a work-related illness or injury, and providing a medical rationale for how those modifications relate to an accepted medical condition. The face-to-face examination must occur within 60 days of the date of the LMN. Specifically, the

*LMN must provide an explanation as to how the prescribed modification to the claimant's vehicle will accommodate the claimant's need for medical transportation.*

- (2) Evidentiary Requirements. Evidence supporting the need for specific vehicle modifications must include a description of the required equipment and/or labor operations necessary to modify the claimant's current vehicle, along with product information such as pamphlets, or technical diagrams, depicting the materials/equipment being proposed as part of the modification process. (For example: the claimant might provide a product brochure with photographs and technical information describing the installation of a lift device, designed for the purpose of transporting the claimant's DEEOIC prescribed mobility device.) The product information may be included with the submission of written estimates, or submitted separately to DEEOIC. Any unique or exceptional circumstances, regarding the nature of the requested modification and estimates for the cost of installation or modifications, are to be explained by the claimant, in a written statement, with supporting documentation, if applicable.*
- (3) Competitive Estimates. The claimant must obtain and submit three, independent, written estimates from appropriately licensed businesses or DEEOIC enrolled providers, detailing the proposed modifications that align with the medical rationale supplied by the claimant's physician. The scope of the estimates must identify the same equipment and/or alterations specified in the LMN. Labor charges for modification of the existing vehicle and/or installation of DME are to be identified separately on the estimate. (This is important, as claims for DME purchase, and labor charges for installation, must be itemized separately when submitting claim forms for reimbursement.)*

  - (a) Estimates for equipment added to a vehicle (e.g., scooter lift platform, motorized wheelchair lift platform, etc.) must specifically identify the description of the durable medical equipment (DME) being purchased. Information must include manufacturer or brand name, model number, and any other identifying information unique to the item described in the estimate.*
  - (b) Estimates for installation costs (labor and materials), for the permanent attachment of DME to the claimant's vehicle (e.g., receiver or other permanent mounting devices attached to the vehicle for mounting purposes) must be provided in separate estimates.*

- b. *MBE Assessment of Medical Evidence. Upon receipt of medical evidence supporting a claim for vehicle modification, the MBE conducts a review to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's vehicle to facilitate the use of that vehicle for the purpose of medical transportation.*
- (1) *Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant's treating physician and the employee, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested vehicle modification is linked to a DEEOIC accepted medical condition(s). If, upon review, either of these conditions are not satisfied, the MBE undertakes development with the claimant and the treating physician seeking the necessary evidence.*
  - (2) *The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested vehicle modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the physician's accurate and comprehensive knowledge of the claimant's medical history, diagnostic, and clinical status.*
    - (a) *In situations where the MBE determines additional information is needed to explain the medical necessity of a vehicle modification, the MBE initiates development with the claimant's treating physician. The treating physician is the principle point of contact for obtaining medical input. The MBE allows the claimant's physician the opportunity to respond to, or provide clarification with respect to, any development issue identified by the MBE. Additionally, the MBE may make referrals to DEEOIC nurse consultants, during the development process, for assistance in clarifying issues, obtaining information, or in seeking recommendations for additional development.*
    - (b) *In those instances, where development occurs with the treating physician, the MBE allots 30 days for the submission of necessary evidence to support a vehicle modification claim. For an initial request, the MBE allots 15 days to allow for a response. If the MBE does not receive the requested evidence within the 15-day period, the MBE sends a second development letter, providing an additional 15 days for submission of the requested evidence.*

- (c) *When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed vehicle modification, the MBE refers the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested vehicle modification. Upon receipt of the SECOP results, the MBE reviews the SECOP report and conducts a full examination of the case evidence, including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a vehicle modification, as prescribed by the claimant's physician, the MBE proceeds with a review of the cost estimates for the modifications.*

*If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the recommendation of the SECOP, and issues a recommended decision; or, the MBE can request that the claimant revise and resubmit any requested vehicle modification. If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a vehicle modification, the MBE proceeds with a referral for a referee examination. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving conflicting medical opinions.*

- (d) *Depending on the outcome of medical development, the MBE proceeds with adjudication of the claim. Where the medical evidence establishes the necessity for a vehicle modification, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity for a vehicle modification, the MBE issues a recommended decision denying the claim.*

- c. *MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a vehicle modification, the MBE reviews the competitive estimates from the claimant. It is the*

