U.S. Department of Labor

Office of Worker's Compensation Programs
Division of Energy Employees Occupational
Illness Compensation
Washington, D.C. 20210

MEMORANDUM

DATE: February 17, 2015

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RE: CONTRACTOR MEDICAL CONSULTANTS AND SECOND OPNION MEDICAL SPECIALISTS INFORMAL AUDIT

The National Office recently conducted an audit of case referrals made to Contractor Medical Consultants (CMC) and Second Opinion Medical Specialists (SECOP).

The purpose of the review was to assess the quality of district office and physician work product and referral packages through the QTC (CMC/SECOP scheduling contractor) web portal and the quality of the physician responses. CMC review includes referrals for all issues except impairment evaluations (e.g., diagnosis, causation, consequential conditions, and medical necessity of treatment). SECOP review included all referrals. Since the claims staff provides the necessary background materials and factual framework for any review, this audit also assessed the quality of district office inputs to the final CMC and SECOP work product.

CMC Audit Background Information

Cases were randomly selected from the universe of non-impairment CMC referrals completed program-wide during the period of April 1 to August 30, 2014. The size of the universe was 362 completed file reviews. From this total, a sample of 126 cases (approximately one-third of the universe) was selected at random from each district office, in proportion to that office's share of the universe of CMC referrals during the review period. However, because five of the 126 cases sampled were incorrectly coded as "causation referrals" instead of "impairment referrals," and two of the cases were duplicates, the review sample size decreased to 119 cases.

Element I - Quality of District Office Inputs. This category assessed the appropriateness of the referral, the quality and completeness of the SOAF, and appropriateness of the questions asked by the district office. From the 119 cases reviewed, the results showed the following:

- There are 22 incidents in which the district office did not contact the claimant's treating physician for causation and diagnosis, even when the treating physician was an active participant and volunteered to answer any question(s). No action was taken to notify the claimant of the opportunity to seek assistance from his or her treating physician in these situations.
- There are 8 incidents where there were no supporting documents, objective or otherwise, of an existing medical condition. It is unclear of the necessity of CMC referral because the district office should have issued a negative decision citing insufficient medical evidence to establish a diagnosis.
- There are 6 incidents in which the district office, using the regular formatted development letter, requested that the employee provide causation medical evidence AFTER the CMC review resulted in negative causation. The requests did not provide the employee with a copy of the CMC reports.
- There are 8 incidents where the medical evidence was sufficient to provide a diagnosis, yet the district office referred the case for a CMC review for diagnosis anyway.

- There are 17 incidents in which the SOAFs did not provide any description of the nature, extent or duration of exposure.
- There are 10 incidents in which the SOAFs for causations included the entire listing of potential of toxins identified in the SEM.
- There are 4 incidents in which the district office used the causation standard when asking about the relationship of consequential conditions to the accepted conditions.

Element II - Quality of the Medical Review and Opinion. This category evaluated whether the CMC's written medical report is complete and responsive to the issue under consideration. The reviewer also assessed whether a physician's responses to the questions are well-rationalized and consistent with the totality of the evidence in the case under review.

- There are 19 incidents in which the physicians seemed confused about applying the causation standard to their review of information. For example, the CMC acknowledged the exposures as identified in the SOAF as being causally related to the claimed conditions and then made a generalized, equivocal statement as to causation. The CMC provided little discussion as to his or her analysis of the evidence to arrive at the conclusion. It would appear that the doctors are acknowledging a relationship between disease and exposure could exist, but not applying any critical assessment to the employee's unique exposure profile to come to a justified conclusion of compensability under Part E. For example, in one case, the CMC did not discuss how a toxin (carbon steel) caused, contributed, or aggravated the employee's condition. The CMC discussed two other toxins (manganese and manganese compounds) at length but not this one. It may be that carbon steel is implicitly included in the discussion due to the manganese content, but it is not clear to the layperson; hence it warrants additional explanation.
- There are 6 incidents in which the physicians seem confused when correlating the toxins identified in the SOAF and or IH/toxicologist report to the "at least likely as not" standard. For example, in one case the SEM database results documented the employee's potential exposure to benzopyrenes in the course of employment. However, the CMC stated that "(t)here is no indications in his job duty of working with benzopyrenes." It is unclear if the CMC was making an assessment based on his historical knowledge of

the position, or if he unintentially discounted the employee's potential exposure to this toxin.

- There are 5 incidents in which the physicians provided too much information about the toxins instead of answering the question(s) as concisely as possible. Their reports include entire sections of science material found during their research for the question; however, the application of this research in responding to the specific questions addressed to the physician was not clear.

- There are 6 incidents in which the physicians assumed exposure that was not identified in the SOAF or identified anywhere in the medical information provided.

Analysis/Recommendations:

The audit has resulted in several important findings with regard to the quality of the CMC referral process. One topic that was not specifically a part of the audit measures, but the team immediately identified as a major hindrance to the completion of the audit, was staff compliance to OIS requirements.

