OFFICE OF THE OMBUDSMAN FOR THE
ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM

2022 ANNUAL REPORT TO CONGRESS

OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR

Cover Photo: Welding in the Prefabrication Lab at Oak Ridge's K-25.
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U.S. Department of Labor

Ombudsman
Energy Employees Compensation Program
Washington, D.C. 20210

August 30, 2023

The Honorable Kamala D. Harris
President
United States Senate
Washington, DC 20510

Dear Madam President:

I am pleased to present to 2022 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

Sincerely,

Amanda M. Fallon
Ombudsman for the Energy Employees
Occupational Illness Compensation Program

Enclosure

U.S. Department of Labor

Ombudsman
Energy Employees Compensation Program
Washington, D.C. 20210

August 30, 2023

The Honorable Kevin McCarthy
Speaker
U.S. House of Representatives
Washington, DC 20515

Dear Speaker McCarthy:

I am pleased to present to 2022 Annual Report of the Ombudsman for the Energy Employees Occupational Illness Compensation Program of the United States Department of Labor.

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PREFACE TO THE REPORT

In this Annual Report to Congress, the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program (Ombuds) sets forth the complaints, grievances, and requests for assistance received during calendar year 2022, and provides an assessment of the most common difficulties encountered by claimants and potential claimants in that year. However, before addressing the complaints, grievances and requests for assistance received in 2022, we would like to acknowledge some of the efforts undertaken by the Division of Energy Employees Occupational Illness Compensation (DEEOIC) in 2022 to assist claimants in filing and processing claims under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA):

- DEEOIC published two updates, Version 6.0 and 7.0 of the Federal (EEOICPA) Procedure Manual (PM). The changes to the PM included:
  - Reissuance of Chapter 2 – The EEOICPA in its entirety, to include updated information regarding the organizational structure of the DEEOIC and training provided to its staff. (Version 6.0).
  - Chapter 12 – Representative Services, updated to provide clarification that Claims Examiners (CEs) have sole oversight of the Authorized Representative (AR) appointment process. (Version 6.0).
  - Chapter 15 – Establishing Toxic Substance Exposure and Causation, updated to clarify guidance on validating Site Exposure Matrices (SEM) results prior to the issuance of a recommended or final decision denying a claim for lack of causation. (Version 6.0).
  - Chapter 21 – Impairment Ratings, updated to clarify the role of the CE in considering whether medical disorders named in an impairment have an association to a covered illness of the central or peripheral nervous system; and to clarify procedures for the handling of withdrawn claims for an increase to impairment benefits. (Version 6.0).
  - Chapter 7 – Case Creation, modified to clarify that a claim for chronic silicosis is only evaluated under both Parts B and E when the claimant was employed in either Nevada or Alaska *during* the mining of underground tunnels. (emphasis in original) (Version 7.0).
  - Exhibit 15-4, Section 9: Hearing Loss, updated to modify the employment requirements for hearing loss claims to create an alternate pathway for employees who did not work in a "qualifying" labor category, or did not have 10 consecutive years of verified employment with potential exposures to a qualifying toxic substance prior to 1990. (Version 7.0).
  - Chapter 18 – Eligibility Criteria for Non-Cancerous Conditions, Silicosis, edited to remove the reference to assumed exposure, and make the distinction that it is the CEs role to make a factual finding of exposure that a physician must then judge as sufficient to meet the criterion for establishing a covered illness under Part E. (Version 7.0).
  - Chapter 31 – Tort Action and Election of Remedies, updated to clarify that a Form EN-16 response is applicable for six months unless there is a new exposure or illness (including consequential) being accepted. (Version 7.0).

- The following in-person outreach events and virtual webinars were hosted by DEEOIC:
  - Webinar - National Office Roles and Responsibilities (January),
  - Webinar - NIOSH Dose Reconstruction and Stakeholder Updates (February),
  - Webinar - Radiation Exposure Compensation Act (RECA) (March),
  - Webinar - U.S. Department of Energy's Former Worker Medical Screening Program (April),
  - Webinar - Resource Center Responsibilities and Authorized Representative Service (May),
  - Webinar - Medical Benefit Authorizations (June),
  - Joint Outreach Task Group Event in Aiken, SC (June),
  - Webinar - Energy Compensation Program Tools and Resources (July),
  - Webinar - Site Exposure Matrices (SEM) (August),
  - Webinar - Claim Process and Post Adjudication Actions (September),
  - Webinar - Customer Experience (October), and
  - Webinar - New Billing Authorization Codes for Home and Residential Health Care (November).

In addition, we wish to acknowledge the many instances throughout the year where members of DEEOIC staff assisted claimants and the Ombuds in resolving matters brought to their attention.

INTRODUCTION

Section 7385s-15 of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, requires the Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program to submit an annual report to Congress. *See* 42 U.S.C. § 7385s-15. In this annual report, we are to set forth: (a) the numbers and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and (b) an assessment of the most common difficulties encountered by claimants and potential claimants during that year. *See* 42 U.S.C. § 7385s-15(e). The following is the Office of the Ombudsman's annual report for calendar year 2022.

I. An Overview of the Energy Employees Occupational Illness Compensation Program Act (the EEOICPA)

Congress enacted the EEOICPA as Title XXXVI of Public Law 106-398, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, on October 30, 2000. The purpose of the EEOICPA is to provide for timely, uniform, and adequate compensation of covered employees, and where applicable, survivors of such employees, suffering from illnesses incurred by such employees in the performance of duty for the Department of Energy (DOE) and certain of its contractors and subcontractors. 42 U.S.C. § 7384d(b).

In enacting this program, Congress recognized that:

1. Since World War II, Federal nuclear activities have been explicitly recognized under Federal law as activities that are ultra-hazardous. Nuclear weapon production and testing have involved unique dangers, including potential catastrophic nuclear accidents that private insurance carriers have not covered and recurring exposures to radioactive substances and beryllium that, even in small amounts, can cause medical harm.
2. Since the inception of the nuclear weapons program and for several decades afterwards, a large number of nuclear weapons workers at sites of the Department of Energy and at sites of vendors who supplied the Cold War effort were put at risk without their knowledge and consent for reasons that, documents reveal, were driven by fears of adverse publicity, liability, and employee demands for hazardous duty pay.
3. Many previously secret records have documented unmonitored exposures to radiation and beryllium and continuing problems at these sites across the Nation, at which the Department of Energy and its predecessor agencies have been, since World War II, self-regulating with respect to nuclear safety and occupational safety and health. No other hazardous Federal activity has been permitted to be carried out under such sweeping powers of self-regulation.

See 42 U.S.C. § 7384(a)(1), (2), and (3).

As originally enacted in October 2000, the EEOICPA contained two parts, Part B and Part D. Part B, which is administered by the Department of Labor (DOL), provides the following compensation and benefits:

- Lump-sum payment of $150,000 and the payment of medical expenses (for the accepted illness starting as of the date of filing) for:

  a) Employees of the DOE, as well as its contractors, subcontractors, and employees of atomic weapons employers (AWEs) with radiation-induced cancer if: (a) the employee developed cancer after working at a covered facility; and (b) the cancer is "at least as likely as not" related to covered employment.[1]
  b) Employees who are members of Special Exposure Cohort (SEC) and who develop one of the specified cancers outlined in 42 U.S.C. § 7484l(17).[2]
  c) All federal employees, as well as employees of the DOE, its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and who develop Chronic Beryllium Disease (CBD).
  d) Employees of the DOE or its contractors and subcontractors who worked at least 250 days during the mining of tunnels at underground nuclear weapons test sites in Nevada or Alaska and who develop chronic silicosis.

  If the employee is no longer living, eligible survivors of the employees listed above are entitled to $150,000 in lump sum compensation under Part B.

- Uranium miners, millers, and ore transporters, or their survivors, who are awarded $100,000 under Section 5 of the Radiation Exposure Compensation Act (RECA), 42 U.S.C. § 2210 note, are entitled under the EEOICPA to a lump-sum payment of $50,000 and to medical expenses for the accepted illness.
- All federal employees, as well as employees of the DOE, and its contractors and subcontractors, or designated beryllium vendors who worked at a covered facility where they were exposed to beryllium and whose claims for beryllium sensitivity are accepted under Part B are entitled to medical monitoring to check for the development of CBD.
- Part D of the EEOICPA required the DOE to establish a system by which DOE contractor employees and their eligible survivors could seek assistance in obtaining state workers' compensation benefits if a Physicians Panel determined that the employee sustained an accepted illness as a result of work-related exposure to a toxic substance at a DOE facility. On October 28, 2004, Congress abolished Part D and created Part E as Subtitle E of Title XXXI of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005, Public Law 108-375, 118 Stat. 1811, 2178 (October 28, 2004). Part E is administered by DOL.

[1] An atomic weapons employer is an entity, other than the United States, that: (A) processed or produced, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining and milling; and (B) is designated by the Secretary of Energy as an atomic weapons employer for purposes of the compensation program [EEOICPA]. *See* 42 U.S.C. § 7384l(4).
[2] If a claimant qualifies for inclusion in a SEC class and develops one of the specified cancers, that claimant receives compensation for that specified cancer without the completion of a radiation dose reconstruction by the National Institute for Occupational Safety and Health, and without a determination by DOL of the probability of causation that the cancer was caused by exposure to radiation at a covered facility.

The compensation and benefits allowable under Part E are as follows:

- DOE contractor and subcontractor employees who develop an illness due to exposure to toxic substances at certain DOE facilities are entitled to medical expenses and may receive monetary compensation of up to $250,000 for impairment and/or wage-loss.
- Eligible survivors of DOE contractor and subcontractor employees receive compensation of $125,000 if the employee's death was caused, contributed to, or aggravated by the covered illness. If the employee had between 10 and 19 years of wage-loss, the survivor receives an additional $25,000. If the worker had 20 or more years of wage-loss, the survivor receives an additional $50,000.
- Uranium miners, millers, and ore transporters are eligible for medical benefits, as well as up to $250,000 in monetary compensation for impairment and/or wage-loss, if they develop an illness as a result of toxic exposure at a facility covered under Section 5 of RECA. (These uranium miners, millers, or ore transporters are eligible for compensation and medical benefits under Part E even if they did not receive compensation under RECA).

DOL has primary authority for administering Part B and Part E of the EEOICPA. However, other federal agencies are also involved with the administration of this program.

- The DOE ensures that all available worker and facility records and data are provided to DOL. This includes: (1) providing DOL and/or the National Institute for Occupational Safety and Health (NIOSH) with information related to individual claims such as employment verification and exposure records; (2) supporting DOL, NIOSH, and the Advisory Board on Radiation and Worker Health with large-scale records research and retrieval efforts at various DOE sites; (3) conducting research, in coordination with DOL and NIOSH, on issues related to covered facility designations; and (4) hosting the Secure Electronic Records Transfer (SERT) system, a DOE hosted environment where DOL, NIOSH, and DOE can securely share records and data.
- NIOSH conducts activities to assist claimants and supports the role of the Secretary of Health and Human Services (HHS) under EEOICPA. These activities include: (1) developing scientific guidelines for determining whether a cancer is related to the worker's occupational exposure to radiation; (2) developing methods to estimate worker exposure to radiation (dose reconstruction) and using those methods to prepare dose reconstructions for claimants; (3) recommending that classes of workers be considered for inclusion in a SEC class; and (4) providing staff support for the independent Advisory Board on Radiation and Worker Health that advises HHS and NIOSH on dose reconstructions and SEC petitions.
- The Ombudsman to NIOSH helps individuals with a variety of issues related to the SEC petition process and the dose reconstruction process. The Ombudsman to NIOSH also conducts outreach to promote a better understanding of the EEOICPA, as well as the claims process.

II. The Office of the Ombudsman

Public Law 108-375, which was enacted on October 28, 2004, also established within the DOL an Office of the Ombudsman. The National Defense Authorization Act for 2021, which became effective January 1, 2021, amended the EEOICPA to provide for the permanent extension of the Office of the Ombudsman within DOL. Public Law 116-283, § 3145 (Jan. 1, 2021). The EEOICPA outlines four (4) specific duties for the Office:

1. Provide information to claimants and potential claimants on the benefits available under Part B and Part E, and on the requirements and procedures applicable to the provision of such benefits.
2. Provide guidance and assistance to claimants.
3. Make recommendations to the Secretary of Labor regarding the location of resource centers for the acceptance and development of EEOICPA claims.
4. Carry out such other duties as the Secretary specifies.

See 42 U.S.C. § 7385s-15(c).

The EEOICPA also requires the Office to submit an annual report to Congress which sets forth:

1. The number and types of complaints, grievances, and requests for assistance received by the Office during the preceding year; and
2. An assessment of the most common difficulties encountered by claimants and potential claimants during the preceding year.

See 42 U.S.C. § 7385s-15(e)(2).

Additionally, not later than 180 days after the submission to Congress of the annual report, the Secretary shall submit to Congress in writing, and post on the public Internet website of the Department of Labor, a response to the report that—

(A) includes a statement of whether the Secretary agrees or disagrees with the specific issues raised by the Ombudsman in the report;
(B) if the Secretary agrees with the Ombudsman on those issues, describes the actions to be taken to correct those issues; and
(C) if the Secretary does not agree with the Ombudsman on those issues, describes the reasons the Secretary does not agree.

See 42 U.S.C. § 7385s-15(e)(4).

SUMMARY OF ISSUES AND RECOMMENDATIONS

1. **EEOICPA Awareness and Outreach Efforts**: COVID-19 pandemic-related limitations on in-person gatherings continued to severely limit in-person outreach opportunities in 2022. As in 2020 and 2021, DEEOIC is to be commended for its efforts to provide outreach via monthly online webinars. At eleven webinars held in 2022, attendees were provided information regarding various aspects of the EEOICPA, as well as the roles played by the National Institute for Occupational Safety and Health (NIOSH), the Department of Justice (DOJ), and the DOE Former Worker Programs (FWPs). Attendees also submitted written questions to the panelists during each webinar. However, as noted in our 2020 and 2021 annual reports, those with limited or no internet access were unlikely to be aware of the webinars or able to participate in them.

   In order to promote timely awareness of the EEOICPA, the Ombuds recommends DEEOIC communicate with the DOE FWPs to develop a plan to begin sending direct mailings to former DOE workers who may be unaware of the EEOICPA. The DOE FWP maintains rosters of former DOE workers and the rosters are kept up to date via address-update services. These rosters are the primary method by which the DOE FWPs inform former workers of their eligibility to receive free medical screenings. DEEOIC has previously acknowledged coordination with the DOE FWPs to utilize the rosters to notify former DOE workers of in-person outreach events in their area. However, this limited use of the rosters should be expanded to provide notice of the EEOICPA to any/all former DOE workers, regardless of their proximity to in-person outreach meetings. Given the challenges of outreach during the past three years, it is imperative for DEEOIC to move beyond its previous efforts so that notice of the EEOICPA is provided to all former DOE workers and their families. For example, former DOE workers who do not live close to DEEOIC Resource Centers or near locations where in-person outreach events are regularly conducted are much less likely to learn of the EEOICPA. The Ombuds recommends that the DEEOIC initiate communication with the DOE FWPs in an effort to identify a path forward for enhanced outreach coordination via utilization of the DOE FWP rosters.

   Moreover, there are areas of the country where a sizable number of non-DOE employers are located, and for whom the FWP Projects have no rosters. At last check, there were 190 AWE facilities, seventy-five beryllium vendors, and hundreds of uranium mines, uranium mills, and ore transporters. DEEOIC should develop targeted outreach methods to inform these workers of the EEOICPA, particularly because a considerable number of AWE facilities and beryllium vendors were smaller facilities that were last operational in the 1950s and 1960s. It will require ongoing planning, as well as persistent and purposeful action to reach out to and inform AWE, beryllium vendors, and uranium workers of the EEOICPA. However, such outreach can be conducted in a variety of ways, and the Ombuds encourages DEEOIC to focus such efforts on these groups of workers.

2. **Delays**: In 2022, various types of individuals involved with the EEOICPA brought questions and complaints regarding delays to the attention of the Ombuds, which included unexplained delays, lack of communication that caused delays, and errors that resulted in delays. Others complained about the impact of delays on their ability to obtain medical care or on their financial security. In each instance, the individuals who contacted our office sought assistance in obtaining an update or information on their claim, and/or assistance in finding out why there was a delay in their claim.

   In order for the DEEOIC to confirm whether an employee worked at a covered DOE facility during a covered time period, DEEOIC sends a request to the DOE using the Secure Electronic Record Transfer (SERT) system. In response, DOE uses the SERT system to provide employment records and verification documents to DEEOIC. However, when a breakdown occurs in this process, claimants are usually not informed of the reason for the resulting delay. The circumstances of one particular claim raised the question, if documents are missing from the request sent from DEEOIC to DOE via the SERT system, is there a process for this issue to be brought to the attention of the claims examiner who initiated the request? Other concerns were raised with respect to DEEOIC's delayed request for Document Acquisition Request (DAR) records from DOE, as well as delays caused by the receipt of illegible DAR records from the DOE. It is unclear whether a change has occurred within the SERT system used by DEEOIC and DOE, or whether errors in the utilization of the SERT system resulted in the delays reported in 2022. A closer examination of the employment verification process by DEEOIC, with an eye towards creating a more robust tracking and troubleshooting mechanism to address delays, including the SERT system, is recommended. Likewise, it is recommended that claimants be informed when delays during the employment verification process impact the adjudication of their claims.

   When DEEOIC began distributing claims for adjudication nationally instead of regionally, concerns were raised that the claims staff at some DEEOIC district offices did not have the experience or institutional knowledge to effectively and efficiently adjudicate claims involving particular DOE facilities. For instance, claimants from a cluster of DOE facilities in southern California noted delays in the adjudication of their claims as a result of their employment records not being fully understood by claims staff in the district offices that did not have experience reviewing employment records from their DOE worksites. It was alleged that this lack of understanding caused delays in the employment verification process and in some SEC eligibility determinations. Such delays resulted in claims being referred to NIOSH for dose reconstruction prior to completing verification of employment at different facilities, and issues of benefits being delayed as documents establishing SEC employment were not obtained and reviewed in a timely fashion.

   For claimants with accepted claims who need medical care, delays in the authorization of payment for medical treatment can not only have an impact on their physical and mental health, but on their family members who are supporting them. Claimants and ARs described extensive delays in obtaining authorization of payment from DEEOIC for prescription medications, including chemotherapy. Some of the issues involved repeated requests for the same information from DEEOIC, as well as confusion among numerous DEEOIC personnel during the decision-making process on an individual claim. Claimants and their ARs are seeking more frequent, detailed communication from DEEOIC regarding the status of their claim. They are seeking to know precisely what information or documentation they need to provide DEEOIC in order to have payment of their medical treatment authorized.