*responsibility of the claimant to produce valid, complete, and accurate competitive estimates that reflect only the work necessary to accommodate the claimant's need for medical transportation. Unless exceptional reasons exist, that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the estimates to determine if the scope of the requested modification(s) reasonably aligns with the modifications prescribed in the physician's LMN. The MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the written estimates reflect a medically necessary accommodation of the claimant's transportation needs. MBEs may also request input from nurse consultants regarding alternatives for accommodating the claimant's medical transportation needs.*

- (1) Comparing Competitive Estimates. The MBE examines the estimates to determine whether the scope of the proposed vehicle modification aligns with the physician's opinion of medical necessity. Each estimate must represent a proposal from a separate and distinct bidder desiring to perform the medically necessary vehicle modification. Estimates must be similar in their description of the equipment to be installed or work to be performed. For modifications to the existing vehicle, such as hand controls, modified driver seat, etc., the estimates must provide an itemization of the cost of materials, and the associated labor charge for each operation performed. As outlined above, DME, and the cost of modifying the vehicle to accommodate the DME, must be itemized in separate estimates. Unusual or exceptional circumstances, associated with the requested modification, must be clearly described in the estimate. The MBE is to undertake a careful, comparative analysis to determine if each estimate represents a viable proposal for completing a cost-effective modification consistent with the physician's LMN. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular service provider, or any other factors that relate to the requested modification.*
- (2) Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work, detailed in the contractor bids, is inconsistent with either the LMN or the condition (i.e., year, make, model) of the claimant's owned vehicle, or, if a viable alternative modification, or alternative transportation option exists, the MBE prepares a letter to the claimant. The letter should outline the deficiency(ies) in what is being claimed, and specifically describe the evidence needed from the claimant to support further assessment of the claim. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to*

*contact the claimant directly, to explain a problem and describe the necessary steps for submission of needed evidence. When a development letter is necessary, the MBE allots the claimant a total of 30 days for the submission of the requested evidence. For initial requests, the MBE allots 15 days to allow for the submission of responsive documentation. If the requested evidence is not received within the initial 15-day period, the MBE sends a second development letter, allotting an additional 15 days for a response.*

- (a) Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary vehicle modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.*
- (b) If a deficiency is found to exist, with a request for prior authorization of reimbursement for a vehicle modification, and the claimant is unable to produce evidence or information that addresses the deficiency, the MBE determines whether the deficiency prevents the MBE from proceeding with consideration of the reasonably comparable estimates. If the determination is that the MBE cannot proceed because of that deficiency, the MBE proceeds with the issuance of a recommended decision denying the request for prior authorization of reimbursement. In the recommended decision, the MBE must clearly explain the specific deficiency(ies) in the evidence resulting in an inability to grant prior authorization of the reimbursement request.*
- (3) Issuing Authorization Decisions. Upon reaching a decision to grant a request for prior authorization of reimbursement, the MBE writes a detailed letter-decision to the claimant advising of the approval. The letter should specifically describe the modification(s) being approved and should include a blank Form OWCP-915 with instructions to use that form when submitting reimbursement requests. For approvals involving the installation of DME on a vehicle, the approval letter should instruct the claimant to separately list the purchased DME from labor charges necessary to complete the installation.*

d. *Retroactive Requests for Reimbursement. In those instances, where a claimant did not request prior authorization from DEEOIC and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide an LMN that meets the same evidentiary requirements as a prior authorization request, i.e., it must be sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's vehicle. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.*

(1) *Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement for a vehicle modification, the MBE collects all available information from the claimant regarding the completed modification. With the exception of requiring three estimates, the evidentiary requirements for a retroactive review are no different than those previously outlined for prior authorization requests. The MBE reviews the available evidence to determine if the claimed expenses appear reasonably in line with similar modification requests. The MBE calculates and deducts any costs for materials and/or labor not related to, or not necessary to complete the requisite vehicle modification. Upon completion of a thorough review, the MBE prepares a memo to file outlining any calculations performed and provides an explanation as to how the MBE arrived at a final cost for approval of any reasonable and medically necessary vehicle modifications.*

(2) *Issuing a Decision. Having determined that reimbursement is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE's final calculations of documented and/or reasonable costs represent an amount less than the amount claimed, or if the MBE recommends a denial of the requested amount, the MBE issues a recommended decision. In that decision, the MBE must fully explain the analysis of available evidence and how the MBE arrived at the recommended amount of reimbursement. This explanation must include any reference materials or other information, utilized by the MBE, to calculate the reimbursable amount.*