DEEIOC policy directs that the district offices scan the entire CMC referral packages, including all documentation submitted, to the doctor for review. However, this did not regularly occur. Instead, some district offices scanned only the referral sheet to the CMC contractor; others scanned the Statement of Accepted Facts (SOAF) and question(s) to the physician; others just scanned the medical documents. These inconsistencies exist within all of the district offices.

The district offices also do not consistently enter the correct indexing information into the "Category" field of OIS. Some Category entries are correctly identified as CMC or SECOP and include notes in the "Description" field which reflect a positive or negative report; however, not all of the entries include descriptive notes. Other indexing entries merely identify the CMC/SECOP reports as "medical" evidence. Again, these inconsistencies exist within all of the district offices. OIS policy dictates that the Category correctly reflects the scanned document. Ideally, the Category will reflect CMC or SECOP referral and or report with notes in the Description field.

The overall findings of the audit with regard to CMC referrals support that the system is working satisfactorily. There are

five specific areas of concern which will require further action to improve performance:

- The audit shows that more effort is needed to better interact with a treating physician before proceeding with a CMC or SECOP referral. Policy requires that the CE make every attempt to seek the input or opinion of a treating physician before deciding to make a case referral to a CMC. The audit demonstrates elevated referral to CMC without proper interaction with the treating physician first.
- As is demonstrated in the review of SOAF findings, CEs clearly need to undertake more development of exposure data to offer clarifying description of the nature, extent and duration of exposure. Admittedly, this is a difficult topic that the DEEOIC has been developing guidance on, but providing CMCs with more enhanced data on exposure will produce more probative and compelling medical causation outcomes.
- The audit shows CEs clearly need further guidance on making proper referrals. Policy establishes that an obvious defect in case evidence must exist for which a medical opinion is necessary. When the medical evidence clearly delineates a diagnosis, a CMC referral for diagnosis is unnecessary.
- As demonstrated in the review of the CMC reports, it is critical that the CEs evaluate the rationale presented by the physician to ensure that it presents a clear, compelling and medically substantiated position. A medical opinion based on a poorly justified medical analysis of the relevant evidence reduces the probative value of the opinion in allowing the program to decide claim outcomes.

Demographics:

Cleveland CMC

- The reviews were evenly referred with one exception; Dr. Robert Hoffman reviewed twice as many cases as the next physician.

- With a ratio of 11 positive opinions to 17 negative opinions, the review trend for CLE is negative.

Denver .CMC

- The reviews were evenly referred.
- With a ratio of 8 positive opinions to 16 negative ones, the review trend for DEN means that for every positive opinion there are two negative ones.

Jacksonville CMC

- The reviews were evenly referred.
- With a ratio of 6 positive opinions to 10 negative ones, the review trend for JAC means that for every three positive opinions there are five negative ones.

Seattle CMC

- The reviews were evenly referred with three exceptions: Dr. Ralph McLaury, Dr. Ricky Langley, and Dr. Elizabeth Gresch reviewed twice as many cases as the next physician.
- With a ratio of 21 positive opinions to 24 negative ones, the review trend for SEA is the most balanced because for every three positive opinions there are four negative ones.

SECOP Audit Background Information

The review consisted of all SECOP referrals completed during the period of January 1 through August 30, 2014. The size of the universe was 15.

Element I - Quality of District Office Inputs: This category assessed the appropriateness of the referral, the quality and completeness of the SOAF, and appropriateness of the questions asked by the district office. From the 15 SECOP cases reviewed, the results showed the following:

- There are 12 cases in which the SOAF and or questions to the SECOP are not available for review. With no findings

or comments on the remaining 3 cases, the findings are *de minimis*.

Element II - Quality of the Medical Review and Opinion: This category evaluated whether the SECOP's written medical report is complete and responsive to the issue under consideration. The reviewer also assessed whether a physician's responses to the questions are well-rationalized and consistent with the totality of the evidence in the case under review.

- There are 7 incidents in which the SECOP physician provides little or no explanation of the employee's medical history in the report.
- There are 4 incidents in which the SECOP physician provides little or no rationale for the conclusion provided.
- There are 3 incidents in which the SECOP physician does not discuss the employee's activities of daily living or delineate the duration/frequency of the nursing services to be performed.

Analysis/Recommendations:

The overall finding of the audit with regard to SECOP evaluations seem to be working satisfactorily. There is one specific area of concern which will require further action to improve performance:

- As demonstrated in the review of the SECOP reports, a more definitive explanation to the physician regarding the format and rationale she/he provides in the report. The physician's report impacts the outcome; therefore a more concise response with reasonable explanation is required.

Demographics:

Cleveland SECOP

- The reviews were evenly referred
- With a ratio of 1 positive opinion to 3 negative opinions, the review trend for CLE is negative.

Denver SECOP

- The reviews were evenly referred.
- With a ratio of 5 positive opinions to 1 negative ones, the review trend for DEN is positive.

Jacksonville SECOP

- The lack of information does not allow a determination of trend.

Seattle SECOP

- The lack of information does not allow a determination of trend.