For claimants who need home health care services, it would be beneficial for DEEOIC to publish a timeline in the PM indicating when a decision regarding their request for benefits (or reauthorization of benefits) will be provided. Claimants and their ARs reported delays in authorization for home health care benefits and expressed frustration due to the lack of information from DEEOIC regarding when they could expect a decision. For those being discharged directly from a hospital to a rehabilitation facility or residential care facility, an additional step is added to the authorization process in that a triage nurse with the bill-pay contractor is to be contacted prior to seeking authorization from the claimant's MBE. The Ombuds received complaints that the triage nurse was not always available when attempts to contact him/her were made, including in one case where 65 days had passed without a determination on the emergency request. It would benefit claimants for a timeline regarding the adjudication of HHC benefits, particularly emergency HHC benefits, to be shared and/or incorporated into the PM. It would also be helpful for the role of the triage nurse to be defined and explained in the PM, and for materials to be provided to claimants and HHC providers regarding this entire process. Moreover, claimants and HHC providers would benefit from updates when a determination on an authorization request was delayed, along with being provided a reasonable expectation regarding when a determination will be issued.

When claimants receive a letter decision denying their request for benefits, claimants have asked the Ombuds whether there is a timeline for a recommended decision to be issued to them after they have requested one. Other claimants have simply asked the Ombuds what happens after they receive denial letter because they did not appreciate the meaning of the italicized language in the letter and time has passed since they last heard from DEEOIC. It would be helpful for DEEOIC to provide claimants with a timeline for when they can expect to receive a recommended decision following a HHC denial letter or when a claim for HHC benefits is being denied. ARs and claimants' family members trying to plan for the care of the claimant at home have reported additional stress due to the uncertainty surrounding when they might receive a formal determination (recommended decision) from DEEOIC.

With respect to payment or reimbursement for medical bills, some claimants seek guidance and assistance regarding a single outstanding medical bill. However, in 2022, the Ombuds also received requests for assistance from those with significant outstanding medical bills covering treatment for lengthy periods of time. Claimants who had received organ transplants to treat their covered illnesses complained of insufficient and inefficient assistance from DEEOIC and the bill-pay agent in resolving long-standing medical billing problems. The ARs for these claimants were their spouses, both of whom reported frustration, stress, and fear of financial insecurity due to the threat of the outstanding bills being turned over to collection agencies. Another instance brought to the Ombud's attention highlighted the fact that some individuals are sued by health care providers over outstanding medical bills that had been submitted to DEEOIC for payment. An AR/child of a claimant who passed away with outstanding medical bills was sued by the claimant's health care provider after extensive delays in receiving payment from DEEOIC. The AR/child was forced to hire an attorney to represent him/her in court and then paid the bills in full in order to avoid further legal action. Finally, a number of months later the executor shared that DEEOIC was processing the bills he/she had paid.

DEEOIC should consider developing a position and unit to specifically assist claimants as they navigate this very complicated process. The Ombuds appreciates the work of the Resource Center staff and MBEs, but given the broad responsibilities of these positions, suggests that DEEOIC dedicate resources to specifically assist claimants and health care providers who find themselves attempting to resolve billing issues for months or years at a time. Delays in the resolution of outstanding bills are often the result of a few different issues that repeatedly arise in the bill-pay process. It is important for DEEOIC to respond to claimants, their ARs, and executors of claimants' estates in a timely fashion. DEEOIC is uniquely situated, and some claimants would argue, should be responsible for recognizing and taking action to address these ongoing complaints, particularly for those individuals who experience delays in the payment of medical bills that result in referrals to collection agencies.

When a claimant is at the end-stage of an illness, DEEOIC has policies and procedures to expedite the processing of these claims. For some families, after requesting expedited processing of the claimant's claim for benefits, DEEOIC had responded by asking for additional medical evidence to support the severity of the claimant's prognosis. The ensuing delays in obtaining a terminal designation can then place family members in the uncomfortable position of spending time attempting to generate additional medical evidence of the claimant's prognosis while wishing to spend as much time with their loved one as possible. The Ombuds has been informed by ARs that at times, the DEEOIC staff member's assessment of the medical evidence and their communication regarding the additional evidence needed lacked sound medical judgment as well as sensitivity. In 2022, DEEOIC requested additional, more specific medical evidence, regarding the prognosis of a claimant with grade 4 glioblastoma and a claimant who had been admitted to hospice care, which by definition means the individual has a life expectancy of 6 months or less.

Given the frequency with which this issue is raised by claimants' families and ARs, additional information regarding how DEEOIC assesses the medical evidence submitted to support a terminal designation is needed. Absent further clarification, it appears that some DEEOIC staff may have interpreted the guidance in the PM to mean a specific timeframe or timeline must be provided with respect to the prognosis. While the PM does not indicate a life expectancy timeframe that a physician must include in their documentation of the claimant's prognosis, it would be helpful for the PM to explicitly include this information. The delays caused by additional development of such requests continue to have an impact on the claimants and their families, and the Ombuds recommends further clarification of the policy and procedures by DEEOIC in order to mitigate, if not avoid, delays going forward.

3. **Need for Assistance**: Difficulties finding health care providers willing to accept payment from DEEOIC was a recurring theme for claimants. This issue was brought to the attention of the Ombuds from claimants in three general groups. The first group was claimants who lived in rural areas and already had fewer health care providers available to treat them, making the task of finding one that accepted payment from DEEOIC all the more challenging. The second was claimants who lived in suburban or urban areas, where they faced issues identifying providers who accepted payment from DEEOIC or had been informed by their existing health care providers that they were no longer accepting payment from DEEOIC. The third was claimants who were seeking treatment in a residential care setting, whether it was for a short-term stay following a period of hospitalization or for long term care. The value of medical benefits coverage for an accepted illness under EEOICPA is significantly limited when claimants are unable to find health care providers willing to accept payment from DEEOIC. In certain areas of the country,

when a physician or medical group decides to no longer accept payment from DEEOIC, claimants find themselves unable to use this benefit. It would be helpful for claimants to have the ability to receive a list of physicians, by name, in their area who are currently accepting payment from DEEOIC. It would also be helpful for claimants if DEEOIC sought to find out why some health care providers no longer accept payment from DEEOIC and endeavored to reestablish the business relationship.

DEEOIC has a number of online resources that can be accessed by the public, claimants, ARs, and health care providers. Claimants and ARs complained to the Ombuds regarding difficulties in registering to access the ECOMP and EDP, as well as difficulties uploading documents into the EDP. ARs specifically complained of limitations on the amount of documents that could be uploaded to a claim file at one time using the EDP. Moreover, claimants complained of difficulties when attempting to upload documents into the EDP.

The Ombuds also heard from claimants and their ARs that the claim status page in ECOMP did not always accurately reflect the status of a claim, nor did it contain sufficient detail with respect to the claim status history. Moreover, another common challenge posed by ECOMP is that the portal does not contain certain broad categories of documents that are located in claim files. ECOMP does not provide the claimant access to claim file records from NIOSH, any records from the DOE, or any documents that were originally in paper form that were scanned into an electronic format. Thus, when claimants seek assistance from the Ombuds regarding issues such as covered employment, toxic exposure, Part E causation, and diagnostic medical evidence, claimants are unable to readily access these claim file records in ECOMP. DEEOIC should inform claimants of the existence of these categories of records in their claim files that are not found in ECOMP and should advise claimants how they can obtain copies of these records in the very beginning of their claims process.

Finally, the Medical Bill Processing Portal and the Provider Search Tool were the most challenging for claimants and ARs to access and navigate in 2022. Claimants and ARs who did not have a background in medical billing reported that the Medical Bill Processing Portal was not easy to navigate or user-friendly when it came to identifying issues with medical bills that had been submitted for approval. The challenges of using the Provider Search Tool included difficulties using the filters in the search tool to produce a reasonable number of search results.

It appears that based upon the complaints brought to the attention of the Ombuds, that a small percentage of DEEOIC staff are responsible for the majority of the complaints regarding inappropriate or rude behavior. The issues involving claimants' difficulties being connected to the correct person to address their questions or of not having telephone calls returned in a timely fashion were more widespread.

Unfortunately, the DEEOIC website and the written materials disseminated by DEEOIC do not contain information notifying the public where and how to file complaints or concerns regarding poor customer service. Moreover, claimants and their ARs continued to express fear of retaliation should they share a complaint or concern about a CE, MBE, or RC staff person with someone in the same office, let alone the person they have a complaint about. Likewise, it has been shared with the Ombuds that after a complaint or concern is shared, there is no mechanism or timeframe within which the claimant can expect a response from DEEOIC. In some instances, claimants are even reluctant to share customer service-related

complaints or concerns with the Office of the Ombudsman due to a lack of trust in the government as a result of their own earlier work for the government. Thus, having a publicly stated process by which claimants and EEOICPA stakeholders can lodge specific complaints without fear of retaliation, and with an understanding of when and how they will receive a response from DEEOIC, would allow for enhanced communication between claimants and DEEOIC regarding their case-specific concerns.

Many claimants have expressed to the Ombuds that they did not know the difference between the RC staff person who answered their call and their CE, MBE, or HR, because the role of the individual they had spoken with had not been made clear. It was also unclear to claimants and ARs that the RC staff do not make decisions or determinations regarding their claims for benefits. Thus, when a claimant is provided information by a RC staff member, some claimants mistakenly believe that the RC staff person was the person who would be issuing a decision on their claim. Furthermore, when a claimant had subsequent questions, there was no guarantee they would be routed to the same RC staff person when they called back. It would be helpful for EEOICPA stakeholders if all calls were answered in a way that identified the location and role of the person the caller had reached, as well as how to contact them again for follow up assistance. As the role of the RC staff has significantly expanded over the past few years, it would be helpful for EEOICPA stakeholders to still have the option to contact their CE, HR, and/or MBE directly regarding certain questions and issues.

4. **Lack of Clarity and Consistency**: Since DEEOIC transitioned away from allowing claimants to directly call their CEs, MBEs, and HRs, the Ombuds has noted an increase in the number of individuals who reported that they do not know who they were speaking with when they called one of the main DEEOIC telephone numbers. Based upon feedback from claimants and ARs, it appears that the RC staff did not always identify the location of the RC office the caller had reached, and instead provided a general greeting indicating the caller had simply reached the DEEOIC. Thus, individuals who believed they were calling a district office, medical benefits office, or a final adjudication branch office to speak to their case worker were sometimes unaware that they were speaking to someone who had not been assigned to work on their case, and who was not in the same office as their case worker. Individuals also complained that they were unable to speak to the same person twice as a result of their calls being routed to the various RCs. It is important for EEOICPA stakeholders to clearly understand who they are speaking with, where that person is located, and the person's role in the EEOICPA claims process. Sometimes there can be "too many cooks in the kitchen" and the effect on claimants is confusion and a lack of clarity when it comes to who to contact regarding specific claim-related questions.

   The requests for assistance and guidance regarding DEEOIC policies and procedures were wide-ranging, from questions regarding how DEEOIC contract industrial hygienists evaluate evidence and reach their opinions on toxic substance exposures, to questions about the policy for hearing loss, to questions regarding eligibility for impairment compensation or certain medical benefits. Therefore, with such a large body of guidance published by DEEOIC regarding the claims adjudication process, claimants and ARs found it challenging to keep current and understand how the latest DEEOIC policy guidance may be implemented in their claim.

As in 2021, an area of concern for claimants and their ARs was the use of language by DEEOIC contract IHs that was similar to the language of rescinded Circular No. 15-06. While DEEOIC policy guidance issued in October 2022 may have eliminated the "exposures within regulatory limits" language from IH reports, the reports have continued to state that significant exposures to toxic materials at DOE facilities was greatly reduced after the mid- 1990s, and that any work processes, events, or circumstances leading to a significant exposure would likely have been identified and documented in employment records. To date, the conclusions reached by IHs asked to review the toxic exposures of workers with DOE employment after the mid-1990s often remain the same, i.e., in the absence of documentation of a workplace exposure violation or incident, any workplace exposures were not significant and were incidental or, in passing only. In the absence of exposure documentation from DOE, IHs consistently noted that claimant's exposures occurring after the mid-1990s were not significant, which in turn formed the basis for a CMC's negative causation opinion. The updated language DEEOIC has provided to IHs to assess claims with employment after the mid-1990s appears to be causing confusion and requires further clarification regarding its meaning and usage.

DEEOIC first created policy criteria for the acceptance of bilateral sensorineural hearing loss (hearing loss) claims in 2008, and this policy has undergone a number of updates since then, including most recently in October 2022. From the initial publication of the policy, the Ombuds has received complaints, concerns, and requests for assistance with respect to the policy criteria itself, as well as questions regarding what action DEEOIC does or does not take following a policy change. In many cases, the policy criteria have been strictly interpreted by CEs and HRs to mean that if claim file evidence failed to meet the three components of the hearing loss criteria, the claim was denied without further evaluation of the evidence to determine if it was at least as likely as not that exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the claimed hearing loss.

On October 20, 2022, the DEEOIC updated the hearing loss employment criteria in Version 7.0 of the PM. This update appeared to apply to a claimant's case that had been brought to the attention of the Ombuds, and so the Ombuds informed the claimant's AR of the new policy language. The AR inquired as to whether DEEOIC would be automatically conducting a review of claims that could be impacted by the policy update, but DEEOIC had not indicated such a review would be conducted. The Ombuds informed the AR in this case, and all others similar to it, that it would be best for them to take action if they wished to have the claim further reviewed. Unfortunately, claimants with denied hearing loss claims are unaware of whether DEEOIC will be, 1) notifying them of the updates to the hearing loss policy, and 2) reviewing previously denied hearing loss claims to identify those that could be impacted by the updated policy. The Ombuds recommends that DEEOIC notify all claimants with previously denied hearing loss claims of all policy updates that may impact their claims.

5. **Other Issues and Complaints**: When claimants receive any type of correspondence from DEEOIC, they expect to be provided information that allows them to understand what is happening with their claim, and why their claim is or is not in a posture to be accepted. For example, when DEEOIC sends a letter to a claimant requesting additional evidence, claimants expect to be informed what they need to provide to DEEOIC and how that evidence is necessary to support their claim. In decisions, claimants expect to see a discussion of the evidence in the claim file and an explanation of how the

claims examiner weighed that evidence when reaching their conclusions. Moreover, if decisions do not identify the evidence submitted by claimants in support of their claims, or do not weigh the evidence so claimants can understand the conclusions reached by the claims examiner, not only are claimants unaware of why their claims were denied, but the decisions are inconsistent with DEEOIC policy. Absent a clear understanding of the deficiencies in their claim, claimants struggle to produce relevant evidence within the timeline they are provided on appeal. The Ombuds encourages DEEOIC to specifically assess whether decisions denying benefits include a discussion of the evidence submitted and an explanation of how that evidence was weighed in reaching the conclusions.

Most claimants and ARs do not check online for DEEOIC policy or program updates. It would be beneficial for all claimants to be notified of policy updates that could impact their claims. Likewise, it would be beneficial for DEEOIC to publish a policy clearly stating whether claims will be automatically identified and reviewed by DEEOIC when a new or updated policy could have an impact on previously adjudicated claims. Claimants and ARs have expressed the general concern that communication from DEEOIC primarily consists of requests for information and evidence but does not provide sufficient information and guidance for claimants to meaningfully participate in the processing of their own claims. Notifying claimants of new or updated policies that could impact their claims, as well as creating a procedure to identify when and how policy updates will trigger DEEOIC's automatic review of previously denied claims would be beneficial for all claimants. Finally, when a claim is impacted by a new policy or procedure, claimants want to understand the reasoning/rationale for this change. Claimants want the opportunity to review the policy and the documentation relied upon in making the change (or to have their own experts review the policy and underlying documentation). When claimants are not provided an opportunity to fully review these determinations, they sometimes come up with their own explanations for these changes. And when this happens, some claimants conclude that the change was specifically made in order to deny their claim.

TABLES

Background

The Office of the Ombudsman is required to submit to Congress an Annual Report that sets forth: (1) the number and types of complaints, grievances, and requests for assistance that we receive in the preceding year, and (2) an assessment of the most common difficulties encountered by claimants and potential claimants received in the preceding year. 42 U.S.C. § 7385s-15(e)(2). Setting forth the number and types of complaints, grievances, and requests for assistance that we receive in the calendar year is sometimes a challenge.

First, each claimant who we encounter comes with their own unique set of problems which they articulate to us in their own unique manner. Under these circumstances identifying the type or nature of a complaint can be difficult since claimants rarely express their concerns using the terms and phrases commonly utilized by those who administer the program.

Second, the Office typically attends approximately 20 to 25 in-person outreach events each year, and at those events we hear from many potential claimants, claimants, authorized representatives (AR), and health care providers. Meeting in person affords us the time to connect with individuals and hear not only their initial questions or concerns, but their whole story, which frequently reveals additional questions, concerns, and requests for assistance. During 2022, as a result of the cancellation of all in-person outreach events except one, our opportunities to connect with and to assist the claimant community at in-person outreach events were largely eliminated.

Moreover, when our Office hosts in-person outreach events, we routinely send invitations to those living in a large geographical area around each event location. While those who live farther away from the event location may not be able to attend the event itself, we have found that many people contact our Office by telephone or email after receiving notice of the event. And it is in these conversations that we also hear the questions and complaints of claimants in that particular area of the country. Furthermore, identifying the specific complaints, grievances, and/or requests for assistance raised by claimants is generally achieved by asking questions, and obtaining additional documents that shed light on the claimants' concerns.

The inability of our Office to host in-person outreach events in 2022 had an impact on the number of individuals we communicated with and assisted. In the table that follows, the focus is on the concerns or requests that prompted the individual to contact us, and not necessarily every issue discussed during the conversations.

table continued on next page

TABLE 1
COMPLAINTS, GRIEVANCES, AND REQUESTS FOR ASSISTANCE

NATURE OF COMPLAINT	NUMBER OF COMPLAINTS
Difficulties filing a claim for EEOICPA benefits	**5**
Difficulties collecting records/evidence	
Employment records	23
Exposure records	7
Concerns with the dose reconstruction	5
Concerns with information found in SEM	2
Difficulties establishing causation	**11**
Information missing in SEM database	7
Complaints regarding CMC reports	7
Complaints regarding IH reports	9
Complaints regarding weighing of evidence, particularly claimant's evidence	7
Complaints regarding CBD under Part B	9
Complaints regarding diagnosis of sarcoidosis/CBD	4
Difficulties establishing a diagnosed medical illness	**3**
Difficulties establishing a consequential illness	**8**
Difficulties establishing eligibility in SEC class or diagnosis of a specified cancer	**11**
Difficulties establishing survivorship eligibility	**10**
Difficulties establishing terminal status	**7**
Requests for assistance	**55**
Request for status of claim	9
Request for assistance with a RECA claim	3
Request for assistance completing Form EN-16	2
Request for statutory or regulatory updates	7
Customer Service	
General concerns/complaints	26
Difficulties reaching DEEOIC contact – e.g., claims examiner, medical benefits examiner	18
Telephone calls not returned	14
Insensitive or rude behavior	8
Delays in claim processing	38
Technical issues – ECOMP portal, Energy Document Portal (EDP), Medical Bill Processing Portal	5
Difficulties with obtaining hearing transcripts	2

table continued on next page

TABLE 1, cont'd.