- Ch. 29.14 has been updated to provide clear guidance for assessing the medical necessity of a claim for home modification. The language in v4.2 previously read:

14. Housing Modifications. *This section provides clarification with regard to the evidence needed to approve housing modifications, and provides procedural guidance with regard to the process for review, development, and authorization of housing*

*modifications. The MBE considers home modification only when deemed medically necessary due to an accepted condition. A MBE's responsibility is to grant authorization to modify an existing structure to accommodate the claimant's medical needs. The treating physician must describe in a LMN the particular home modifications needed to accommodate the claimant's work-related illness.*

- a. Modifications to Owned Property. Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical, with respect to the quality of construction materials and workmanship.*
  - (1) Modifications may include certain additions where warranted. For example, if a ground-floor recreation room is converted to a bedroom, to accommodate a wheelchair-bound individual, and if no ground-floor bathroom facilities exist, then the addition of a bathroom on the ground floor could be approved. Similarly, if there is no suitable space for conversion of a bedroom on the ground floor, then the addition of a bedroom on the ground floor could be approved, if no other reasonable alternative exists.*
  - (2) Modifications may include certain appliances, such as air conditioning or air filtration equipment, if deemed to be medically necessary by the treating physician, and necessary for the relief of accepted medical conditions. For example, if the claimant suffers from respiratory or cardiac conditions that have been accepted, his or her physician may order that the claimant be kept in an air conditioned environment, in which case the expense for these modifications would be allowed.*
  - (3) When considering modification requests, the MBE should consider whether a portion of a home can be modified, as compared to a whole-house modification. An example of this would be one or two room air conditioning units, versus installing a whole-house air conditioning system.*
  - (4) Maintenance expenses. The MBE approves maintenance expenses for equipment furnished to the claimant, as well as replacement costs, after the normal life expectancy of the appliance.*
- b. Modifications to Non-Owned Property. Any modifications to property not owned by the claimant, and his or her family, are subject to approval by the landlord or owner. This is in addition to the preceding guidelines established for owned property. When presented with a request for modifications to non-owned property, the MBE considers the following points:*

- (1) *Rental property may be subject to federal Americans with Disabilities Act (ADA), state, or local statutes that mandate barrier-free accessibility for persons with disabilities. The claimant should discuss any change in housing needs with his or her landlord, who may be able to offer modifications or alternative accommodations better suited to the needs of the individual.*
- (2) *If the landlord is unable or unwilling to pay for modifications, or offer other suitable accommodations, approval must still be obtained from the landlord prior to making any changes or alternations to the non-owned property. Any such changes must be made at the claimant's expense, and are subject to review and approval by DEEOIC, prior to any reimbursement.*
- (3) *If the landlord/owner will not permit modifications, or if the costs are excessive, and if suitable housing arrangements are available elsewhere, within the same geographic area, it may be more cost-effective to consider paying relocation expenses rather than paying for modifications at the current location. If changing locations is the most cost-effective alternative, the MBE may authorize a subsidy for any increase in rent, if warranted, in addition to the relocation expense. For example, if the claimant lives in an apartment with stairs, and is no longer able to climb stairs due to his or her accepted condition(s), DEEOIC would reimburse the claimant for the most nearly comparable apartment available that offers an elevator and any other accommodations required to fulfill the claimant's medical needs arising from the claimant's accepted condition(s).*
- (4) *The Government is entitled to reimbursement only for the value of special equipment that can be removed and sold separately, once the claimant no longer needs that equipment. Improvements or modifications, and any increase in property value resulting from such changes, accrue to the benefit of the owner.*

c. *Proposals. If the MBE determines that the claimant is eligible for housing modifications, the MBE asks the claimant to submit a detailed written proposal for review and consideration. The MBE advises the claimant that the proposed housing modifications should be of a quality and grade consistent with the existing architecture and construction materials, not superior to them. Further, the claimant should be cautioned that structural modifications must not compromise the integrity of the existing structure.*

*Modifications will be no more expensive than necessary to accomplish the required purpose. For example, when remodeling a bathroom, it may be*

*feasible to re-install an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one.*

*Conversely, modifications must be in keeping with the standard of the décor of the current or pre-illness accommodations. For example, if the claimant's dwelling requires that a sink or commode be changed for handicap accessibility, and if it is necessary to tear out and replace tile, then the tile in the entire bathroom or kitchen may have to be replaced with similar quality tile in order to maintain the architectural décor of the room.*

*Proposals must include the following information:*

- (1) A medical report detailing the physical limitations for which the requested modifications are necessary. This report should be prepared by a physician who is a recognized authority in the appropriate medical specialty.*
- (2) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical or rehabilitation professional familiar with the needs of the disabled.*
- (3) If the claimant lives in a rented or non-owned premise, a written statement from the landlord/owner must be obtained, approving and authorizing the specific plans and proposed modifications.*
- (4) The MBE reviews the itemized proposal and determines if the specified modifications are warranted. If the MBE identifies technical issues regarding implementation, the MBE develops the issue further to identify alternate solutions.*

*d. Fees and Bids.*

- (1) Reasonable fees may be paid for the medical or rehabilitation professional's visit to the site, and for the preparation of the detailed report. The same applies to any architectural drawings that are required for significant structural changes.*
- (2) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an AR remains the claimant's obligation.*
- (3) The claimant must provide two or more bids for the proposed changes from licensed and/or certified contractors. The bids*

*submitted must be for exactly the same modifications so that comparison of the competitive bids can be made.*

- (a) If construction work is required, the bids obtained must be for binding estimates of the cost. No fees will be paid for the bids or estimates.*
- (b) If special accessories or devices are required, the MBE stipulates that the price quoted by the vendor includes any necessary installation.*
- (4) The MBE reviews the bids to determine that the same workmanship and materials are specified in the competitive bids, and normally selects the lowest cost bid, unless there is a sound reason for a higher-cost alternative, such as increased durability. If the MBE selects a bid other than the lowest-cost bid, a memorandum to the file is required, explaining any variance or the justification for accepting a higher bid.*
- (5) Additional Information. If the MBE determines that additional information is necessary, the MBE sends a letter to the claimant requesting additional documentation that is necessary to continue with the review process.*
- e. Approval and Payment Options. Upon approval of the request, the MBE writes a detailed letter decision to the claimant advising of the approval (Exhibit 29-6 provides a sample of the home modification approval letter.) The approval letter is to include guidance to the claimant of the payment options available and requests that the claimant respond in writing, indicating his/her preferred payment option. For payment of home modification, the following is necessary:*
  - (1) The claimant submits medical evidence and two proposals for home modifications. Upon review the MBE approves the lower cost bid proposal and sends a letter to claimant stating DEEOIC agrees to the approved scope and cost of repairs, and, at the claimant's request, will make direct payment to the enrolled contractor, once the agreed upon work has been completed. The letter states that upon completion of the agreed-upon work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that payment be made to the contractor. The MBE sends a courtesy copy of this letter to the contractor.*

- (2) *Upon receipt of the claimant's attestation and request to pay the contractor, the MBE acknowledges the claimant letter and advises that the enrolled contractor should submit Form OWCP- 1500, along with a final invoice, in order to receive payment of the agreed upon price. The OWCP Code for HOME MODIFICATION - HSMDF is used, when preparing the Form OWCP-1500.*
- (3) *In certain situations, the MBE may authorize payment of a pre-construction deposit if required by the contractor whose bid has been accepted by the MBE. In these situations, the contractor is to specify the total cost for specified home modification, along with the amount of any deposit (up to one-third of the total cost) required to initiate work. With MBE approval, the contractor may then submit Form OWCP-1500, to receive partial payment for the deposit amount of the estimated cost. The OWCP code for HOME MODIFICATION - HSMDF is used when preparing the Form OWCP-1500. Upon completion of the work, the claimant must submit a written attestation to DEEOIC stating that the agreed upon work has been completed by the contractor, to the claimant's satisfaction, and requesting that final payment be made to the contractor. The contractor submits a separate Form OWCP-1500, requesting payment of the balance of the agreed upon amount.*
- (4) *For guidance regarding problems encountered during the course of home modifications, or for other billing questions, (e.g.; billing difficulties, disputes or other irregularities), the MBE should contact the NO Policy Branch for assistance.*

It has been updated in v4.3 to:

14. Housing Modifications. *DEEOIC requires claimants to obtain prior authorization for reimbursement of modifications to their residence to accommodate the effect(s) of an accepted, work-related illness. It is the role of the Medical Benefits Examiner (MBE) to evaluate such claims and to grant authorization for reimbursement of those home modification costs that are determined to be medically necessary. For the purposes of claim processing under the DEEOIC, a medically necessary home modification means an alteration, addition to, or repair of an existing residential structure to overcome a deficiency limiting or preventing the claimant, with an accepted, work-related illness, from performing activities of daily living.*