NATURE OF COMPLAINT	NUMBER OF COMPLAINTS
Complaints	
Complaints regarding NIOSH dose reconstruction	12
Complaints involving claims for impairment benefits	15
Complaints concerning the cap on compensation benefits	1
Complaints regarding interactions with a health care provider	1
Complaints regarding death of employee prior to award of benefits	3
Complaints regarding DEEOIC's application of policy or procedure	**15**
Limit on number of toxins referred to an IH for review	3
Hearing Loss	7
Covid-19 as a consequential illness	5
Other presumptions	6
Election of benefits for survivor claim	2
Medical Benefits	
Difficulties using medical benefits card	4
Delayed receipt of medical benefits card	2
Difficulties finding a medical provider	6
Difficulties obtaining pre-authorization for medical treatment	11
Denial of medical benefits	3
Issues involving home health care benefits	11
Issues involving durable medical equipment	6
Issues with obtaining prescription medication	1
Medical Billing	
Difficulties obtaining payment of medical bills	17
Complaints regarding medical billing contractor	5
Complaints regarding Medicare paying bills for treatment of accepted DEEOIC medical condition	5
Medical bill coding issues	6
Medical travel reimbursement issues	3
Difficulties obtaining payment for deceased employee's medical bills	3
Reconsideration/Reopening Issues	**5**
Statutory and Regulatory Concerns	**9**
TOTAL	**489**

TABLE 2
CONTACTS BY FACILITY

In order to assist claimants, it is not always necessary to identify the facility where the worker was employed. Moreover, even when identifying the facility is necessary, this does not suggest any fault on the part of the facility. Rather, the intent of the Table of Facilities is to illustrate the reach of this program and the need for more outreach. Claimants who worked at facilities all across this country contact us with complaints, grievances, and requests for assistance. Some of the facilities in this Table employed large numbers of employees, while others employed smaller numbers. Some operated as covered facilities for many years, while others engaged in covered employment for a relatively brief period of time. Yet, regardless of the size of the facility or the number of years it operated as a covered facility, there are those who work, or once worked, at these facilities who have questions and concerns that need to be addressed.

FACILITY	LOCATION	NUMBER OF COMPLAINTS
Allied Chemical Corp. Plant	Metropolis, IL	2
Amchitka Island Test Site	Amchitka Island, AK	1
Area IV of the Santa Susana Field Laboratory	Santa Susana, CA	5
Carpenter Steel Co.	Niagra Falls, NY	1
Canoga Avenue Facility	Fernald, OH	5
De Soto Avenue Facility	Cincinnati/Evendale, OH	5
Feed Materials Production Center	Fernald, OH	4
Hanford	Richland, WA	6
Idaho National Laboratory	Scovile, ID	2
Kansas City Plant	Kansas City, MO	2
Kerr-McGee Mining Co.	Crescent, OK	1
Lawrence Livermore National Laboratory	Niagara Falls, NY	2
Los Alamos National Laboratory	Los Alamos, NM	3
Nevada Test Site	Mercury, NV	3
Norton, Co.	Worcester, MA	1
Oak Ridge	Oak Ridge, TN	2
Oak Ridge Gaseous Diffusion Plant (K-25)	Oak Ridge, TN	1
Oak Ridge National Laboratory (X-10)	Oak Ridge, TN	5
Oak Ridge Y-12 Plant	Oak Ridge, TN	4
Pacific Northwest National Laboratory	Richland, WA	1
Paducah Gaseous Diffusion Plant	Paducah, KY	11
Pinellas Plant	Clearwater, FL	3
Portsmouth Gaseous Diffusion Plant	Piketon, OH	3
Riverton Uranium Mill	Riverton, WY	1
Rocky Flats Plant	Golden, CO	15
Sandia National Laboratories	Albuquerque, NM	2
Savannah River Site	Aiken, SC	37
Uranium Mines	Various Locations	4
Wah Chang	Albany, OR	1
TOTAL		**133**

CHAPTER I.
EEOICPA AWARENESS AND OUTREACH EFFORTS

Since the EEOICPA was implemented in 2001, some of the most common ways by which individuals who worked in our nation's nuclear weapons programs have learned of the EEOICPA have been by attending in-person outreach events, outreach conducted by the DEEOIC's Resource Centers, and word of mouth.

A. DOE Former Worker Medical Screening Program (FWP) Employee Rosters

In the 2013 Annual Report to Congress, the Ombuds noted that outreach events hosted by the Joint Outreach Task Group (JOTG)[3] in Livermore and Emeryville, California, were largely successful because the DOE's FWP utilized their DOE employee rosters to directly mail former workers an invitation to the meetings.[4] Each year since 2014, the Ombuds has reported to Congress that direct mailings to potential claimants would be a more effective and efficient method of informing potential claimants of the existence of the EEOICPA. Moreover, utilization of the DOE FWP Projects rosters beyond notifying former workers of upcoming in-person JOTG outreach events is increasingly important for two reasons.

First, there is no statute of limitations in the EEOICPA, meaning there is no time limit on when a person can file a claim. A potential claimant who worked at a covered facility 30 or 40 years ago can file a claim at any time and will not be barred because too much time has passed. However, the population of employees who worked in the nuclear weapons complex in the 1940s, 1950s, and 1960s, and are potentially eligible for benefits, has decreased since 2000. Thus, while it is never too late for a former worker to file a claim for benefits, they must first be aware of the EEOICPA in order to do so. Unfortunately, the Ombuds continues to encounter former workers who are only now learning of the EEOICPA.

Second, the COVID-19 pandemic has had a significant impact on in-person outreach events where potential claimants have an opportunity to learn of the EEOICPA program. Since 2009, the JOTG agencies have coordinated a number of in-person outreach events, but due to the pandemic, all in-person outreach was halted in March 2020. No JOTG sponsored in-person outreach events were held in 2021, and only one was held in 2022. Likewise, the individual agencies that comprise the JOTG almost entirely halted their respective in-person outreach events through 2022. DEEOIC pivoted to hosting monthly webinars in June 2020, and the DOE FWPs also conducted its first webinar in October 2022. Email distribution lists were utilized by DEEOIC and the FWP Projects to provide notice of the webinars to those who had signed up to receive emails from DEEOIC and the FWP Projects. However, the email distribution lists are not as effective at targeting individuals who have never heard of the EEOICPA because in order to be added to the email distribution list, individuals on the list must consent to receiving emails from the agencies.

[3] The Joint Outreach Task Group is comprised of DEEOIC, DOE, DOE FWPs, DOJ, NIOSH, the Office of the Ombudsman for the EEOICPA, and the Ombudsman for NIOSH.
[4] *See* Office of the Ombudsman 2013 Annual Report to Congress. https://www.dol.gov/sites/dolgov/files/ombudsman/annualreport/2013.pdf.

The webinars provided attendees an opportunity to learn about specific EEOICPA-related topics and pose written questions to agency leaders. However, as noted in the 2021 annual report, it is unlikely that those without reliable internet access learned of the webinars or were able to attend. This is particularly true for areas of the country where internet service is spotty or for those who cannot afford internet service or the devices necessary to participate in online events. Claimants of advanced age have also frequently informed our office that they do not own or use personal computers or other such devices. In contrast, the FWP Projects' primary method of outreach is direct mailing to former workers inviting them to participate in the medical screening program.[5] Despite the absence of a centralized database of former DOE workers, the DOE Office of Environment, Health, Safety & Security works closely with DOE Headquarters program offices to obtain employee rosters from site contractors and field/site offices.[6] The FWP Projects send invitations to former workers using their last known address, and when addresses are inaccurate or outdated, address-update services are used to obtain current contact information.[7] During the time period from 1997 through September 2022, the FWP Projects have provided conventional screening exams to 97,992 participants.[8] Given the total participation of 97,992 former workers, it can be assumed that the six FWP Projects have directly mailed hundreds of thousands of invitations to former workers since 1997.[9]

The Ombuds does not know if the DEEOIC, DOE, or FWP Projects maintain statistics regarding the number of FWP participants who have filed a claim for benefits under the EEOICPA. However, based upon the increased participation at outreach events where the FWP Projects have utilized their rosters to directly mail notice of the event to former workers, it is apparent that some former workers are being reached beyond those who have already filed a claim for EEOICPA benefits.[10]

The Ombuds has consistently recommended direct mailings to potential claimants as a more efficient and effective way of informing potential claimants of the EEOICPA, especially those who do not live near a Resource Center or the location of an outreach event. Moreover, the Ombuds is unaware of any other agency or entity besides the FWP Projects that maintain rosters of individuals who worked in our nation's nuclear weapons complex.

In 2021, the Ombuds recommended DEEOIC expand its efforts to directly contact those who do not live within the mailing radius for an in-person outreach event by requesting assistance from the FWP Projects to contact former workers directly utilizing the FWP rosters. As further noted in the 2021 annual report to Congress, while contacting as many of the thousands of former workers as possible (and as soon as possible) is the goal, it is one that can be achieved in stages with thoughtful coordination and planning, and hopefully with the highest priority given to those areas where no

[5] The DOE's FWPs began providing free medical screening examinations for former DOE federal, contractor, and subcontractor workers in 1997. The FWP medical screening exams check for potential adverse health effects caused by exposures to radiation, beryllium, asbestos, silica, welding fumes, lead, cadmium, chromium, solvents, noise, and other toxic substances and hazardous conditions. *See* **https://www.energy.gov/ehss/former-worker-medical-screening-program-0**

[6] *See* **https://www.energy.gov/ehss/former-worker-medical-screening-program-0**

[7] The FWP Projects also periodically checks the list of workers' names against the National Death Index to ensure they do not send letters of invitation to deceased individuals. Ibid.

[8] *See* **https://www.energy.gov/ehss/former-worker-medical-screening-program-0.**

[9] The DOE FWP includes four regional projects located near major DOE sites, and two nationwide projects. The regional projects are: Pantex Former Worker Medical Surveillance Program, Medical Exam Program for Former Workers at Los Alamos and Sandia National Laboratories, Worker Health Protection Program, and Former Burlington Atomic Energy Commission Plant and Ames Laboratory Workers Medical Screening Program. The two nationwide projects are: National Supplemental Screening Program and Building Trades National Medical Screening Program. *See* 2020 Former Worker Medical Screening Report.

[10] The DEEOIC mails notice of upcoming outreach events to people who have already filed a claim for benefits under the EEOICPA. Thus, direct mailings by DEEOIC only reach those who are already aware of the EEOICPA.

outreach has been conducted to date. Given the challenges of the past three years, it is imperative for DEEOIC to move beyond its previous efforts to provide timely notice of the EEOICPA to all workers and their families.

In response to the Ombuds 2021 recommendation in this regard, DEEOIC stated,

> **[T]he Energy program does not have access to the DOE/FWP mailing lists, as they contain Personally Identifiable Information and are the property of DOE. The Energy program has no authority over DOE to require the DOE/FWP to send outreach materials, invitation letters, or educational materials to employees on their mailing lists; however, DEEOIC does ask the DOE/FWP to assist us with mailing materials whenever they deem such mailings appropriate and feasible. DEEOIC is open to further discussion with DOE/FWP to explore opportunities for collaboration to reach out to existing and former DOE workers.** *See* DOL's Response to the Office of the Ombudsman's 2021 Annual Report to Congress.

The Ombuds is encouraged by DEEOIC's openness to discuss exploring opportunities for collaboration to reach out to existing and former DOE workers. Former workers who played a role in building the nation's nuclear weapons complex, beginning with the Manhattan Project, now live all across the United States, and with each passing year it becomes increasingly important for those who do not live near one of the DEEOIC Resource Centers or in one of the communities where in-person outreach events are routinely conducted, to be directly notified of the EEOICPA. Delayed notification of the EEOICPA often results in claimants experiencing greater difficulties providing the medical, employment, and/or toxic exposure documentation necessary to prove their claim, and always results in their benefits being delayed until they file their claim for benefits.[11] Surviving children of former workers also face a narrower path to benefits under Part E of the EEOICPA than worker's or their surviving spouses. Prompt notice of the EEOICPA avoids the negative impact to a claim filed by the former worker and/or their surviving spouse had they received prompt notice of the EEOICPA. It is the Ombuds belief that over the past two decades, had DEEOIC sought to forge an agreement or understanding with the FWP Projects to mail notices and information directly to all the former workers on its rosters, it is likely that far more individuals and/or their survivors would have learned of the EEOICPA.

B. Outreach by Word of Mouth

An additional, welcome byproduct of in-person outreach events has been that when newspaper and/or radio advertisements are released leading up to the event, those who did not receive an invitation in the mail can still potentially learn of the event.[12] Additionally, people who see or hear the advertisements sometimes pass the information along to family or friends who may have an interest in attending. However, the effectiveness of word of mouth as a method of informing potential claimants of the EEOICPA has distinct limitations, such as only those living in the geographic area where the event is being held will see or hear the ads or be in the right place at the right time to see or hear

[11] For a claimant with an approved claim, the EEOICPA states that their medical benefits begin on the date the claim form is filed. Therefore, where a claimant's accepted medical condition was diagnosed and medical bills were incurred for treatment prior to the filing of a claim for benefits, only those medical bills incurred on or after the date the claim form was filed will be covered by DEEOIC.

[12] It is the understanding of the Ombuds that DEEOIC has utilized press releases and newspaper notices with greater frequency than radio advertisements when advertising for in-person outreach events.

an advertisement, or to learn of the event from someone else who heard or saw an advertisement. Furthermore, the information shared by word of mouth is not always accurate or complete, and the Ombuds has been contacted by individuals who are disappointed to learn the EEOICPA is more complex than they were lead to believe or does not cover all employees for all illnesses at all facilities.[13] For those people who have only heard mention of the EEOICPA in passing, or never heard of it at all, direct mailings and in-person outreach events remain some of the most successful means of informing these individuals of the program.

C. AWE, Beryllium Vendors, and Uranium Workers

There remain areas of the country where the eleven DEEOIC Resource Centers have not conducted outreach, and where no in-person outreach events have been held. Former DOE workers likely reside in these areas of the country, and targeted, direct mailings informing them of the EEOICPA would ensure that they receive notification of this important compensation program. Likewise, there are areas of the country where a sizable number of non-DOE employers[14] are located, and for whom the FWP Projects have no rosters. At last check, there were 190 AWE facilities, seventy-five beryllium vendors,[15] and hundreds of uranium mines, uranium mills, and ore transporters. DEEOIC should develop targeted outreach methods to inform these workers of the EEOICPA, particularly because a considerable number of AWE facilities and beryllium vendors were smaller facilities that were last operational in the 1950s and 1960s. Individuals who worked at these locations, as well as their family members, may struggle to be aware of the EEOICPA as a federal workers' compensation program for which they may qualify unless the outreach is specific and targeted to them. For example, prior to an outreach event near an AWE facility in West Valley, New York, a number of years ago, a woman who had received an invitation called the Ombuds and complained that she did not understand why the Department of Labor was still sending invitations to her and her mother. However, during the course of the conversation with the Ombuds, the caller realized that while her mother's claim for survivor benefits had previously been denied based upon her father's employment at a DOE facility, the caller herself had actually worked at the AWE facility that was the focus of the outreach event. The caller knew her prior employer, the AWE facility, by a different name and was surprised to learn that she was potentially eligible for benefits under the EEOICPA. In this instance, the combination of the invitation and a call to the Ombuds were needed before this woman realized she was potentially eligible for benefits as a former AWE employee. It will require ongoing planning, as well as persistent and purposeful action, to reach out to and inform AWE, beryllium vendor, and uranium workers of the EEOICPA. However, such outreach can be conducted in a variety of ways, and the Ombuds encourages DEEOIC to focus such efforts on these groups of workers.

[13] This scenario commonly occurs, for example, when a former AWE employee or their surviving family member contacts the Ombuds regarding a claim for benefits, and is disappointed to learn that AWE employees are only covered for cancer under Part B of the EEOICPA and not any other Part B illnesses or any illness under Part E.

[14] Non-DOE employers include atomic weapons employers, beryllium vendors, uranium mines, uranium mill, and uranium ore transporters.

[15] The DOE created a Facility List database to provide public access to summaries of information collected on the facilities listed in the Federal Register. The summary for each facility includes the facility name, state, location, time period, facility type, and facility description. **https://ehss.energy.gov/Search/Facility/findfacility.aspx**.

CHAPTER II.
DELAYS

In 2022, various types of individuals involved with the EEOICPA brought questions and complaints regarding delays to the attention of the Ombuds, which included unexplained delays, lack of communication that caused delays, and errors that resulted in delays. Others complained about the impact of delays on their ability to obtain medical care or on their financial security. In each instance, the individual who contacted our office sought assistance in obtaining information, an update on their claim, and/or assistance in finding out why there was a delay in their claim.

A. Employment Verification

When a person files a claim for benefits under the EEOICPA, one of the forms that are required to be completed is the Employment History for a Claim under the EEOICPA (Form EE-3). The claimant fills out the name of the facility where the employee worked, the dates they worked there, and other relevant employment information.[16] The DEEOIC claims examiner (CE) then takes action to verify the employment information on the Employment History form. In some cases, the employment verification process is simple and straightforward. In others, particularly claims where subcontractor employment is involved, the process can be challenging due to the fact that many DOE subcontractors did not provide employment records to the DOE, and therefore DOE has fewer records to search. Moreover, whether the employer was a DOE facility, AWE, or beryllium vendor also determines how a CE will proceed to verify the claimed employment.

One of the first actions a CE takes to verify claimed DOE employment is a search of the Oak Ridge Institute for Science and Education (ORISE) database. "A CE will consider the data in ORISE accurate and valid employment information, even if it only provides partial affirmation of claimed employment." *See* EEOICP Procedure Manual (PM), Chapter 13.7 (Version 7.0) (October 20, 2022). Thus, if the CE's search of the ORISE database confirms all or some of the claimed employment, the CE needs to take no further action to verify that employment.

If the CE cannot verify the claimed employment through ORISE, the CE submits an employment verification form (Form EE-5) to the DOE[17] through the Secure Electronic Record Transfer System (SERT).[18] The DOE then conducts a search of available records and responds to the CE via the SERT. If the CE does not receive a response from the DOE within 30 days, the CE sends a reminder to the DOE Operations Office through the SERT using the "reminder" button. *See* EEOICP PM Chapter 13.8(g) (Version 7.0) (October 20, 2022). If no response is received from the DOE within 60 days from the initial request, the CE contacts the appropriate Operations Office by telephone or emails the DOE Point of Contact and inquiries about the request for employment verification. See EEOICP PM Chapter

[16] If an individual worked at more than one facility, they can include information for additional employers on the same Form EE-3.
17 The CE directs the employment verification package to the appropriate DOE Operations Office. *See* EEOICP PM Chapter 13.8(b) (Version 7.0) (October 20, 2022).
[18] The SERT is a DOE-hosted environment where DOL and NIOSH send and receive records and data to DEEOIC in a secure manner. *See* EEOICP PM Chapter 13.8 (Version 7.0) (October 20, 2022).

13.8(h)(1) (Version 7.0) (October 20, 2022). If there is no response from the DOE after 60 days, the CE contacts the claimant for additional employment information. *See* EEOICP PM Chapter 13.8(h)(2) (Version 7.0) (October 20, 2022).

In August 2022, an AR contacted the Ombuds seeking information and assistance regarding a claim for cancer that had been filed in April 2022 for which there seemed to be a delay in verifying the claimed employment.[19] The AR expressed concern that perhaps the SERT system was not functioning properly because more than 60 days had passed since the employment verification process had begun and the CE was reporting that the DOE had not provided a response. On August 8, 2022, the AR was informed that the employment verification request sent to DOE was missing two of the required forms, and that the CE would correct the issue and resubmit the employment verification request for expedited processing.