- a. *Home Modification Claims Submissions. For the MBE to assess a claim for home modification, a claimant is responsible for submitting medical and factual documentation necessary to support an authorization for reimbursement.*

- (1) *Letter of Medical Necessity (LMN).* A qualified physician who has conducted a face-to-face examination with the patient is to submit a LMN prescribing home modifications to address the effect of a work-related illness or injury, and how those modifications relate to an accepted condition. The face-to-face examination must occur within 60 days of the date of the LMN. The LMN must provide the physician's rationale justifying the medical need for a modification to the claimant's residential structure. Specifically, within the narrative of the LMN, the physician has to explain the reasons for a home modification and how the modification will serve to overcome an established inability of the claimant to perform an activity of daily living arising from an accepted medical condition.
- (2) *Evidentiary Requirements.* The claimant must submit evidence substantiating the need for home modifications, including a description of the required modifications, digital photographs of the existing areas requiring modification, and any other plans, drawings, or documentation, supporting the required modifications. This information should clearly depict the area or areas requiring modification and should show evidence of the existing grade and quality of construction in the home. The claimant may include this information with the initial submission of written estimates, or submit it separately. Any unique or exceptional circumstances regarding the nature of the requested modification and the competitive estimates are to be explained by the claimant in a written statement with accompanying supportive documentation, if applicable. Any modification to property not owned by the claimant is subject to approval by the landlord or owner.
- (3) *Competitive Estimates.* The claimant must obtain and submit three, independent written estimates, from appropriately licensed contractors or vendors, detailing the proposed modifications that align with the medical rationale supplied by the claimant's physician. The estimates must include the same alterations, additions, or repairs as specified in the LMN. These estimates are to include itemized unit costs, broken down into materials and labor, for each operation (e.g. number of square feet of drywall or flooring, with the associated cost of materials and labor per square foot). Construction estimates are to include the grade of proposed construction materials and contain specifics describing the type and manufacturer of fixtures and appliances (such as sinks, cabinets, bathtubs, flooring materials, etc.). Building materials and construction quality, described in the construction estimates for a medically necessary home modification, must conform to the same construction quality as the existing structure.

*Any additional services, improvements, or upgrades, desired by the claimant, which are not within the scope of medically necessary modifications, are to be itemized distinctly and separately in the estimate. Such services, improvements, or upgrades are not reimbursable as a medically necessary home modification.*

- b. *MBE Assessment of Medical Evidence. Upon receipt of the evidence supporting a claim for home modification, the MBE first conducts a review and assessment of the medical evidence. The function of this review is to ensure that the weight of medical evidence supports the medical necessity for making modifications to a claimant's residence to accommodate the effects of a work-related illness on the employee's ability to perform activities of daily living.*
- (1) *Initial Review of the LMN. The MBE reviews the LMN to determine whether it documents a face-to-face examination between the claimant and the treating physician, within 60 days of the LMN. Moreover, the MBE screens the LMN to ensure that the requested home modification is linked to the DEEOIC accepted medical conditions. If, upon review, either of these conditions is not satisfied, the MBE undertakes development with the claimant and the treating physician, seeking the necessary evidence.*
  - (2) *The MBE must evaluate the weight of medical evidence to determine if the physician's LMN provides a sufficiently supported medical justification for the requested home modification. The MBE may consider multiple factors when assessing the available evidence and in reaching a decision. The LMN should reflect the following: the physician's accurate and comprehensive knowledge of the claimant's medical history; diagnostic and clinical status; living circumstances; and functional capacities. The LMN should include the physician's consideration of such information and how the physician relates the need for, and the scope of any home modification, to an established deficiency in the claimant's capacity to perform activities of daily living arising from an accepted, work-related illness.*
    - (a) *In those situations, where the MBE determines that additional information is necessary to explain the medical necessity of a home modification, the MBE is to initiate development with the claimant's treating physician as the principle point of contact for obtaining medical input. Moreover, the MBE is to allow the claimant's physician the opportunity to respond to, or provide clarification with respect to, the development issue identified by the MBE. At any time in this process, the MBE may make referrals to*

*DEEOIC nurse consultants for assistance in clarifying issues, obtaining information, or recommending additional development.*

- (b) *In those instances, where development occurs with the treating physician, the MBE should allot 30 days for the submission of necessary evidence to support a home modification claim. 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, the MBE sends a second development letter providing an additional 15 days to submit the requested documentation. No further time will be granted for a response from the treating physician, unless extenuating circumstances exist and are documented.*
- (c) *When development with the prescribing physician does not produce evidence necessary to establish the medical appropriateness of the prescribed home modification during the allotted 30 days, the MBE is to refer the case for a Second Opinion (SECOP) medical examination. The function of the SECOP examination is to obtain an independent assessment of the medical need for the requested home modification.*

*Once the SECOP medical examination is complete, the MBE will need to review the SECOP report and conduct a full examination of the case evidence including any medical evidence submitted by the treating physician. If the SECOP examination results in a validation of the need for a home modification, as prescribed by the claimant's physician, the MBE is to proceed with a review of the cost estimates for the modifications.*

*If the SECOP examination results in an opinion that differs from that of the claimant's physician, the MBE weighs the opinions of the two physicians. If the MBE determines that the opinion of the SECOP physician is of greater weight than that of the treating physician, the MBE proceeds with the claim, based on the recommendation of the SECOP, and issues a recommended decision. In the alternative, the MBE can request that the claimant revise and resubmit any planned home modification. If, for whatever reason, including receipt of new evidence from the prescribing physician, the MBE determines that the weight of medical*

*evidence is the same between the treating physician and the Second Opinion physician, and there is a conflict regarding the medical need for a home modification, the MBE is to proceed with a referral for a referee examination. The MBE is to consider the opinion of a referee medical physician as possessing special weight in resolving a conflict of medical opinion.*

*(d) Depending on the outcome of medical development, the MBE will proceed with adjudication of the claim. Once the medical necessity of a home modification is established by the weight of medical evidence, the MBE proceeds with collection, and/or review of any competitive estimates for the validated modification. If the weight of medical evidence does not support the medical necessity of a home modification, the MBE is to issue a recommended decision denying the claim.*

*c. MBE Assessment of Competitive Estimates. Once the MBE establishes that the weight of medical evidence warrants a home modification to accommodate the claimant's inability to perform an activity of daily living, the MBE reviews competitive estimates, submitted by the claimant, to accomplish the proposed home modification. The claimant is responsible for producing valid, complete, and accurate, competitive estimates that reflect the work to be done to accommodate a medically necessary modification. Unless exceptional reasons exist that can be adequately explained, the claimant is to submit a minimum of three competitive estimates. The MBE assesses the three estimates to determine if the scope of the requested modification(s) reasonably aligns with the information supplied in the physician's LMN. If necessary, the MBE may seek consultative advice from DEEOIC nurse consultants for input as to whether the proposals reflect a medically necessary accommodation of the claimant's needs and whether those modifications align with the treating physician's LMN. MBEs may also request input from nurse consultants regarding medically feasible options or alternatives for accommodating a medical need. If a claimant chooses to also have improvements outside the scope of medical necessity performed at the same time, the bids should provide a distinction between the medically necessary portion of the work and the personal improvements requested by the claimant.*

*(1) Comparing Competitive Estimates. The MBE examines the contractor estimates to determine whether the scope of the proposed home modifications aligns with the physician's opinion of medical necessity. Each bid must represent a proposal from a separate and distinct contractor, desiring to perform the medically necessary home modifications as spelled out in the LMN, which will*

*serve to accommodate the claimant's medical need. Estimates must be similar in their description of the operations to be performed. Further, estimates must contain an itemization of the cost of materials and the associated labor charge for each operation performed. All estimates must reflect the use of construction materials comparable to the existing quality or grade of the structure to be modified. Unusual or exceptional circumstances associated with the requested modification must be clearly described in the estimate. The MBE is to undertake a careful comparative analysis to determine if each estimate represents a viable proposal for completing a cost-effective modification to the claimant's residence to accommodate an established medical need. The MBE may consider any input that the claimant wishes to express regarding a preference for a particular contractor, or any other factors that relate to the requested modification.*

(2) *Undertaking Development. If, during the examination of each bid, the MBE determines the scope of the work detailed in the contractor bids is inconsistent with either the LMN or the existing grade and quality of the claimant's dwelling; or if viable alternative modification options exist, the MBE prepares a letter to the claimant. The letter should outline any deficiencies, and specifically describe the evidence needed from the claimant to support further assessment of the request. This could include a request for resubmission of a modified estimate or estimates. It may be helpful, in some instances, for the MBE to contact the claimant directly, to explain a problem, and describe the necessary steps for submission of needed evidence. In those instances in which the MBE issues a development letter to the claimant, the MBE allots 30 days for the submission of the necessary evidence. 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. No further time will be granted for the submission of this documentation, unless extenuating circumstances exist and are documented.*