On September 2, 2022, the AR wrote to DEEOIC that, "***No*** work has been done on this claim since we discussed it on 8/3. The employment records have still not been received…I want to remind you that this is a cancer claimant, and I believe it is an SEC claim. It is cruel to continue with these delays." On the same date, a DEEOIC supervisor informed the AR the response from DOE had, in fact, been uploaded into the SERT system on August 8, 2022. The supervisor told the AR that the CE would be notified that the employment verification had been received and that it verified several of the claimed employment dates. The AR requested that the claims adjudication process be expedited and expressed frustration with the delay.

On September 6, 2022, the ORISE database was searched, and it verified that the employee was hired at a covered DOE facility on August 5, 1968, and terminated on April 14, 1978. Also on September 6, 2022, the district office issued a recommended decision to accept the employee's claim for benefits under Part B of the EEOICPA, based upon his covered employment during a designated Special Exposure Cohort (SEC) class and the diagnosis of a specified cancer.[20]

A couple of weeks later, the AR informed the DEEOIC that the claimant's health had taken a turn for the worse and requested the expedited payment of compensation to the employee under Part B, as well as the expedited processing of a claim for impairment compensation under Part E. The DEEOIC took significant steps to expedite the Part B compensation payment to the employee on the day prior to his passing. Unfortunately, the employee's claim for impairment compensation was unable to be adjudicated in time.

There were numerous delays in this case, each of which contributed to the employee being prevented from receiving the full complement of benefits available under the EEOICPA, as well as his spouse having to initiate and go through her own claims process with the DEEOIC. First, it appears that the ORISE database was not searched until September 6, 2022, a little over four months after the employee filed a claim for benefits and over a month after the DOE had verified the employee's claimed

[19] As early as May 12, 2022, the AR informed the CE that the claimant was quite ill and that it was important the claim adjudication be kept on track.

[20] The EEOICPA established the SEC to compensate eligible members of the Cohort without the need for a radiation dose reconstruction and determination of the Probability of Causation (PoC). This means an employee who meets the necessary employment criteria to be included in a designated SEC class and is diagnosed with a specified cancer receives a presumption of causation that employment-related radiation caused the specified cancer. *See* EEOICP PM Chapter 14.1 (Version 7.0) (October 20, 2022). In most instances, coverage under a SEC and diagnosis of a specified cancer reduce the amount of time necessary to develop a claim for cancer under Part B of the EEOICPA.

employment. As DEEOIC policy states, had the ORISE database been searched at the inception of the claim in April 2022, the need to send the employment verification request through the SERT system could have likely been avoided, along with the delays that accompanied it.

It is also worth noting that the AR for this claimant understood the process of employment verification and contacted the DOE Operations Office directly in an effort to resolve the delay. The AR then shared the information obtained from the DOE Operation Office with DEEOIC and expressed concerns about the SERT system and the apparent lack of follow-up to address the delay. Absent the engagement of the AR, it is possible that the employment verification delays could have resulted in the employee's claim not being adjudicated prior to his passing.

Second, when it was discovered some months later that documents were missing from the CE's original employment verification request, it appears DEEOIC's procedures for submitting an employment verification request via the SERT system were not followed. This likewise begs the question, if the original employment verification package was missing required documents when submitted to DOE through the SERT system, is there a process for this problem to be brought to the attention of the CE, and if there is a process, was it followed in this case?

Third, there appears to have been no meaningful follow-up regarding the DOE's lack of response to the CE's employment verification request. It is unclear if the CE utilized the reminder button when 30 days had passed since the request was sent to DOE through the SERT system. It is also unclear if the CE called or emailed the DOE Operations Office following 60 days without a response from the DOE. Finally, on August 8, 2022, when the DOE verified the covered employment through the SERT system, it still took DEEOIC until September 6, 2022, to issue a recommended decision to accept the employee's claim for benefits. While the employee was awarded $150,000 compensation under Part B, he was unable to have his claim for impairment compensation adjudicated prior to his passing.[21]

An additional case brought to the Ombuds attention involved a case where the employment verification package sent to DOE via the SERT system was not done correctly and resulted in delayed adjudication of the claim. The use of the SERT system to request and receive employment verification works in many cases, but it appears that when a breakdown occurs, claimants are not informed of the reason for the delay. Moreover, a closer examination of the employment verification process by DEEOIC, with an eye towards creating a more robust tracking and troubleshooting mechanism within the SERT system, is recommended.

The Ombuds also heard from claimants in 2022 who complained of difficulties proving that they were employed by DOE subcontractors at covered DOE facilities. As has been discussed in prior annual reports, the main challenge for these workers is proving a contract existed between their employer and a DOE contractor or proving that they performed work on site at a covered DOE facility. Almost all DOE subcontractors find it difficult to find a contract between their employer and the DOE contractor for the time period when they worked or to find colleagues who can attest to the details of their employment in an affidavit. Employees who complain of their inability to produce such documentation express

[21] Impairment compensation under Part E of the EEOICPA is based upon the whole person impairment percentage for the covered illness(es) as determined by a qualified physician. For each percentage of whole person impairment, the claimant is awarded $2,500. For a claimant with 90% or 100% whole person impairment rating, the compensation awarded would be $225,000 or $250,000, respectively.

frustration about being asked to prove something that they know is true and that they believe DOE or DEEOIC would be better equipped to obtain documentation of than them.

The Ombuds was informed by DOE subcontractor employees that their companies never shared their business contracts with them.[22] Moreover, many subcontractor employees worked in the trades industry and thus worked with a variety of colleagues at a number of locations over the years. For these individuals, it is often quite challenging to track down former colleagues and persuade them to fill out an affidavit specifying in detail of when and where they worked together. The DEEOIC Procedure Manual discusses the evidentiary weight CEs are to give affidavits, but no longer addresses the weight given to employee affidavits attesting to their own employment. *See* EEOICP PM Chapter 13.12(d) (Version 7.0) (October 20, 2022). However, it has been reported that employee affidavits are usually given little weight due to concerns that such affidavits are self-serving and thus require corroboration through other documents. This is true even when there is no other evidence available. The Ombuds suggests that DEEOIC determine the probative weight of employee affidavits based upon the details of the affidavits themselves rather than based upon the identity of the person providing the affidavit.

B. Documents Acquisition Request (DAR) Records

When it comes to establishing that a worker was employed at a covered DOE facility during a covered time period, DAR records[23] from the DOE can provide probative evidence of covered employment. This is especially true in cases involving DOE subcontractor employment or employees who traveled from one DOE facility to another and were considered by DOE to be "visiting" on-site. *See* EEOICP PM Chapter 13.8(i) (Version 7.0) (October 20, 2022). DAR records can include personnel records, site medical records, job descriptions, industrial hygiene records, radiological records, incident or accident reports, and others. *See* EEOICP PM Chapters 13.8 and Chapter 15.5(c) (Version 7.0) (October 20, 2022). The CE can initiate a DAR request through the SERT system at the same time the employment verification request is submitted to DOE.

In August 2022, a complaint was made to the Ombuds that a request for DAR records had not been received by the DOE Operations Office in the four months since the claim for benefits was filed.[24] In addition to noting DEEOIC's delay in requesting the DAR records, the Ombuds was informed that the claim had been sent to NIOSH for dose reconstruction prior to receipt of the DAR records. The concern raised was the potential impact that the delayed DAR records request could have on the NIOSH dose reconstruction results. For instance, the DAR records can include personnel records to support additional dates of covered employment, and/or incident/accident reports or dose records relevant to the dose reconstruction process. In the event the DAR records contained relevant information that would affect the NIOSH dose reconstruction process, the delays would be compounded by the fact that the NIOSH dose reconstruction process would have to be stopped, the case sent back to DEEOIC from NIOSH, and then the updated claim file be sent back to NIOSH again for a rework of the dose reconstruction. This process of sending the case back and forth between DEEOIC and NIOSH extends

[22] Affidavits alone are usually insufficient to prove the existence of a contractual relationship between DOE and a company. EEOICP PM Chapter 13.12(d) (Version 7.0) (October 20, 2022).
[23] The CE requests DOE work records on specific employees by submitting a DAR request to the DOE.
[24] As discussed in the preceding subsection, as one of the first steps taken after a claim for benefits is filed, the CE routinely sends the request for employment verification and DAR records to the appropriate DOE Operations Office via the SERT system.

the adjudication timeline even further. The individual who contacted the Ombuds inquired as to whether something had changed in the SERT system that was causing these delays.

In another instance, a claimant was diagnosed with cancer while working at a covered DOE facility and received medical treatment for the illness while still employed at the DOE facility. In response to a DAR request, the DOE produced some records, but the worker's personnel and medical records produced by DOE pertained to other, unrelated illnesses, and not the cancer diagnosis. Because the DAR records were relevant to determining when the worker was diagnosed with cancer, it was anticipated that the personnel and medical records would have included documents reflecting the employee's cancer diagnosis and time taken off from work to obtain medical treatment. Unfortunately, a number of additional, illegible records were included in the DAR response and because the copies were too light or too dark, they could not be read. It is unclear if the CE contacted DOE regarding the issue of the illegible records, or if other means of establishing a date of diagnosis were available, but the delay in obtaining legible records appears to have impacted the adjudication of this claim.

C. Special Exposure Cohorts

For cancer caused by radiation exposure, there are two paths to compensation under Part B of the EEOICPA. One path is to have NIOSH perform a radiation dose reconstruction and if the probability of causation, as calculated by DEEOIC, is 50% or higher, the worker is eligible for benefits.[25] The other path is to have covered employment at a designated SEC facility for the requisite covered time period and be diagnosed with one of twenty-two specified cancers.[26] The Ombuds often refers to the SEC path as the "fast track" because the claims process can be more straightforward in that once the employment is established and the diagnosed specified cancer is confirmed, the worker is eligible for compensation benefits.

With respect to establishing employment at a covered DOE facility during a designated SEC time period, it is easier to establish employment at some facilities than at others. Prior to 2018, the DEEOIC assigned claims to the four district offices in Seattle, Denver, Cleveland, and Jacksonville based upon the location of the facility where the worker was employed. For example, if a person worked at the Rocky Flats Plant, their claim was assigned to the Denver District Office, or if a person worked at the Pinellas Plant, their claim was assigned to the Jacksonville District Office. This allocation of claims allowed the staff of the respective DEEOIC offices to build an understanding of specific details of the facilities in their region, as well as the types of records produced by DOE regarding those facilities. When, in 2018, claims started being distributed nationally instead of regionally, the Ombuds began receiving questions and concerns regarding DEEOIC staff being asked to adjudicate claims involving DOE facilities they did not have any experience with and for which there was a lack institutional knowledge of the facilities.

Despite the initial concerns raised in 2018 and 2019, there was optimism that as time went by these concerns would dissipate to the point of no longer being an issue. While some of the concerns have

[25] If the claimant is a survivor of the former worker, the claimant must meet additional criteria to receive compensation under Part B of the EEOICPA.
[26] For some specified cancers, the EEOICPA also requires a latency period between the initial occupational exposure and diagnosis of the illness.

dissipated, that unfortunately has not been the case for certain facilities. Without going into the full history of the DOE facilities in the Los Angeles area, it can generally be said that workers have experienced difficulties over the years proving covered employment at Area IV of the Santa Susana Field Laboratory, Canoga Avenue Facility, De Soto Avenue Facility, and Downey Facility. Each of these DOE sites has designated SEC time periods, with the most extensive period being from January 1, 1955, through December 31, 1998, for Area IV of the Santa Susana Field Laboratory.[27]

Until 2018, claims for those who worked at the Los Angeles area DOE facilities were adjudicated by a single district office. As a result, the staff of this office developed institutional knowledge of the types of documents produced by the DOE contractors, the worker classifications for those who worked at these facilities, and the routine practice of worker rotation between the facilities. In 2022, complaints of delays filed by claimants who worked at these LA area facilities all stemmed from district offices that had previously not adjudicated these claims. In one instance, the complaint was made that employment records and coworker affidavits submitted by the worker were not fully understood by the CE, and resulted in the misunderstanding that a worker visiting a DOE facility could not be accepted as covered employment. In other instances, workers who produced evidence of SEC covered employment and a specified cancer found their claims delayed, in part, due to the lack of understanding of employment records provided by DOE.

Another example involves a case where a surviving spouse filed a claim for benefits based upon kidney cancer and pancreatic cancer after the worker passed away in 2021. The employee had covered employment at Hanford from January 1, 1978, to December 31, 1982, as well as additional periods of covered employment after 1982. Hanford is a covered DOE facility, with a designated SEC period for all DOE employees, DOE contractors, and DOE subcontractors who worked for a number of workdays aggregating at least 250 workdays between July 1, 1972, through December 31, 1983.[28] The worker was diagnosed with kidney cancer in 2008 and pancreatic cancer in 2001, which are both specified cancers under Part B of the EEOICPA.

In 2022, the surviving spouse received a Recommended Decision to deny the claim for kidney cancer and pancreatic cancer under Part B, based upon a NIOSH dose reconstruction that resulted in a PoC of less than 50%. Not fully appreciating the impact of the waiver that accompanies DEEOIC recommended decisions, the surviving spouse signed the waiver, thereby giving up his/her right to file objections to the recommended decision. Had the surviving spouse not sought the assistance of a third-party, who in turn sought the assistance of the Ombuds, a final decision denying the surviving spouse's claim would have likely been issued within 30 days of the recommended denial.

The issue in this case was DEEOIC's lack of recognition of a worker who was a member of the Hanford SEC class of July 1, 1972, through December 31, 1983, and was diagnosed with two specified cancers.[29] The third-party assisting the claimant sought assistance from the Ombuds, in part, because the evidence clearly supported acceptance of this claim under the "fast track"[30] to Part B compensation benefits and it was confusing to them why the claim had been recommended for denial.

27 The SEC period for Canoga Avenue is January 1, 1955, through December 31, 1960; for De Soto Avenue is January 1, 1959, through December 31, 1964; and for Downey Facility is January 1, 1948, through December 31, 1955.

28 To be a member of the SEC, covered employment at another SEC facility can contribute to the 250-workday requirement.

29 This SEC class became effective on September 2, 2012.

30 The Ombuds refers to the SEC class/specified cancer adjudication pathway under Part B as the fast-track because it typically results in claims moving through the adjudication process faster than the NIOSH dose reconstruction pathway.

The Ombuds suggested the surviving spouse immediately take the following steps:

- send DEEOIC a letter retracting the waiver of objections,
- file a letter of objection to the recommended denial, specifically citing the worker's SEC employment and diagnosis of two specified cancers,
- confirm to DEEOIC that the employee passed away from one of the specified cancers, thereby opening up the surviving spouse's claim under Part E of the EEOICPA,
- and request reversal of the denial of benefits under Part B.

It took a few more months for the claim to be adjudicated, but the surviving spouse was eventually awarded benefits under Part B and Part E of the EEOICPA. This case exemplifies the delays some claimants encounter during the claims adjudication process that they are sometimes completely unaware of until it is brought to their attention by someone with more EEOICPA experience. Likewise, had this surviving spouse not contacted another person for assistance, this case would have been one of benefits denied, instead of benefits delayed.

D. Authorization for Medical Treatment

For claimants with accepted claims who need medical care, delays in the authorization of payment for medical treatment can not only have an impact on their physical and mental health, but on their family members who are supporting them. The majority of individuals who assist claimants in an official capacity, known as authorized representatives (AR), are usually family members or a friend of the claimant.[31] For family members or friends, it can be challenging to assist the claimant as they receive treatment for a covered illness(es) while also assisting them with the EEOICPA claims process. Claimants and their ARs work with a medical benefits examiner (MBE) in order to submit the necessary medical records for their pre-authorization request to be approved. This process is required when pre-authorization medical benefits is needed, and/or to obtain payment for outstanding medical bills or out-of-pocket medical expenses.

i. Prescription Medication and Exception Processing

Under the EEOICPA, medical expenses related to the treatment of an accepted covered illness, or consequential illness, are the responsibility of the DEEOIC and claimants cannot be billed for co-payments or the unpaid balance of a covered medical bill. Medical benefit coverage includes a variety of services, such as prescriptions, hospitalizations, organ transplants, various forms of physical and other therapies, durable medical equipment, such as supplemental oxygen, assistive walking devices, hospital beds, etc., as well as home and residential health care, home modifications, and vehicle modifications or purchase. Some types of medical treatment must have pre-authorization from DEEOIC, which requires a letter of medical necessity (LMN).

31 There are lawyers and other professionals who serve as ARs, but there are far fewer professional ARs than family members and friends who serve as ARs.

> **[The LMN] is a narrative statement prepared and signed by a qualified physician, who has been treating the claimant for one or more DEEOIC- accepted conditions. The LMN represents that physician's independent assessment and opinion, including a brief review of the claimant's pertinent medical history, a brief statement regarding the claimant's current medical condition, and an explanation of the claimant's medical need for treatment, services, or accessories, necessary to provide relief for the DEEOIC-accepted medical condition(s).** *See* EEOICP PM Chapter 29.3(a) (Version 7.0) (October 20, 2022).

Some medical treatment, services, or prescription drugs are not included in one of the Office of Workers' Compensation Programs (OWCP) treatment suites, and when this occurs, the claimant can seek to have the rejected service, prescription or other medical benefit approved on an exception basis. *See* EEOICP PM Chapter 29.6 (Version 7.0) (October 20, 2022).[32]

A spouse, who also served as the claimant's AR, sought assistance from the Ombuds in seeking the status of a request for the authorization of two prescription chemotherapy medications to treat the claimant's metastatic cancer. The two medications were not in the OWCP treatment suite for the accepted covered illness, so the authorization request had to proceed through DEEOIC's exception process.

The AR noted that he/she was a retired pharmacist, and therefore had greater knowledge of the medications being prescribed and of the need for proper documentation when medications required preauthorization. However, according to the AR, in the four months since the medications were prescribed by the claimant's oncologist, DEEOIC had not reached a decision regarding whether to authorize them. The AR further indicated that the MBE had escalated the authorization request to the National Office, and they had still not received a decision.

In response to an inquiry from the Ombuds, it appears there was more than one reason for the delays in this claim. The claimant's oncologist wrote the LMN on July 14, 2022, and provided a scientific research article to support the use of the prescription medications as well. When the MBE first sent the request to the National Office for evaluation on August 15, 2022, the wrong accepted medical condition was identified in part of the referral. Then, on August 16, 2022, the reviewing official only addressed and approved one of two requested medications. A DEEOIC staff member confirmed that one medication had been authorized and paid for, but that the second medication had been denied according to the pharmacy. The DEEOIC staff member again requested review of the second medication. Later on August 16, 2022, the reviewing official incorrectly assumed that the second medication had previously been approved and asked if the recommendation for approval of the second medication should be resubmitted.[33] It was not until October 14, 2022, that a DEEOIC staff member sent the following message to the reviewing official,

[32] Treatment suites categorize those medical services that a physician routinely and customarily uses to treat the effect of an accepted medical condition. Using that categorization, DEEOIC automates payment of billed charges that align with services permitted under the treatment suite. *See* EEOICP PM Chapter 29.6 (Version 7.0) (October 20, 2022).

[33] The reviewing official also noted that the two medications were chemotherapy drugs meant to be used in combination to treat the claimant's accepted cancer.

> **I have reviewed your emails below, and want to make sure I am interpreting them correctly. It appears that you approved [medication 1], and assumed that the [medication 2] was already approved. However, [medication 2] is also denying at the pharmacy. Based upon your email below, should [medication 2] also be approved?** (Email from DOE staff member to National Office reviewing official, October 14, 2022.)

On October 14, 2022, the reviewing official confirmed that the treating doctor's LMN was sufficient for the two medications to be authorized for the claimant indefinitely under the direction of his/her oncologist and medical team.

This claimant was prescribed two chemotherapy medications to be used in combination to treat his/her metastatic cancer and worked with DEEOIC staff to no avail for four months prior to contacting the Ombuds for assistance. The authorization request then took another two months to be resolved before the claimant began receiving the prescribed medications. The claimant's AR made every effort to assist the claimant yet was unaware of and unable to do anything about the communication errors and lack of follow up within DEEOIC that resulted in the delays. A review of the correspondence shows that ten DEEOIC personnel and a contractor employee were involved in processing this authorization request and during the process, at least multiple communication errors compounded the delays. Moreover, because DEEOIC is the primary payor for the claimant's accepted medical condition, the claimant could not receive approval for the medications from another payor until DEEOIC had reached a decision on the authorization request.

The AR relayed frustration to the Ombuds regarding the delays in obtaining the medication necessary for the treatment of his/her spouse, as well as having little information regarding why it took months for DEEOIC to make a decision. This case exemplifies more than one aspect of the complaints brought to the Ombuds regarding delays in obtaining authorization for medical treatment. Sometimes the authorization process takes longer than a claimant would like because DEEOIC needs more evidence to support the requested treatment. However, there are also issues with a process, as in this claim, that took approximately six months and involved ten DEEOIC personnel in eight different positions to reach a decision on two prescription medications. With the number of personnel and layers of decision-making involved in the exception process, it would be helpful for claimants to receive more frequent and detailed communication from DEEOIC. It would also be helpful for claims involving life-saving treatment to be automatically reviewed if a certain period of time had elapsed without a determination. If DEEOIC denies authorization for requested treatment, some claimants may have alternative means, such as Medicare or other health insurance, to obtain the treatment, but only after a determination is made by DEEOIC. The lack of meaningful communication with the AR during this process exacerbated an already difficult period in the AR and claimant's life.

ii. Home Health Care Benefits

In addition to claimants and ARs, health care providers contacted the Ombuds in 2022 seeking assistance with authorization request delays for claimants seeking home health care (HHC) benefits. When a claimant seeks home or residential health care benefits for an accepted covered illness, the process by which MBEs make such determinations is outlined in Chapter 30 of the EEOICP Procedure Manual. The PM identifies the documents necessary to support a claim for HHC benefits, and the policy considerations the MBE is to follow when assessing those records. However, the procedures outlined in Chapter 30 of the PM do not mention a timeline or timeframe by which the MBE is to process HHC claims. The lack of a timeline or timeframe leaves both claimants and HHC providers uncertain regarding how long the authorization process on any given HHC claim will take.[34]

One claimant's physician ordered emergency HHC for 24 hours per day upon discharge from the hospital and further indicated that the claimant's accepted covered illness was terminal. According to the PM, a request for emergency authorization of HHC benefits is to be first routed through DEEOIC's bill processing agent, who in turn forwards the emergency request to an MBE to be adjudicated. *See* EEOICP PM Chapter 30.11 (Version 7.0) (October 20, 2022). "Emergency requests are handled separately – they are initiated by calling the Bill Processing Agent (CNSI) and speaking to the Triage Nurse. *See* DEEOIC Medical Benefits, Letters of Medical Necessity, Webinar Slides, Slide #20 (June 22, 2022). However, the PM does not mention that the request for emergency HHC is to be routed to the triage nurse at CNSI, thereby leaving out a potentially important detail for those seeking emergency HHC services.[35]

According to the HHC provider in the instant case, they were unable to connect with the triage nurse after leaving telephone messages that were not returned. The HHC provider then contacted the MBE directly, however, after 65 days without a determination on the emergency request, the HHC provider contacted the Ombuds to file a complaint and seek assistance. The HHC explained that they had already communicated with the MBE and a supervisory MBE, and after still not receiving a decision, the claimant's family began questioning whether the HHC provider had submitted the medical documentation and LMN to DEEOIC.[36]

The HHC provider expressed three concerns to the Ombuds. One, there appears to be no timeline by which DEEOIC is to make a determination on routine or emergency requests for HHC benefits, thereby leaving claimants and providers in the dark regarding when they might receive a decision. The apparent lack of a timeline also impacts the claimant's ability to consider other options due to the uncertainty of when a decision will be received. For example, some claimants and their families are unable to spend the time or resources identifying and evaluating residential or hospice care while waiting for a decision from DEEOIC. Then, if the requested HHC benefits are denied by DEEOIC, the claimant is that much farther behind in their efforts to obtain suitable care.

[34] The only timeline for MBEs mentioned in Chapter 30 of the PM is a notice requirement that states 60 days prior to the expiration of an existing home or residential health care (HRHC) authorization, the MBE is to notify the claimant of the need for a renewal request and updated LMN. See EEOICP PM Chapter 30.7(e) (Version 7.0) (October 20, 2022).
[35] The triage nurse at CNSI is different from the nurse consultants employed by DEEOIC to assist the MBEs with routine requests for HHC benefits.
[36] A week after contacting the Ombuds, the claimant was authorized to receive 12 hours/day HHC. It is unclear whether the requested 24 hours/day was ever authorized.

Second, the provider stated that the CNSI triage nurse is often unavailable, and so waiting for a return call creates delays in initiating the review of the request for emergency HHC benefits.[37] If routine HHC authorization requests are sent directly by the BPA to the MBEs, and emergency HHC requests are ultimately sent to an MBE as well, the question was raised as to why the additional step of contacting a triage nurse with CNSI was required. It appears that this added step causes delays in the processing of some requests for emergency HHC authorizations.

Third, the concern was articulated that MBEs routinely refer HHC authorization requests to DEEOIC nurse consultants for review, sometimes even when sufficient medical evidence is submitted to support the request, and this has the effect of further delaying the benefits determination. It would benefit claimants for the timeline regarding the adjudication of HHC benefits, particularly emergency HHC benefits, to be shared and/or incorporated into the PM. It would also be helpful for the role of the triage nurse to be defined and explained in the PM, and for materials to be provided to claimants and HHC providers regarding this entire process.

When medical evidence submitted to support a request for HHC benefits is incomplete or defective, 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 is to send a second development letter providing an additional 15 days to submit the requested evidence. If the response to the MBE is still not adequate, the MBE can issue a partial authorization, a denial of the request, or decide to undertake additional development. *See* EEOICP PM Chapter 30.7(b) (Version 7.0) (October 20, 2022). Based upon this guidance, it appears that a decision regarding a HHC authorization request would be issued within 30 days or so of the initial request. However, when the Ombuds was contacted for assistance with another claim, the claimant's home health care recertification request had been pending 129 days while the request for an increase in the home health aide's hours was under MBE review. This same recertification request was also 60 days beyond the expiration of the original HHC authorization. Additionally, two other claimants' requests for initial HHC benefits were brought to the attention of the Ombuds when they were still pending after 100 days and 106 days, respectively. Neither the HHC provider nor the claimants were provided an explanation regarding the delay in the adjudication of their claims for HHC benefits.

It would be helpful for claimants and HHC providers to be kept apprised of the status of their requests for HHC benefits with updates containing more details than simply that the requests are pending. For example, it would be helpful for claimants to be given a specific timeline or timeframe by which they could expect a determination. Moreover, it would be helpful for claimants and HHC providers to be provided updates when a determination on an authorization request was delayed, along with being provided a reasonable expectation regarding when the determination will be issued.[38] Claimants and HHC providers have expressed their frustration to the Ombuds that they must produce evidence under

37 The role the triage nurse with CNSI plays in emergency HHC authorization requests is unclear because their role is neither defined nor discussed in the EEOICP PM.

38 The absence of a timeline or timeframe for HHC authorization determinations makes it difficult for claimants and HHC providers to know when a request is actually delayed, but some HHC providers track outstanding authorizations and have developed a sense of how long it sometimes take to receive a determination. Also, when HHC authorizations are set to expire, HHC providers track the period of time they sometimes provide services beyond the period authorized by DEEOIC. This places the HHC provider in the position of then having to seek retroactive payment for services already rendered to the claimant. In this situation, if the services are not approved, the HHC provider must choose to either go without payment or seek the payment from the claimant, neither of which is a desired outcome.

timelines set by DEEOIC, but that it appears DEEOIC does not hold itself to adjudication timelines for making determination on requests for authorization of HHC. Absent reasonable timelines, claimants have no sense of when DEEOIC has taken longer than necessary to make a determination, or when there is a serious problem or communication error within DEEOIC that is causing the delay of their claim.

iii. Recommended Decisions regarding HHC Benefits

Where DEEOIC has determined that a component(s) of a claim for HHC benefits will be authorized, but other component(s) denied, the MBE will issue a letter decision to the claimant that must include the following language:

> ***If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.*** (Emphasis provided) EEOICP PM Chapter 30.8(a)(6)(a) (Version 7.0) (October 20, 2022).

Furthermore, when DEEOIC determines that a request for HHC benefits will be denied in its entirety or where there will be a reduction of previously authorized HHC, the MBE will issue a recommended decision to deny or reduce the level, frequency, or duration of HHC previously authorized.[39] *See* EEOICP PM Chapter 30.9 (Version 7.0) (October 20, 2022).

Claimants and their ARs contacted the Ombuds in 2022 seeking information regarding their options after being informed that their request for authorization/reauthorization of HHC benefits was denied or their benefits were being reduced. The procedures outlined above are not always communicated to claimants, and even when they are, they are not always consistently communicated to claimants. There is confusion regarding when a claimant can expect to receive a recommended decision in any of the scenarios previously described. When contacting the Ombuds regarding a delayed response from DEEOIC, claimants ask whether there is a timeline for a recommended decision to be issued to them after they have requested one following a letter denial. Other claimants have simply asked the Ombuds what happens after they receive a letter denial because they did not appreciate the meaning of the italicized language in the denial letter and time has passed since they last heard from DEEOIC.

Due to the lack of a published timeline or timeframe, the Ombuds usually recommends claimants send follow-up letters to their MBEs seeking this information, but it is unclear how many claimants do so and what answers they receive. To that end, it would be helpful for DEEOIC to provide claimants with a timeline for when they can expect to receive a recommended decision following a HHC denial letter or when a claim for HHC benefits is being denied. ARs and claimants' family members are trying to plan for the care of the claimant who they understand needs additional support at home, and the uncertainty surrounding when they might receive a formal determination (recommended decision) from DEEOIC creates additional stress for these individuals.

[39] When the recommended decision is to reduce previously authorized HHC benefits, the MBE is to communicate that DEEOIC will continue to extend the existing authorization until the Final Adjudication Branch (FAB) determines whether to finalize the RD. *See* EEOICP Chapter 30.9 (Version 7.0) (October 20, 2022).

E. Payment or Reimbursement for Medical Bills

The EEOICPA states that a claimant with an accepted covered illness shall be furnished with the services, appliances, and supplies prescribed or recommended by a qualified physician for a covered illness that the President considers likely to give cure, relief, or reduce the degree or period of that illness. *See* 42 U.S.C. § 7384t(a). The EEOICPA also provides for necessary and reasonable transportation and expenses incident to the securing of such services, appliances, and supplies. *See* 42 U.S.C. § 7384t(c).

Towards the end of 2021, the Ombuds was contacted by a claimant's AR regarding outstanding medical bills for treatment of the claimant's accepted covered illnesses which required a double organ transplant in January 2020, and an extended hospitalization due to surgical complications. In response to a request from the Ombuds, DEEOIC contacted the hospital billing department and explained that some of the bills were denied because they did not appear to be related to the claimant's transplant surgery, and in order to be paid the hospital would have to follow the exception process by submitting a LMN along with supporting documentation to explain how the bills were related to the accepted conditions or transplant. DEEOIC also advised the hospital that for any denied bills related to the accepted covered conditions/transplant the hospital would have to identify the Transaction Code Number (TNC) for each bill and write RTT (Related to Transplant) on the bills and then fax that documentation to the MBE. Upon receipt, the MBE was to forward the bills to CNSI to reprocess the denied bills. (Email from DEEOIC to Ombuds, November 9, 2021). No explanation was offered regarding why the bills related to the accepted illnesses and transplant were required to be resubmitted.

However, in January 2022, the hospital contacted the Ombuds seeking further assistance regarding unpaid medical bills for treatment of the claimant's accepted illnesses, the double organ transplant, and subsequent extended hospitalization for COVID-19 beginning in November 2021. The hospital billing representative provided 82 pages of bills to the Ombuds. In response to a follow-up inquiry from the Ombuds, at the end of February 2022, DEEOIC shared a spreadsheet of medical bills that were in line to be reprocessed by CNSI, the bill processing agent for DEEOIC. The spreadsheet indicated the status of 71 bills was "to be paid" and 4 bills were denied.

It appeared there had been some resolution until the hospital again sought the assistance of the Ombuds in May of 2022. The hospital attached a spreadsheet of outstanding charges for treatment related to the claimant's accepted covered illnesses by their physicians totaling $4,985 and hospital charges totaling $1,407,200.70. The dates of service for the medical bills covered the time period from August 26, 2019, through January 17, 2022. The patient account specialist for the hospital wrote,

> **I have attached 2 spreadsheets with the patient's physician bill and hospital bills that keep being denied even with the medical records sent showing they are related to the work injury. I am not sure what needs to be done in order to get these account paid or if they are just going to continue to be denied. I have sent a fax to [DEEOIC Medical Bill Processing Specialist] as well, since [he/she] was the one entering the patient's bills to get them processed and paid, however, I have sent [him/her] a couple faxes recently and have received no response by phone, email, or fax. If you could just let me know if there is anything that we can do to get these bills processed and paid or if they are just going to continue to deny. I just didn't want to keep submitting these bills only to get the same response. I hope you can help this patient in some way or another.** (Email from Patient Account Specialist to Ombuds, May 12, 2022.)

These bills were forwarded to DEEOIC by the Ombuds. Then, in early July of 2022, the claimant's AR notified the Ombuds that they had engaged the "dispute office" for the hospital billing department in an effort to avoid having the outstanding bills for the claimant's treatment referred to collections. On July 8, 2022, the claimant was informed by a patient relations specialist for the hospital that the outstanding bills would not be sent to collections, and they were hopeful they would be able to address this issue with DOL.

The claimant's AR in this claim is their spouse, and throughout this process, they have been the primary caregiver in addition to representing them before the DEEOIC. The claimant's AR also found themselves attempting to resolve problems that required DEEOIC, CNSI, and the health care provider's assistance to resolve. However, the delays in resolving the medical billing issues significantly impacted the claimant and the AR. The AR communicated to DEEOIC, the Ombuds, and the hospital the toll the delays were having on them and the frustration that ensued.

Concerns regarding outstanding medical bills being referred to collection as a result of non- payment heightened their stress and raised the fear of financial insecurity.

With multiple DEEOIC staff members in various roles involved in the bill pay process, perhaps DEEOIC should develop a role to specifically assist claimants and ARs as they navigate this very complicated process. The Ombuds appreciates the efforts of the Resource Center staff and MBEs, but given the broad responsibilities of these positions, suggests that DEEOIC dedicate resources to specifically assisting claimants and health care providers who find themselves attempting to resolve billing issues for months or years at a time.

Another example of a claim where medical bills and out-of-pocket expenses remained outstanding for an extended period of time also involved a claimant who received an organ transplant as a result of his/her accepted covered illnesses. The claimant wrote to the Ombuds,

> **I have requested status and follow up numerous times via telephone call and fax over the past two years from both [MBE] and [supervisory MBE]. When asked to provide letters of medical necessity, I have responded promptly. I have also requested assistance from the local Resource Center. Unfortunately none of these avenues have been able to provide a resolution. Therefore, I am writing to you.** (Email from claimant to Ombuds, June 7, 2022.)

The claimant's spouse later informed the Ombuds of the claimant's passing in August of 2022, and sought assistance with outstanding medical bills for several medical procedures that were performed secondary to the claimant's organ transplant. Additionally, the surviving spouse noted that DEEOIC had paid for the claimant's anti-rejection medication in 2018 but had not paid for the same prescription medications from 2016 to 2018. The surviving spouse also submitted to the Ombuds copies of outstanding requests for reimbursement totaling $9,971.12 related to the accepted covered conditions from 2014 through 2019. The claimant had paid the expenses out- of-pocket in order to avoid the medical bills being turned over to a collection agency. By the end of 2022, DEEOIC began the process of reviewing this information and instructing CNSI to issue payment to the employee's estate for some of the outstanding medical expenses.[40] The delays experienced by the claimant and the claimant's surviving spouse occurred over a period of multiple years and upon review of the documentation provided, it would have been helpful for this family to have someone from DEEOIC dedicated to assisting them.

Some claimant's hire attorneys or professional ARs to represent them, but the EEOICPA is silent regarding compensation for attorneys or ARs who provide representation beyond that of obtaining lump-sum compensation benefits.[41] As a result, the Ombuds receives requests for assistance with delayed payment of medical bills or reimbursement of medical expenses from both claimants who are not represented by professional ARs as well as those who are represented by professional ARs.

As a final example, the Ombuds was contacted by an AR, who was also the child of a claimant who passed away in April 2022. The AR/child then became the executor of the claimant's estate. The executor complained that one bill from the hospital for treatment of the claimant's covered medical conditions was slow to be paid by DEEOIC, which resulted in the hospital refusing to submit a second bill to DEEOIC and instead sending the bill directly to the executor to be paid. The executor wrote,

> **All I want to do is get the bills paid and go away. I have contacted this bill pay person [and] they say they will call you back and no one does…There is no help and everyone runs for the hills. I will be glad to send proof of whatever documents you need. I also want to know are the legal fees a reimbursable expense as this is an issue that has presented itself from the system.** (Email from executor of claimant's estate to Ombuds, August 24, 2022).

[40] Any reimbursement from DEEOIC for medical expenses paid by the claimant/employee subsequent to his/her passing are made payable to the employee's estate, not in the employee's name. EEOICP PM Chapter 28.13 (Version 7.0) (October 20, 2022).
[41] Under 20 C.F.R. § 30.603, for services rendered in connection with a claim pending before DEEOIC, a representative may not receive more than the following percentages of a lump-sum payment made to a claimant: (1) 2% for the filing of an initial claim with OWCP, provided that the representative was retained prior to the filing of the initial claim; plus (2) 10% of the difference between the lump-sum payment made to the claimant and the amount proposed in the RD with respect to objections to the RD. EEOICP PM Chapter 12.8(a) (Version 7.0) (October 20, 2022).

The hospital's legal department then informed the executor that because the bill remained unpaid, the hospital was permitted to take legal action to obtain payment from the executor personally. The executor had already paid $400 in legal fees to defend himself/herself in this action and stated that he/she anticipated additional legal expenses.