(a) *Once all development actions are complete, the MBE must carefully weigh the totality of available evidence and assign the greatest weight to the estimate that represents the most qualified and cost-effective proposal for accomplishing the medically necessary home modification. While cost is a factor in the MBE's analysis, it is not the sole determiner in the selection process. Each estimate*

*must be assessed on its merits, along with any input from the claimant, in order to identify the estimate with the greatest weight.*

- (b) If a deficiency is found to exist, and the claimant is unable to overcome it, the MBE is to issue a recommended decision denying the request for home modification reimbursement. In the recommended decision, the MBE clearly explains the specific deficiencies in the evidence.*
- (3) Issuing Authorization Decisions. Upon reaching a decision to grant prior authorization of a reimbursement request, the MBE writes a detailed letter decision to the claimant advising of the approval. (Exhibit 29-4 provides a sample of the home modification approval letter.) In the letter, the MBE provides guidance to the claimant regarding the payment options available (as detailed in the exhibit letter) and requests that the claimant respond in writing, indicating the preferred payment option.*
- d. Retroactive Requests for Reimbursement. In those instances where a claimant did not request prior authorization from DEEOIC, and subsequently submits a request for reimbursement for work already performed, the MBE conducts a review of the evidence to determine the amount, if any, that can be authorized for reimbursement. The claimant must provide a LMN that is sufficient for the MBE to make a determination regarding the medical necessity of a modification to the claimant's residence. If necessary, the MBE conducts development to obtain sufficient medical evidence supporting the claimant's request.*

  - (1) Calculating Costs to Determine a Reimbursable Amount. Once the MBE establishes the medical necessity of a request for retroactive reimbursement of a home modification, the MBE must collect all available information from the claimant about the home modification that occurred. With the exception of requiring three estimates, the evidentiary requirements are no different from those previously outlined for prior authorization requests, and the burden of proving reasonableness of cost remains with the claimant. Supportive evidence could include diagrams, blueprints or floor plans, pictures, written descriptions, manufacturer and model number of appliances or fixtures, invoices, estimates, paid receipts, or other descriptive information. To the extent possible, the claimant must also document the pre-modification condition of the residence including photographic evidence and a description of preexisting structural grade and quality. In assessing a reimbursable amount, the MBE is to evaluate all the available*

*evidence to ascertain only those materials and labor expenses that reasonably align with the cost of completing a medically necessary modification. The MBE must exclude any costs associated with materials and/or labor not necessary to complete the requisite home modification. Moreover, the MBE may calculate and deduct adjusted costs for any building materials or labor charges determined to exceed the pre-modification construction grade or quality of the residence. Once the MBE has conducted a thorough consideration of the available evidence and calculated the reasonably necessary cost required to accomplish the medically necessary modification (s), the MBE is to complete a memo to file, outlining in detail the analysis performed and calculations used in arriving at the reimbursable amount.*

(2) *Issuing a decision. Once the MBE has determined that reimbursement to the claimant is appropriate, the MBE issues a letter decision authorizing reimbursement for the claimed amount. If the MBE is unable to obtain evidence supporting reimbursement at the claimed amount, or if the MBE's calculation of allowable costs represents a figure that is less than the amount claimed, the MBE will issue a recommended decision. Within the content of the recommendation, the MBE is to provide a detailed accounting of the MBE's analysis of available evidence and how the MBE determined the reimbursable amount. This includes any reference materials or other tools utilized to calculate those costs that are attributable to modifying the claimant's residence at a cost comparable to the existing grade and quality of construction.*

- **Chapter 32 – Coordinating State Workers' Compensation Benefits**

- Chapter 32.4 has been edited to clarify the circumstances under which coordination is required as it relates to an election of employee benefits by a survivor. The language in v4.2 previously read:

4. *When Coordination is Required. Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary received benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is also asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.*

*Similarly, in cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits through the date of employee's death awarded to the survivor requires coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.*

*However, if the employee or the deceased employee's estate (considered same as the employee) receives SWC benefits for asbestosis and the accepted covered illness for which the survivor is entitled to Part E benefits is also asbestosis, the CE will not consider this claim for coordination (unless that survivor also received some form of SWC benefits for asbestosis, such as death benefits).*