In a follow-up correspondence, the executor confirmed that the hospital had filed two legal actions against him/her in the local circuit court in the amount of $20,368.43 and $357.59. Facing increasing legal costs to defend himself/herself, the executor paid the hospital bills in full, and informed the Ombuds that he/she had called DEEOIC on multiple occasions for assistance and "once again it is radio silence or it is top secret. All of this paperwork has been sent to the department of labor [*sic*] still with no follow-up." (Email from executor to Ombuds, August 28, 2022).

Finally, on December 2, 2022, DEEOIC confirmed that it had communicated to the executor the status of the reimbursement payments. The executor was also informed that payment of the hospital bills was being processed. The executor of the claimant's estate expressed the overriding frustration that, "This system was put in place in 2000 executive order 13179 and it is broken it [*sic*] should get better over time [*sic*] if this was the private industry, we would have automated it and we would expect a 36-hour turnaround or less." (Email from executor to Ombuds, August 28, 2022).

The Ombuds does not know how often unpaid medical bills for the treatment of claimants' accepted medical conditions are turned over to collection agencies or for legal action to be filed against claimants or their family members. However, the Ombuds has discussed in prior annual reports the concerns expressed by claimants who have been threatened with having outstanding medical bills turned over to collections, and the impact that has had on them financially and emotionally. Delays in the resolution of outstanding bills are often the result of a few different issues that repeatedly arise in the bill-pay process. It is important for DEEOIC to respond to claimants, their ARs, and executors of claimant estates in a timely fashion when they request information and assistance from DEEOIC.

Claimants complain of frequently being told to speak with a person in another office or branch of DEEOIC, or to someone with the bill-pay contractor, or the Resource Center, or the health care provider's office when they have the least knowledge of the issues that have caused the payment delays. DEEOIC is uniquely situated, and some claimants would argue, should be responsible for, recognizing and taking action to address these ongoing complaints, particularly for those individuals who experience delays in the payment of medical bills that result in referrals to collection agencies.

F. Expedited Claim Processing for Claimants with Terminal Illness

For claimants who are at the end-stage of an illness, DEEOIC has policies and procedures to expedite the processing of these claims.

> **District Office and FAB HRs are instructed to watch for indicators of an end- stage terminally ill claimant any time they are reviewing a case file or preparing a decision. Indicators of end-stage terminally ill claimants include requests for hospice care, medical evidence stating that the claimant is at the end-stage of an illness, or telephone calls or letters from RCs, congressional offices, ARs, family members, or medical providers regarding the claimant's illness.**
>
> **The District Director (DD), Assistant District Director (ADD), or FAB Manager must use sound judgment in determining if priority handling needs to occur. If medical documentation or other information indicate that the claimant is in the end-stage of his/her illness or that death is imminent, the DD/ADD or FAB Manager directs case action to occur in an expedited manner and ECS is updated to include the terminal indicator.**
>
> **********
>
> **If the claimant's terminal medical status is unclear, the DD/ADD or FAB Manager must initiate development to obtain medical evidence to establish the status of the claimant is at the end-stage of the disease or illness.** *See* EEOICP PM Chapter 11.8 (Version 7.0) (October 20, 2022).

For some families, after requesting the expedited processing of the claimant's claim for benefits, DEEOIC had responded by asking for additional medical evidence to support the severity of the claimant's health. The ensuing delays in obtaining a terminal designation can then place family members in the uncomfortable position of spending time attempting to generate additional medical evidence of the claimant's prognosis while wishing to spend as much time with their loved one as possible. The Ombuds was contacted by an AR after having received a letter from DEEOIC seeking further medical evidence to support the terminal status of a claimant with newly diagnosed Glioblastoma brain tumor, which carried a World Health Organization grade 4 diagnosis, and an average overall survival rate reported in the literature between 10 and 20 months with the best available treatment according to the treating physician. The treating physician further described the claimant's mobility issues due to the location of the tumor, as well as the numerous types of DME necessary for him/her to return home along with 24 hour/day home health care. The physician also noted a concern with the neurocognitive impact of the tumor in that the claimant exhibited confusion, very limited short-term memory, and reduced insight into functions. The CE advised the Ombuds that with respect to the treating physician's report,

> **It only discusses the average overall survival rate reported in literature, as opposed to the current life expectancy of the claimant. Therefore, we have no evidence indicating the claimant is in the end-stage of his/her illness or that death is imminent. In order to designate the claimant as terminal we would need to receive evidence indicating that the claimant is in the end-stage of his/her illness or that death is imminent.** (Email from DEEOIC to Ombuds, September 9, 2022).

When this information was relayed to the AR, there was concern regarding the need to seek a more definitive prognosis by way of a timeline from the treating physician, as some physicians are not comfortable speculating in this regard. Moreover, for claimant's who do not have an AR, the burden falls upon their family members to seek a more specific prognosis or information from a treating physician. The Ombuds has been informed by ARs that at times, the DEEOIC staff member's assessment of the medical evidence and their communication regarding the additional evidence that was needed, lacked sound medical judgment as well as sensitivity.

In another instance, an AR complained to the Ombuds after a claimant, who had been referred for hospice care by their treating physician, was denied a terminal designation. The AR understood that individuals with a life expectancy of 6 months or less qualify for hospice care and sought clarification from DEEOIC regarding the evidence that was needed. The AR stated they were informed by a DEEOIC staff member that a physician must state that a claimant has only "days to live" in order to be considered end-stage terminal and therefore eligible to have their claim expedited. In response to a Congressional inquiry regarding the same matter, DEEOIC responded that it does not have a policy requiring that the physician state the claimant has only "days to live" in order to be considered end-stage terminal and apologized for any misinformation.

As noted in the 2021 Annual Report to Congress, given the frequency with which this issue is raised by claimants' families and ARs, additional information regarding how DEEOIC assesses the medical evidence submitted to support a terminal designation is needed. Absent further clarification, it appears that some DEEOIC staff may have interpreted the guidance in the PM to mean a specific timeframe or timeline must be provided with respect to the prognosis. To be clear, the PM does not indicate a life expectancy timeframe that a physician must include in their documentation of the claimant's prognosis, however, it would be helpful for the PM to explicitly include this information. The delays caused by additional development of such requests continue to have an impact on the claimant and their family, and the Ombuds recommends further clarification of the policy and procedures by DEEOIC in order to mitigate, if not avoid, delays in going forward.

CHAPTER III.
NEED FOR ASSISTANCE

Each year, claimants, potential claimants, ARs, health care providers, and other individuals involved with the EEOICPA contact the Ombuds for assistance. Many of these people have already attempted to obtain assistance directly from DEEOIC or one of the Resource Centers. Others have recently learned of the EEOICPA or have recently filed a claim for benefits. What all of these individuals have in common is the need for someone to spend time speaking with and/or reviewing their paperwork with them. They need their questions answered, an understanding of where they are in the EEOICPA process, what information and evidence they are expected to provide, how and where to find it, and what comes next for them. Some individuals share their complaints and grievances as well.

In 2022, the Ombuds was contacted by individuals who needed assistance finding a health care provider willing to accept payment from DEEOIC, as well as assistance resolving technical issues with the various DEEOIC online portals. People also sought assistance with figuring out who in DEEOIC to report instances of poor customer service or inappropriate behavior to, when they felt uncomfortable filing a complaint with the CE, MBE, or DEEOIC staff person they were experiencing difficulties working with.

A. Finding Health Care Providers

Difficulties finding health care providers willing to accept payment from DEEOIC was a recurring theme for claimants in 2022. This issue was brought to the attention of the Ombuds from claimants in three general groups. The first group was claimants who lived in rural areas and already had fewer health care providers available to treat them, making finding one that accepted payment from DEEOIC all the more challenging. The second was claimants who lived in suburban or urban areas, where they faced issues identifying providers who accepted payment from DEEOIC or had been informed by their existing health care providers that they were no longer accepting payment from DEEOIC. The third was claimants who were seeking treatment in a residential care setting, whether it was for a short-term stay following a period of hospitalization, or for long term care.

Each group of claimants presented their own challenges to finding a health care provider, with a number of them observing that health care providers were more likely to bill other agencies or payors when they experienced issues with receiving payment from DEEOIC. Unfortunately for claimants, when another payor covers the cost of treatment for an illness accepted under the EEOICPA, the claimant is oftentimes charged a deductible, co-pay, and/or co-insurance payment.[42] Other claimants must pay for medical expenses out-of-pocket when they can't find a provider willing to accept payment from DEEOIC. In these cases, the claimant must pay the full cost of the medical bill and then file with DEEOIC to receive reimbursement per the Office of Workers' Compensation Program (OWCP) fee schedule, which is usually much less than the amount they paid the health care provider. For claimants who pay for medical expenses out-of- pocket and then seek reimbursement from DEEOIC, they also do so without knowing exactly how much they will be reimbursed ahead of time. Finally, some claimants travel

[42] When DEEOIC pays for a claimant's medical expenses, the claimant does not have any out-of-pocket expenses. Moreover, DEEOIC does not reimburse claimants for out-of-pocket expenses paid as deductibles, co-payments, or co-insurance payments.

significant distances by car or airplane to receive medical treatment from health care providers willing to accept payment from DEEOIC.[43] These claimants then have the added responsibility to arrange for pre-authorization from DEEOIC where the roundtrip exceeds 200 miles. Regardless of whether pre-authorization is required, claimants must submit documentation of all travel expenses incurred along with the appropriate DEEOIC reimbursement forms in order to be reimbursed.[44]

For tech savvy claimants, DEEOIC has an online portal where claimants can search for health care providers who have enrolled to receive payment from DEEOIC. However, the portal does not indicate whether the provider is actively accepting DEEOIC claimants. The portal also does not identify the names of physicians who have their billing managed by an institution such as a hospital or group medical practice. In fact, a physician contacted the Ombuds in 2022 after being unable to find themselves in the portal, and DEEOIC indicated it was likely because the physician billed under a hospital or group practice. Therefore, for claimants seeking physicians who are affiliated with a hospital or group practice, the names of those physicians are not listed in the online portal.[45]

A claimant contacted the Ombuds and shared that he/she had been receiving medical benefits from DEEOIC for many years and now needed to find a new doctor to treat his/her covered illness. This claimant lived in a suburb of a major metropolitan city and had already sought the assistance of a Resource Center to help find a physician who accepted payment from DEEOIC.[46] The claimant reported that the physicians identified by the Resource Center were either too far away from him/her or were no longer accepting DEEOIC patients. The Ombuds sought further assistance for the claimant from DEEOIC and was informed that there were over 1,600 physicians enrolled in the state where the claimant lived, as well as in the neighboring state, but it could not be determined if any of these physicians specialized in treating the claimant's accepted covered illness. Upon conveying this information to the claimant, he/she expressed disappointment and frustration because they were unable to find a physician who was willing to accept payment from DEEOIC and did not have anyone to assist them with the search.

Another claimant contacted the Ombuds after being informed by his/her home health care provider that they no longer had sufficient staff to provide the services to him/her as prescribed. The claimant was desperate to continue receiving the home health care services that had been authorized by DEEOIC, but there were no other home health care providers in his/her locality that accepted payment from DEEOIC. This claimant lived in a small city and was concerned that if he/she was unable to find a home health care provider, they would have to seek residential services.

Finally, an AR contacted the Ombuds regarding his/her efforts to find residential care services for a claimant, who was also his/her parent. In this instance, the claimant had been prescribed home health care services, but his/her health was deteriorating quickly and necessitated 24-hour per day home health care or residential care. The AR sought assistance from the Resource Center to identify

[43] Claimants are limited to reimbursement based upon the per diem rates for overnight stay and mileage reimbursement rates as published on the General Services Administration (GSA) website, and airfare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare). *See* EEOICP PM Chapter 29.5(i) (Version 7.0) (October 20, 2022).
[44] The Ombuds has also received complaints from claimants regarding both the amount of time it takes for DEEOIC to provide pre-authorization for travel, as well as the amount of time it takes to be reimbursed for travel expenses.
[45] As group medical practices become more prevalent, the lack of individual physician names in the online portal will further diminish the value of this online tool.
[46] The Resource Center staff use the same online portal that is publicly available to assist claimants in their search for health care providers.

residential care facilities in their area that accepted payment from DEEOIC but was unable to identify any. While the AR was attempting to find a residential care facility, the home health care benefits authorization expired, which added to the AR's concern regarding the claimant's ability to receive the necessary level of services. The AR complained to the Ombuds of being overwhelmed by the responsibility of arranging care for his/her parent while working and trying to have the home health care authorization renewed with increased services, and at the same time trying to find a residential care facility that accepted payment from DEEOIC. The AR indicated they were unable to pay for a residential care facility on his/her own and understood that the only way to have this type of care fully covered was to find a facility that accepted payment from DEEOIC.

The value of medical benefits coverage for an accepted illness under EEOICPA is significantly limited when claimants are unable to find health care providers willing to accept payment from DEEOIC. In certain areas of the country, when a physician or medical group decides to no longer accept payment from DEEOIC, claimants find themselves unable to use this benefit. It would be helpful for claimants to have the ability to receive a list of physicians, by name, in their area who are currently accepting payment from DEEOIC. It would also be helpful for claimants if DEEOIC sought to find out why some health care providers no longer accepted payment from DEEOIC and endeavored to reestablish the business relationship.

B. Issues with DEEOIC Online Resources

DEEOIC has a number of online resources that can be accessed by the public, claimants, ARs, and health care providers. From the DEEOIC homepage, the public can access the physician locator portal and the Site Exposure Matrices (SEM) database. Employee claimants and ARs can register to obtain log-in credentials for the Employees' Compensation Operations & Management Portal (ECOMP), the Electronic Document Portal (EDP), the Medical Bill Processing Portal, and the Pharmacy Bill Processing Portal. Likewise, health care providers can obtain log-in credentials to access the Medical Bill Processing Portal and the Pharmacy Bill Processing Portal.

For those who are tech savvy, online tools such as ECOMP, the Medical Bill Processing Portal, and the Pharmacy Bill Processing Portal offer access to specific claim file information, while the EDP allows claimants and their ARs to upload documents directly to their claim file. Once uploaded, the CE and/or MBE associated with the claim should have immediate access to the uploaded documents.

In 2022, claimants and ARs complained to the Ombuds regarding difficulties registering to access the ECOMP and EDP, as well as difficulties uploading documents into the EDP. ARs specifically complained of limitations on the amount of documents that could be uploaded to a claim file at one time using the EDP. Moreover, claimants complained of difficulties when attempting to upload documents into the EDP. The Ombuds also heard from claimants and their ARs that the claim status page in ECOMP did not always accurately reflect the status of a claim, nor did it contain sufficient detail with respect to the claim status history.

However, the Medical Bill Processing Portal and the Provider Search Tool were the most challenging for claimants and ARs to access and navigate in 2022. Claimants and ARs who did not have a background in medical billing reported that the Medical Bill Processing Portal was not easy to navigate or user-friendly when it came to identifying issues with medical bills that had been submitted for approval. While there are tutorials and reference materials available online, according to claimants, a baseline understanding of medical billing terms and processes was still necessary to understand and utilize the portal. The challenges of using the Provider Search Tool included the limitations discussed in the preceding section, as well as difficulties using the filters in the search tool to produce a reasonable number of search results. For example, a family member AR contacted the Ombuds after being unable to find an oncologist who accepted payment from DEEOIC within 75 miles of their home in a small city in Kentucky. This claimant was unable to proceed with their provider search using the online provider portal until it was explained that they could broaden their search by adjusting the zip code entered into the portal. The resulting search identified a provider a significant distance from their home, yet they were at least able to consider this as an option after being provided information about medical travel authorizations and reimbursements.

One of the more common challenges posed by ECOMP is that the portal does not contain certain broad categories of documents that are located in claim files. ECOMP allows claimants and ARs to check the status of a claim, view accepted medical conditions, see compensation and medical benefit history, view new documents added to the case, access decisions, download viewable documents, as well as view Industrial Hygiene referrals and reports, toxic exposure analysis, Contract Medical Consultant (CMC) and medical reports, and phone records/notes.[47] However, ECOMP does not provide access to claim file records from NIOSH, any records from the DOE, or any documents that were originally in paper form that were scanned into an electronic format. Thus, when claimants seek assistance from the Ombuds regarding issues such as covered employment, toxic exposure, Part E causation, and diagnostic medical evidence, claimants are unable to access these claim file records in ECOMP. Instead, the claimant must submit a written request for these documents to their CE and wait for the records to be mailed to them. Most claimants who contact the Ombuds for assistance are unaware that such documentation may exist in their claim file and are then frustrated when informed that they must submit a written request to view the records. DEEOIC usually provides the requested records to the claimant on an encrypted compact disc (CD), along with a letter sent under separate cover containing the password to access the CD.[48] After waiting to receive the records, claimants have reported being unable to open the CD because they did not have a computer capable of reading a CD, and/or they did not have the ability to print relevant documents from the CD to use in furtherance of their claim.

For claimants and ARs who were informed for the first time by the Ombuds of their ability to request copies of claim file records not found in ECOMP, they are often frustrated to learn that this information was missing from their online portal.[49] Furthermore, being furnished with claim file records in a format that is inaccessible due to the lack of a CD reader adds to the feeling of some claimants that DEEOIC is

[47] Survivor claimants can access information in ECOMP when there is only one survivor claimant in the case. When there is more than one survivor, a survivor may submit a request under the Privacy Act to their CE.
[48] When a claimant specifically requests a paper copy of claim file documents, DEEOIC will sometimes honor their request. However, most claimants are unaware of the need to specifically request a paper copy of their claim file documents.
[49] An infographic in the link for ECOMP identifies the categories of documents that are not available in the portal, but the Ombuds has not encountered a claimant or AR who was aware of this fact as a result of the infographic or understood the relevance of the categories of documents excluded from the portal as described in the infographic.

not sharing relevant information from their claim file in a claimant-friendly way. DEEOIC should inform claimants of the existence of these categories of records in their claim files, but not found in ECOMP, and should advise claimants how they can obtain copies of these records at the very beginning of the claims process.

C. Reporting Poor Customer Service

A common concern for claimants in 2022 involved difficulties communicating with DEEOIC staff and inappropriate or rude behavior by DEEOIC staff. It appears based upon the complaints brought to the attention of the Ombuds, that a small percentage of DEEOIC staff are responsible for the majority of the complaints regarding inappropriate or rude behavior. However, the issues involving claimants difficulties being connected to the correct person to address their questions or of not having telephone calls returned in a timely fashion were more widespread.

The Ombuds was informed of telephone messages left for CEs and MBEs that were not returned, as well as cycles of "phone tag" wherein the CE/MBE and claimant left voicemail messages for one another without actually speaking to one another for a period of days or weeks. Claimants contacted our office when they did not hear back from DEEOIC staff who had said they would be responding to the claimant.

Claimants and ARs are no longer able to directly call their CE or MBE. Instead, all incoming calls are answered by staff at one of DEEOIC's eleven Resource Centers. One AR complained when RC staff informed them that they could not leave detailed notes for the CE when sending the message to the CE in the Energy Compensation System (ECS). The AR relayed that when he/she asked that a specific message be passed to the CE he/she was hung up on by the RC staff member. When the AR later spoke to the CE, the CE had not been informed of the basis for the communication and was unresponsive to the ARs questions. Another claimant complained when an MBE compared their own medical illness to the claimants illness and inferred that the level of health care being sought by the claimant was excessive. Additionally, claimants and ARs complained of unreturned telephone calls to CNSI and Conduent, the medical and pharmacy billing contractors.

DEEOIC responded to the Ombuds' 2021 recommendation that a single point of contact for customer service complaints be created by stating,

> **OWCP's website provides contact information for all of its offices, including the DEEOIC National Office, DEEOIC Field Operations, FAB, District Offices, and Resource Centers. OWCP encourages stakeholders who need assistance to submit correspondence to – or call – any one of these offices, call the toll-free numbers, or visit a Resource Center. Stakeholders have several options if they wish to submit a comment or complaint; they may contact a CE or a HR (or a unit supervisor or branch chief) if they have a case-related or program-related concerns. Stakeholders may also submit questions or comments by phone, public email at DEEOIC-public@dol.gov, through customer satisfaction surveys, or in written correspondence to supervisors or other DEEOIC or OWCP leadership.** *See* OWCP Response to the Office of the Ombudsman's 2021 Annual Report to Congress (January 10, 2023).

Unfortunately, the DEEOIC website and the written materials disseminated by DEEOIC do not contain the information found in the preceding paragraph notifying the public where and how to file complaints or concerns. Moreover, claimants and their ARs continue to express fear of retaliation should they share a complaint or concern about a CE, MBE, or RC staff person with someone in the same office, let alone the person they have a complaint about. Likewise, it has been shared with the Ombuds that after a complaint or concern is shared, there is no mechanism or timeframe within which the claimant can expect a response from DEEOIC. In some instances, claimants are even reluctant to share customer service-related complaints or concerns with the Office of the Ombudsman due to a lack of trust in the government as a result of their earlier work for the government. Thus, having a publicly stated process by which claimants and EEOICPA stakeholders can lodge specific complaints without fear of retaliation, and with an understanding of when and how they will receive a response from DEEOIC, would allow for enhanced communication between claimants and DEEOIC regarding their case-specific concerns.

The difficulties with finding health care providers, accessing and using online resources, and the customer service issues reported in 2022 were from claimants, ARs, and health care providers who first attempted to work through their issues or questions on their own. In seeking assistance from the Ombuds, many of these individuals were initially focused on a question or issue that had to be answered or resolved in a time-sensitive fashion so they could obtain the medical care they needed, avoid a medical bill being turned over to collections, or respond to a letter from DEEOIC giving them a 15 day or 30-day deadline to produce evidence.

We explained to claimants that all communication with the Office of the Ombudsman was confidential, but when informed that the Ombuds does not have access to their claim file information and documents, some claimants questioned how much guidance and assistance the Ombuds could provide. And while the Ombuds endeavors to provide guidance and assistance in a timely fashion, we had to notify claimants that in order to assist them, they had to sign a Privacy Act waiver before DEEOIC would release any claim specific information or documents to us. As noted in the 2021 Annual Report to Congress, for some claimants, the prospect of signing a Privacy Act waiver and returning it to our office was a barrier to obtaining assistance, and for others, this step caused undue delays in receiving guidance and assistance.

Consistent with the mission and statutory duties of the Office of the Ombudsman, it would be helpful for claimants and ARs to be able to provide direct, electronic consent to DEEOIC in order for the Ombuds to access the relevant information and documents in their online claim file record. Unlike DOE and HHS, the Ombuds is located in the same agency as DEEOIC and therefore the sharing of information can be accomplished in the secure, online portals created and used by DEEOIC. Another alternative would be to allow the Office of the Ombudsman to verify the identity of the caller or author of letters to our office in the same manner the RC contractor staff verifies the identity of those who contact the RCs for information and assistance.[50] This would obviate the necessity for a Privacy Act Waiver, and the Ombuds could provide assistance and guidance in a timely fashion.

[50] *See* EEOICP PM Chapter 10.4 (Version 7.0) (October 20, 2022).

CHAPTER IV.
LACK OF CLARITY AND CONSISTENCY

Some EEOICPA stakeholders sought assistance from the Ombuds in 2022 when they did not understand information shared with them during telephone conversations with DEEOIC staff or in letters received from DEEOIC. Questions and concerns were also brought to the attention of the Ombuds when claimants and ARs believed DEEOIC policies and procedures were not clearly explained and/or consistently implemented.

A. Who am I Speaking to, Where are They, and What is their Role?

Since DEEOIC transitioned away from allowing claimants to directly call their CEs, MBEs, and HRs, the Ombuds has noted an increase in the number of individuals who shared that they do not know who they were speaking with when they called one of the main DEEOIC telephone numbers.[51] Based upon feedback from claimants and ARs, it appears that the RC staff did not always identify the RC office as the location the caller had reached, and instead provided a general greeting indicating the caller had simply reached the DEEOIC. Thus, individuals who believed they were calling a district office, medical benefits office, or a final adjudication branch office to speak to their case worker were sometimes unaware that they were speaking to someone who had not been assigned to work on their case, and who was not in the same office as their case worker. Individuals also complained that they were unable to speak to the same person twice as a result of their calls being routed to the various RCs. Furthermore, the central mail rooms for DEEOIC correspondence and medical bills have separate P.O. Box mailing addresses in London, KY, which some EEOICPA stakeholders mistakenly believed were the locations where their case workers were located.

At first, it may not have seemed important for EEOICPA stakeholders to know the name and location of the office they were calling, but since the beginning of the program, it had been the way in which claimants understood where their case was and which person to contact. For example, by calling a district office, the claimant understood they could speak to their CE. By calling the FAB the claimant understood they could speak to their HR, and by calling the national office, they understood they could speak to their MBE. Now, RC staff answer all incoming calls and attempt to assist claimants and ARs with their questions, and when they are unable to do so, the calls are transferred to the CE, HR, or MBE of record.

Unfortunately, in practice, many claimants have expressed to the Ombuds that they did not know the difference between the RC staff person who answered their call and their CE, MBE, or HR, because the role of the individual they had spoken with had not been made clear. It was also unclear to claimants and ARs that the RC staff do not make decisions or determinations regarding their claims for benefits. Thus, when a claimant is provided information by a RC staff member, some claimants mistakenly believe that the RC staff person was the person who would be issuing a decision on their claim. Furthermore, when a claimant had subsequent questions, there was no guarantee they would be

[51] In October 2019, all telephone calls to the main DEEOIC telephone numbers were routed to one of the eleven RC offices around the country.

routed to the same RC staff person when they called back. Thus, a claimant's efforts to continue their conversation with the RC staff person they had recently spoken to could result in communication delays when their call was routed to a different RC, or in the claimant speaking to numerous people, none of whom were responsible for adjudicating their claim.

It would be helpful for EEOICPA stakeholders if all calls were answered in a way that identified the location and role of the person the caller had reached, as well as how to contact that same person again for follow up assistance. Likewise, as the role of the RC staff has significantly expanded over the past few years,[52] it would be helpful for EEOICPA stakeholders to still have the option to contact their CE, HR, and/or MBE directly regarding certain questions and issues.

For example, an AR (who was also the family member of the claimant) contacted the Ombuds and expressed confusion after having communicated with a RC staff person, MBE, and the MBE's supervisor regarding a claim for home health care benefits. As the communications between the AR and the various DEEOIC representatives unfolded in real-time, the AR did not understand the roles of the individuals who were leaving voicemail messages and information for them. The AR wrote to the Ombuds,

> **I received a phone call on my cellphone at 1:10 a.m. this Tuesday from someone speaking on behalf of [NAME] telling me [*sic*] my request for increased hours was turned down. Nobody called my home phone first which I always request and to please leave a message and then call my cell. This comes after about a month ago I was never called on either number…I need to talk to you about what happened. I am not up to putting all of it in an email, but time is of the essence and I don't know what to do at this point.** (Email from AR to Ombuds, March 9, 2022).

Eventually, the AR sorted out who the DEEOIC communications were from, but it was challenging for the AR to determine the identity and role of the appropriate DEEOIC staff person to communicate with. Such challenges can delay the progress of the claim and in some situations can result in a claimant no longer actively participating in their own claim. In this instance, the AR expressed that it appeared it was more important for someone from DEEOIC to leave a voicemail message for him/her than it was for them to speak with him/her directly. It is important for EEOICPA stakeholders to clearly understand who they are speaking with, where that person is located, and the person's role in the EEOICPA claims process.[53] Sometimes there can be "too many cooks in the kitchen" and the effect on claimants is confusion and a lack of clarity when it comes to who to contact regarding specific claim-related questions.

[52] RC staff assist claimants with filing claims, explaining benefits, checking claims status, understanding the development process, conducting Occupational History Questionnaires, uploading forms and documents directly to the case file (EDP), providing an explanation of medical benefits, providing DEEOIC medical benefits brochures, assisting with the completing of medical and travel reimbursement forms, transmitting claimant reimbursement forms to the bill pay agent, assisting in locating enrolled medical providers, troubleshooting medical billing issues for claimants and providers, notifying the Medical Bill Processing Unit and Medical Benefits Adjudication Unit about claimant reimbursement or provider bill issues, assisting providers by explaining DEEOIC provider enrollment, and updating provider enrollment and information on the OWCP Medical Bill Processing Portal and DEEOIC websites. The RC staff also identify outreach needs, identify outreach locations, venues, and oversee logistics for each event, as well as conduct monthly local outreach to include literature distribution, residential mailings, local advertisements, and attending meetings of local community organizations. The RC staff play a role in organizing the Authorized Representative workshops and JOTG outreach events. The RC staff also answer all incoming calls directed to the RC numbers and to the DEEOIC toll free lines, which results in answering approximately 2,500 calls per week. *See* DEEOIC Webinar Presentation – Role of the Resource Centers (May 25, 2022) - **https://www.dol.gov/sites/dolgov/files/OWCP/energy/regs/compliance/Outreach/Outreach_Presentation/role_of_the_rc052522.pdf**.

[53] In addition to RC staff, CEs, MBEs, and HRs, some claimants will be required to communicate with representatives from DEEOIC contractors, CNSI and Conduent.

B. Policies and Procedures

During 2022, claimants and ARs brought their concerns, as well as requests for guidance and assistance, to the Ombuds related to the implementation of DEEOIC policies and procedures. Since 2017, there have been 15 updates to the EEOICP Procedure Manual.[54] From 2002 through 2022, DEEOIC has issued 248 Bulletins,[55] of which 68 remain active, and from 2003 through 2022, DEEOIC has issued 105 Circulars,[56] of which 91 remain active. Thus, DEEOIC staff are responsible for understanding and implementing 159 active bulletins and circulars in addition to the EEOICP PM and various other forms of programmatic guidance.[57]

The requests for assistance and guidance were wide-ranging, from questions regarding how DEEOIC contracted industrial hygienists evaluate evidence and reach their opinions on toxic substance exposures, to questions about the policy for hearing loss, to questions regarding eligibility for impairment compensation or certain medical benefits. Therefore, with such a large body of guidance published by DEEOIC regarding the claims adjudication process, claimants and ARs found it challenging to keep current and understand how the latest DEEOIC policy guidance may be implemented in their claims. Additionally, as will be discussed later in this report, claimants with previously denied claims contacted the Ombuds to inquire about how updates to policies or procedures could impact their claims. The discussion below focuses on concerns regarding the clarity and consistency of the implementation of specific DEEOIC policies and procedures.

i. Industrial Hygiene Reports

As in 2021, an ongoing area of concern for claimants and their ARs was the use of language by DEEOIC contracted IHs that was similar to the language of rescinded Circular No. 15-06. The relevant language of rescinded Circular No. 15-06 is,

> **As a result, the CE can accept the following: For employees diagnosed with an illness with a known health effect associated with any toxic substance present at a DOE facility after 1995, it is accepted that any potential exposures that they might have received would have been maintained within existing regulatory standards and/or guidelines." EEOICPA Circular No. 15-06, Post-1995 Occupational Toxic Exposure Guidance** (December 17, 2014).

On February 2, 2017, at the recommendation of the Advisory Board on Toxic Substances and Worker Health (ABTSWH), Circular No. 15-06 was rescinded. The ABTSWH criticized Circular No. 15-06, in part, because it was doubtful that sufficient industrial hygiene monitoring was performed throughout the DOE complex from 1995 to the present to substantiate the broad claim that all exposures were

[54] Version 7.0 of the EEOICP PM contains 711 pages of policy and procedural guidance. (October 20, 2022).
[55] Bulletins provide detailed guidance to claims staff on handling of new claim situations not addressed in the Federal (EEOICPA) Procedure Manual. Bulletins have a one-year expiration date but remain in effect until incorporated into the Federal (EEOICPA) Procedure Manual or replaced by another Bulletin.
[56] Circulars communicate items of informational value relating to the DEEOIC or announce a program change. No specific action is required relating to the issuance of a Circular.
[57] Links to the EEOICP PM, bulletins and circulars can be found on the DEEOIC homepage at **https://www.dol.gov/agencies/owcp/energy**.

routinely kept below existing standards. The ABTSWH also noted that the last paragraph of Circular No. 15-06 acknowledged that even minimal exposure to some toxins may lead to illness, and in that case, the circular contradicts its own principal conclusion that post-1995 exposures are to be considered, as a rule, insignificant. *See* ABTSWH Recommendation #1 (Adopted at October 17-19, 2016, Meeting.)

Circular No. 17-04 not only rescinded Circular No. 15-06, but it stated that the potential for toxic substance exposure in all claims must be evaluated based upon established program procedure and the evidence presented in support of a claim. *See* EEOICPA Circular No. 17- 04 (February 2, 2017).

Subsequently, the Ombuds received copies of IH reports that contained the following language when the worker had established employment at a DOE facility after the mid- 1990s,

> **There is no available evidence (i.e., person and/or area industrial hygiene monitoring data) to support that, after the mid-1990s, [his/her] exposures would have exceeded existing regulatory standards.**

The effect of the language quoted above was similar to the language of rescinded Circular 15-06 in that contractor IHs consistently determined that workers with covered employment at DOE facilities after the mid-1990s had toxic substance exposure levels that did not exceed existing regulatory standards and thus were incidental, occurring in passing only. Such characterizations by IHs, when relied upon by treating physicians or CMCs, regularly resulted in negative causation determinations and the denial of Part E claims.

On June 29, 2022, after conducting a review of selected individual claims, the ABTSWH again took up the issue of the language used by IHs to describe toxic substance exposure levels for covered DOE employment occurring after the mid-1990s. The ABTSWH published the following formal recommendation,

> **The Board recommends that the EEOICP advise its staff and IH contractor that claim-related industrial hygiene reports and opinions restrict comparisons of claimants' exposures to toxic substances at DOE facilities to regulatory workplace exposure standards only to cases where sufficient industrial hygiene data exist that are relevant to the claim and that support the comparisons. Comparisons of exposures to regulatory standards must describe the available industrial hygiene data and specific regulatory limit referenced, with preference for the most current standards. In the absence of specific industrial hygiene evidence, comparisons of claimants' workplace exposures to regulatory standards lacks objective support and may be prejudicial to an appropriate resolution of the claim.** (ABTSWH Letter to Secretary Martin J. Walsh, July 11, 2022.)

In support of the formal recommendation, the ABTSWH explained that relatively little industrial hygiene data are available from the DOE sites, and that when such data is available, they mostly derive from incident-related short-term releases and exposures, and in contrast, most chronic occupational diseases that are the subject of most EEOICP claims are due to ongoing exposures to toxic substances over

months and years. The ABTSWH further noted that it was uncommon to measure ongoing exposures at DOE sites, especially over the last decade of the 20th century, and thus, objective evidence of exposures to toxic substances at any level (low or high, or above or below regulatory standards) was mostly absent in the evaluation of EEOICP claims and the IH evaluations of these claims. The ABTSWH found that it was incomplete and misleading for the IHs to state that there was no evidence of toxic exposures in excess of regulatory standards when, in most cases, there was either none or minimal industrial hygiene evidence concerning the relevant exposures. *See* ABTSWH Recommendation on IH Report Language, adopted June 29, 2022.

The ABTSWH concluded that a critical problem with the text about not exceeding regulatory standards in IH reports was that the medical consultants or claims examiners who were asked to address causation were very likely to use the conclusions of the IH reports in formulating their causation opinions. If the industrial hygiene conclusion was that no evidence existed that regulatory standards were exceeded, many physicians would use such a conclusion to decide that there was no causation, leading ultimately to claim denial. *See* ABTSWH Recommendation on IH Report Language, adopted June 29, 2022.

By way of background, in preparing to refer a claim to an IH, one of the primary sources of toxic substance exposure information that CEs provide to the IH is data from the DEEOIC Site Exposure Matrices (SEM) database. CEs search the SEM database in an effort to identify toxic substances a worker may have encountered at a DOE facility or uranium mine, mill or ore buying station that have a known link to the worker's claimed medical illness. When the CEs identify such links, they are to provide this toxic substance information to the IH. However, when more than seven (7) toxic substances are identified, the CE is instructed to consult with, "...the National Office IH to identify which toxins were most likely to have been encountered and which would likely have the greatest impact on the claimant's claim. Based on the consult, the CE will include as many of the toxins as is necessary." EEOICP PM Appendix 1, Exhibit 15-5, Industrial Hygiene Referral Instructions (Version 7.0) (October 20, 2022). However, claimants and ARs are not informed when CEs make the decision to limit the number of toxic substances the claimant was exposed to, nor is the claimant consulted during the process to limit the number of toxins referred to the IH.

CEs are further instructed to provide the IHs with the DEEOIC Exposure Worksheet (or equivalent), the Occupational History Questionnaire, relevant DAR records from DOE, the Employment History Form (Form EE-3), and any employee letters about exposures or work duties, affidavits, or other similar documents completed by other sources. EEOICP PM Appendix 1, Exhibit 15-5, Industrial Hygiene Referral Instructions (Version 7.0) (October 20, 2022). Missing from the referral package is the information that the links between toxic substances and medical illnesses in the SEM database only exist where it has been established that exposure to the toxic substance can *cause* the illness. The SEM database contains no information on toxic substance exposures that may *contribute to* or *aggravate* an illness. *See* EEOICP PM Chapter 15.8(a)(5) (Version 7.0) (October 20, 2022). Thus, the information in the SEM database linking toxic substances and medical illnesses only addresses one-third of the claimant's burden of proof under Part E.[58] The combination of the type of information shared with the

[58] Under Part E, a DOE contractor employee must prove by a preponderance of the evidence that it is at least as likely at not that exposure to a toxic substance at a DOE facility was a significant factor in *causing, contributing to*, or *aggravating* the illness, and it is at least as likely as not that the exposure to such toxic substance was related to employment at a Department of Energy facility. *See* 42 U.S.C. § 7385s-4(c). (Emphasis added.)

IH, and the way the information is conveyed are policy determinations that claimants are generally unaware of. Then, the claimant's path to a positive outcome is further narrowed based upon the IH's assumption that toxic exposures are incidental, in passing only, for employment occurring after the mid-1990s in the absence of industrial hygiene data demonstrating toxic exposures that exceeded existing regulatory limits, or an absence of documented workplace violations or incidents.