It has been updated in v4.3 to:

4. *When Coordination is Required.* *Coordination of Part E benefits (there is no coordination of Part B benefits) is required only if the EEOICPA beneficiary receives benefits through a SWC program for the same covered illness for which that same EEOICPA beneficiary is eligible to receive benefits under Part E. This means the CE first determines the employee/survivor's eligibility to receive Part E benefits, and then determines who the beneficiary of the SWC benefits was before determining whether coordination is required. For example, if the employee settles a SWC claim for asbestosis and the accepted covered illness for which the employee is entitled to Part E benefits is asbestosis, coordination of the Part E award is required to reflect the amount of SWC benefits the employee has received.*

*Similarly, where there is an election to receive the employee's benefits by the survivor (refer to Chapter 20.12b for specific requirements for a survivor who elects to receive the employee's benefits rather than survivor benefits), coordination is required if the employee received SWC benefits for the same covered illness. Coordination is required because the survivor is taking the place of the employee in this situation. For example, if the employee received a SWC payment for asbestosis and the survivor elects to receive what the deceased employee would have received under EEOICPA based on asbestosis, the CE must coordinate the benefits payable to the survivor.*

*In cases where the employee had filed a Part E claim but died before payment could be issued, Part E medical benefits awarded to the survivor through the date of the employee's death are subject to coordination if the employee had received SWC benefits for the same covered illness. Coordination of medical benefits is required in this case because the Part E medical benefits were based on the employee's entitlement to Part E benefits and the same employee received SWC benefits for the same covered illness.*

- Chapter 32.5 has been edited to add a new exception to coordination of SWC benefits. The language in v4.2 previously read:

5. *Exceptions. The following are exceptions to the coordination requirement. Review Exhibit 32-1 for additional scenarios and determination as to whether coordination is required.*

- a. *Multiple illnesses. If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.*

*For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.*

- b. *Covered illness. Because a “covered illness” is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a non-DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).*

- c. *Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under \$200.*

*If a waiver is to be granted, the CE prepares a memo to the file, approved by the DD, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.*

- d. *Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.*

It has been updated in v4.3 to:

5. Exceptions. *The following are exceptions to the coordination requirement. Review Exhibit 32-1 for additional scenarios and determination as to whether coordination is required.*

- a. *Multiple illnesses. If the claimant receives SWC benefits for a non-covered illness, or for both a covered and a non-covered illness arising out of and in the course of the same work-related exposure, the CE does not coordinate the Part E award.*

*For example, if the claimant settles a SWC claim for asbestosis and silicosis arising out of the same exposure and the amounts are not apportioned between the two illnesses, and the accepted covered illness for which the claimant is entitled to Part E benefits is only asbestosis, coordination of the Part E benefits is not required.*

- b. *Covered illness. Because a “covered illness” is an illness resulting from exposure to a toxic substance, the same medical condition accepted by DEEOIC and a SWC program may not require coordination. For example, if the claimant settles a SWC claim for asbestosis in a non-DOE facility and is entitled to Part E benefits for asbestosis based on a separate and distinct exposure to asbestos at a DOE facility, coordination of the Part E benefits is not required because it is not the same covered illness (not resulting from the same toxic exposure).*

- c. *Waivers. DEEOIC may waive the requirement to coordinate Part E benefits with benefits paid under a SWC program, if it is determined that the administrative costs and burdens of coordinating Part E benefits in a particular case or class of cases justifies the waiver. A waiver is automatically granted if the total amount of SWC benefits the claimant received is under \$200.*

*If a waiver is to be granted, the CE prepares a memo to the file, approved by the DD, explaining that the requirement to coordinate the benefits is waived due to the dollar amount of the SWC benefits the claimant received.*

- d. *Medical or Vocational Benefits Only Claims. Medical or vocational benefits paid by a SWC program do not require any coordination of benefits.*
- e. *Survivor Claim. In a survivor claim (except as noted in Section 4), the CE does not coordinate even if the employee or the deceased employee’s estate received SWC benefits based on the same covered illness as the survivor’s Part E claim (unless that survivor also received some form of SWC benefits, such as death benefits). For example, if the employee received a SWC payment based on asbestosis and the survivor Part E*

*claim was also based on asbestosis, the CE will not consider this claim for coordination because the survivor did not receive the SWC benefits.*

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