Furthermore, since February 2, 2017, DEEOIC has not published policy guidance addressing the specific language used by IHs regarding the application of existing regulatory standards to exposure assessments for claims with employment after the mid-1990s. Nonetheless, because the language remained ubiquitous in IH reports, the ABTSWH, arguing against this ongoing practice, stated,

> **[T]he Board believes that the industrial hygiene evaluation should adhere to the known facts of the claim combined with the application of their expert opinion regarding activities at DOE sites, but that interpreting the claimant's exposure experience in terms of regulatory standards when no or insufficient industrial hygiene data exist is improper, unfairly tilts the scales against claimant, and should not be employed.** *See* ABTSWH Recommendation on IH Report Language, adopted June 29, 2022.

On October 24, 2022, DEEOIC published Bulletin 23-02 regarding industrial hygiene reporting of exposure levels. Subsequently, DEEOIC's position with respect to the language regarding the assessment of toxic exposure in light of regulatory limits was further clarified at the November 30, 2022, meeting of the ABTSWH,

> **[Bulletin 23-02] eliminated the reference to exposures within regulatory limits.**
>
> **********
>
> **[Industrial Hygienists will] acknowledge that an exposure could have occurred. In other words, that we're not saying that someone who was working after the mid- 1990s couldn't have had contact with a particular toxic substance. *It's just that exposure from the viewpoint of an IH is not significant in the way that we define significant exposure.* So I would encourage the board to definitely take a look at that.**
>
> **********
>
> **So this guidance is now what is in force for IHs as they begin evaluating cases primarily for those individuals that are working after – I would say the later years, 1990s through present.** ABTSWH Meeting Transcript, pgs. 191, 192, & 193 (November 30, 2022) (Emphasis added).

While the issuance of Bulletin 23-02 may have eliminated the "exposures within regulatory limits" language from IH reports, the reports have continued to state that significant exposures to toxic materials at DOE facilities was greatly reduced after the mid-1990s, and that any work processes, events, or circumstances leading to a significant exposure would likely have been identified and

documented in employment records. To date, the conclusions reached by IHs asked to review the toxic exposures of workers with covered Part E employment after the mid-1990s often remain the same, i.e., in the absence of documentation of a workplace exposure violation or incident, any workplace exposures were not significant and were incidental, in passing only.

Moreover, an AR complained to the Ombuds in 2022 that IH reports appeared to have been written from templates, that duration of exposure was not always evaluated, and that not all of the references cited by IHs were current. The AR further expressed the concern that the absence of exposure records at most federal nuclear weapons facilities rendered the conclusions by IHs regarding the frequency and levels of exposure in significant doubt.

The AR also provided information regarding a claimant with covered DOE employment beginning in the 2000s. The claimant's treating physician identified toxic substances the claimant was exposed to that had a link to his/her claimed illness and wrote a causation report on his/her behalf.[59] The CE subsequently referred the claim to an IH, who reported that in the absence of compelling evidence to the contrary, it was highly unlikely the claimant was significantly exposed to the identified toxic substances, and that any exposures would have been incidental and not significant. The IH report was then sent to the claimant's treating physician, and after determining the treating physician's causation report was not well-rationalized, the CE forwarded the IH report and claim file evidence to a CMC. The CMC, who relied upon the IH report, opined that it was not at least as likely as not that exposure to toxic substances at a DOE facility was a significant factor in causing, contributing to, or aggravating the claimed illness.

The concern expressed by the AR was that in the absence of exposure documentation from DOE, the IH noted the claimant's exposures occurred after the mid-1990s and determined that such exposures were not significant, which in turn formed the basis for the CMC's negative causation opinion. The AR questioned how the IH reached the conclusion that the claimant's exposures were incidental without relying upon the rationale that after the mid- 1990s, the exposures would not have exceeded existing regulatory standards. According to the AR, the IH construed the lack of exposure records from DOE to mean that the claimant's exposures were incidental because they occurred after the mid-1990s, and there was no documentation of a workplace exposure violation or incident. The updated language DEEOIC has provided to IHs to assess claims with employment after the mid-1990s appears to be causing confusion and requires further clarification regarding its meaning and usage.

ii. Bilateral Sensorineural Hearing Loss

DEEOIC first created policy criteria for the acceptance of bilateral sensorineural hearing loss (hearing loss) claims in 2008, and this policy has undergone a number of updates since then, including most recently in October 2022. From the initial publication of the policy, the Ombuds has received complaints, concerns, and requests for assistance with respect to the policy criteria itself as well as questions regarding what action DEEOIC does or does not take following a policy change. For example, claimants and ARs have consistently questioned the requirement that the employee establish verified

[59] A search of the SEM database by the CE and HR failed to identify any toxic substances with a known link to the claimant's claimed medical condition. The toxic substances identified by the treating physician were based upon scientific research conducted by the physician.

covered employment within at least one specified job category[60] for a period of 10 consecutive years, completed prior to 1990. Likewise, the criteria requiring documentation of exposure to one or more organic solvents[61] for 10 consecutive years has generated questions and complaints each year.

In many cases, the policy criteria has been strictly interpreted by CEs and HRs to mean that if claim file evidence failed to meet the three components of the hearing loss criteria,[62] the claim was denied without further evaluation of the evidence to determine if it was at least as likely as not that exposure to a toxic substance was a significant factor in causing, contributing to, or aggravating the claimed hearing loss.[63] For example, in decisions shared with the Ombuds, CEs and HRs have cited DEEIOC policy language that has been in effect since 2015 which states,

> **This policy guidance represent [*sic*] the sole evidentiary basis a CE is to use in making a decision concerning whether it is "at least as likely as not" that an occupational exposure to a toxic substance was a significant factor in aggravating, contributing to or causing a diagnosed bilateral sensorineural hearing loss. Claims filed for hearing loss that do not satisfy the conditions for acceptance outlined in this procedure cannot be accepted, because these standards represent the only scientific basis for establishing work-related hearing loss due to exposure to a toxic substance.** *See* EEOICP Transmittal No. 16-01 (November 2015) and EEOICP PM Appendix 1, Exhibit 15-4.9 (Version 7.0) (October 20, 2022).

This policy language has been cited in decisions denying hearing loss claims where the evidence did not support the three components of the hearing loss criteria in the PM, but the evidence did establish exposure to at least one of the specified organic solvents while the claimant was employed in one of the specified labor categories for a period of more than 10 consecutive years that extended beyond the 1990 cut-off date.

For example, in August of 2022, an AR contacted the Ombuds after their request for reopening of the claimant's claim for hearing loss was denied.[64] The AR indicated the claimant was consecutively employed from 1981 through 2016 in two of the labor categories required under the DEEOIC hearing loss criteria, and that the claimant was exposed to one or more of the specified organic solvents during the entirety of his/her verified covered employment. The claim had been denied because the claimant began work at the facility in 1981, and therefore did not have 10 consecutive years of employment prior to 1990. The AR based the reopening request upon a 2022 report from the claimant's ENT treating physician who offered the opinion that a combination of loud noise, exposure to ototoxic chemicals and fumes, and exposure to manganese fumes from 1988 to 2016 caused the claimant's hearing loss. The AR argued that prior DEEOIC decisions had not taken into account the claimant's exposure to manganese, and that training for the use of an alternate air supply while welding did not begin until

[60] There are 22 labor categories identified in EEOICP PM Version 7.0 (October 20, 2022).
[61] There are nine organic solvents identified in EEOICP PM Version 7.0 (October 20, 2022).
[62] The three components are the diagnosis of bilateral sensorineural hearing loss; 10 consecutive years of verified covered employment in at least one or more of the 22 specified labor categories; and exposure to one or more of the 9 specified toxic substances for at least 10 consecutive years of verified employment.
[63] *See* Examples are discussed in the Office of the Ombudsman Annual Reports to Congress in 2014, 2015, 2016, 2017, 2018, and 2019.
[64] The claimant had sought to reopen the September 26, 2019, Final Decision to deny the claim.

2015, and even then, it was not enforced. The claimant's Request for Reopening was denied on July 14, 2022, based upon the finding that the claimant did not have 10 consecutive years of employment in one of the specified labor categories prior to 1990. The AR wrote to the Ombuds that the claimant had worked as a welder for 28 years, and,

> **[u]nder the current Energy Employees Compensation Program, it does not allow for those who develop hearing loss after the cutoff date of 1990. This needs to be amended to include those whose position (welding) exposes them to more than one risk for hearing loss, noise exposure, ototoxic chemical exposure, and exposure to welding fumes (Manganese).** (Letter from AR to Ombuds, August 30, 2022.)

Subsequently, the DEEOIC published Version 7.0 of the PM which updated the hearing loss employment criteria to include the following language,

> **Upon review of the available case evidence, if the CE determines that the evidence establishes that the employee had *any 10-year period* of consecutive (applies to any time period and any labor category) employment during which the employee had exposure to a qualifying toxic substance, the CE refers the claim to an IH who will apply their subject matter expertise to decide whether the employee concurrently had consistent daily exposure to noise of at least 85 decibels.** EEOICP PM Appendix 1, Exhibit 15-4.9(c)(2) (Version 7.0) (October 20, 2022). (Emphasis added).

This update to the hearing loss policy appeared to apply to the claimant's case and so the Ombuds informed the AR of the new policy language. The AR inquired as to whether DEEOIC would be automatically conducting a review of claims that could be impacted by the policy update, but DEEOIC had not indicated such a review would be conducted. The Ombuds informed the AR that it would be best for them to take action if they wished to have the claim further reviewed.

The October 2022 policy update also included additional changes to the hearing loss policy. For example, the policy previously stated,

> **With a well-designed SEM search that correlates to the employee's work history in a qualifying labor category, any identified potential exposure to one of the noted toxins above is sufficient for the CE to accept for application in the hearing loss standard.** *See* EEOICP PM Appendix 1, Exhibit 15-4.8 (Version 6.0) (April 4, 2022).

The policy language was then updated to state,

> **With a well-designed SEM search that correlates to the employee's work history, an identified potential exposure to one of the noted toxins above *is sufficient to proceed with further examination of the hearing loss claim*.** *See* EEOICP PM Appendix 1, Exhibit 15-4.9 (Version 7.0) (October 20, 2022).

The change in the highlighted text suggests that CEs may no longer have the authority to rely upon their search of the SEM database to accept that the claimant had sufficient toxic exposure to satisfy that component of the hearing loss criteria. The full implications of this policy update are somewhat unclear as an insufficient number of cases have been brought to the attention of the Ombuds in order to better understand the implementation of the policy.

Thus, claimants with denied hearing loss claims are unaware of whether DEEOIC will be, 1) notifying them of the updates to the hearing loss policy, and 2) reviewing previously denied hearing loss claims to identify those that could be impacted by the updated policy. The claimant in the case discussed above was fortunate to have been in communication with the Ombuds when the policy update was issued by DEEOIC because the AR was otherwise unaware of the update. The Ombuds recommends that DEEOIC notify all claimants with previously denied hearing loss claims of all policy updates that may impact their claims.

CHAPTER V.
OTHER ISSUES AND COMPLAINTS

IIn 2022, claimants and their ARs contacted the Ombuds with questions and concerns regarding a variety of issues and topics. The remaining discussion addresses issues concerning DEEOIC decisions that did not fully discuss or weigh the evidence in the case, as well as questions raised regarding whether and/or how claimants are notified of DEEOIC policy updates.

A. Decisions Lack Discussion/Weighing of Evidence

When claimants receive any type of correspondence from DEEOIC, they expect to be provided information that allows them to understand what is happening with their claim, and why their claim is or is not in a posture to be accepted. For example, when DEEOIC sends a letter to a claimant requesting additional evidence, claimants expect to be informed what they need to provide to DEEOIC and how that evidence is necessary to support their claim. In decisions, claimants expect to see a discussion of the evidence in the claim file and an explanation of how the claims examiner weighed that evidence when reaching their conclusions.

In June 2022, a claimant sought the assistance of the Ombuds in understanding why his/her claim for a consequential illness had been denied. The claimant had submitted medical evidence supporting the connection between his/her accepted covered illness and the claimed consequential condition, but the CE determined the claimant's medical evidence did not provide a well-rationalized opinion regarding how the accepted medical condition caused, contributed to, or aggravated the consequential condition. Therefore, the CE referred the claim to a CMC for an opinion on this issue. The CMC provided a report that reviewed the available medical evidence and opined that the accepted covered illness had not caused, contributed to, or aggravated the claimed consequential medical condition. However, the final

decision the claimant received described the evidence submitted by the claimant, but simply noted the CMC's conclusion and denied the claim. The decision contained no discussion of the explanation provided by the CMC, nor did it weigh the totality of the evidence submitted in the claim. The Ombuds attempted to assist the claimant in understanding why his/her claim had been denied but was unable to provide a full explanation to the claimant based upon the decision.

When decisions do not identify the evidence submitted by claimants in support of their claims, or do not weigh the evidence such that claimants can understand the conclusions reached by the claims examiner, not only are claimants unaware of why their claims were denied, but the decisions are inconsistent with DEEOIC policy. The Explanation of Findings section of the recommended decision should,

> **...explain the CE's analysis of the case evidence used to arrive at the various factual findings necessary to substantiate a conclusion on benefit entitlement. It is critical that the CE writing the decision include a compelling, robust justification of his or her decision to accept or deny a claim. CE findings made without an explanatory justification or communicated in vague or overly broad language is not appropriate. A poorly written decision increases the likelihood that a claimant will not understand the outcome of the claim and the probability of objection.** *See* EEOICP PM Chapter 24.7(a)(3) (Version 7.0) (October 20, 2022).

While the policy guidance is clear, it is uncommon for a decision recommending denial of a claim to be remanded to the district office when it is inconsistent with the policy guidance addressing the content of decisions. Instead, as the PM section above alludes to, claimants who wish to challenge a recommended denial must file objections to the recommended decision. However, without a clear understanding as to why they received a recommended denial, claimants are at a disadvantage when they attempt to articulate the basis for their objections and, more importantly, when they attempt to identify and submit evidence to address the deficiencies in their claim. Absent a clear understanding of the deficiencies in their claim, claimants struggle to produce relevant evidence within the timeline they are provided on appeal.

The Ombuds encourages DEEOIC to specifically assess whether decisions denying benefits include a discussion of the evidence submitted and an explanation of how that evidence was weighed in reaching the conclusions.

B. Claimants Lack Information About Policy Updates

Most claimants and ARs do not check online for DEEOIC policy or programmatic updates. DEEOIC has conducted reviews of previously denied claims in some circumstances, such as when a new SEC employment period has been created, or when a certain toxic substance has been linked to a specific cancer under Part E.[65] However, DEEOIC has not published a policy regarding when and how claimants are to be notified of policy updates, even when those policy updates could impact the outcome of their claims for benefits.

[65] DEEOIC has not automatically reviewed previously denied claims for all of the policy updates addressing a new link between a toxic substance and a medical condition.

It would be beneficial for all claimants to be notified of policy updates that could impact their claims. Likewise, it would be beneficial for DEEOIC to publish a policy clearly stating whether claims will be automatically identified and reviewed by DEEOIC when a new or updated policy could have an impact on previously adjudicated claims. Claimants and ARs have expressed the general concern that communication from DEEOIC primarily consists of requests for information and evidence but does not provide sufficient information and guidance for claimants to meaningfully participate in the processing of their own claims. Notifying claimants of new or updated policies that could impact their claims, as well as creating a policy to identify when and how policy updates will trigger DEEOIC's automatic review of previously denied claims would be beneficial for all claimants.

For example, the Ombuds heard from claimants in 2022 who reached out for the sole purpose of learning whether there had been any policy changes or updates that could impact their claims. One claimant was a survivor whose parent had worked at two of the gaseous diffusion plants in the 1940s and for whom medical records regarding his/her cancer diagnosis no longer existed. The claimant, who had since moved across the country and away from the vicinity of the facilities where their parent worked, heard mention of the EEOICPA on a local radio station and as a result contacted the Ombuds. While no policy updates were identified that could assist this claimant, the conversation was helpful in that the claimant was provided information regarding how to update their mailing address with the DEEOIC. Another exampled involved a claimant seeking information regarding policy updates that would impact the designation of a particular type of covered facility under the EEOICPA.

Finally, when a claim is impacted by a new policy or procedure, claimants want to understand the reasoning/rationale for this change. Claimants want the opportunity to review the policy and the documentation relied upon in making the change (or to have their own experts review the policy and underlying documentation). When claimants are not provided an opportunity to fully review these determinations, they sometimes come up with their own explanations for these changes. And when this happens, some claimants conclude that the change was specifically made in order to deny their claim.

APPENDIX 1

ACRONYMS (ABBREVIATIONS) USED IN THIS REPORT

ABTSWH	Advisory Board on Toxic Substances and Worker Health
AEC	Atomic Energy Commission
AR	Authorized Representative
AWE	Atomic Weapons Employer
BeLPT	Beryllium Lymphocyte Proliferation Test
CBD	Chronic Beryllium Disease
CE	Claims Examiner
CMC	Contract Medical Consultant (formerly known as District Medical Consultant)
CPWR	Center for Construction Research and Training
CX Team	Customer Experience Team
DCMWC	Division of Coal Mine Workers' Compensation
DEEOIC	Division of Energy Employees Occupational Illness Compensation
DLHWC	Division of Longshore and Harbor Workers' Compensation
DME	Durable Medical Equipment
DOD	Department of Defense
DOE	Department of Energy
DOJ	Department of Justice
DOL	Department of Labor
EEOICPA	Energy Employees Occupational Illness Compensation Program Act
FAB	Final Adjudication Branch
FECA	Federal Employees Compensation Act
FOIA	Freedom of Information Act
FWP	Former Worker Medical Screening Program
HHS	Department of Health and Human Services
HR	Hearing Representative
ICD-10	International Classification of Diseases, 10th Edition
IH	Industrial Hygienist
JOTG	Joint Outreach Task Group
MBE	Medical Benefits Examiner

MED	U.S. Army Corps of Engineers Manhattan Engineer District
NDAA	National Defense Authorization Act
NIOSH	National Institute for Occupational Safety and Health
NO	National Office
OMBUDS	Office of the Ombudsman for the EEOICPA
OWCP	Office of Workers' Compensation Programs
PM	Procedure Manual
PoC	Probability of Causation
RECA	Radiation Exposure Compensation Act
RESEP	Radiation Employees Screening and Education Program
RC	Resource Center
SEC	Special Exposure Cohort
SEM	Site Exposure Matrices
SSA	Social Security Administration
The Act	Energy Employees Occupational Illness Compensation Program Act

APPENDIX 2

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH 2022 RECOMMENDATIONS

Advisory Board on Toxic Substances and Worker Health

June 30, 2022

Mr. Martin J. Walsh
Secretary of Labor
Department ofLabor
200 Constitution Ave.
Washington, DC NW 20210

Honorable Secretary Walsh:

On behalf of the Department of Labor Advisory Board on Toxic Substances and Worker Health, I submit the attached Advisory Board Recommendation that was adopted unanimously at the Board's meeting on June 29, 2022.

We sincerely hope that our advice is useful to the Department. We thank you for the opportunity to serve as Board members and wish the Program continued success in meeting the needs of the United States energy employees. Please let us know if there are questions.

Sinerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Advisory Board on Toxic Substances and Worker Health

RECOMMENDATION ON BORDERLINE BERYLLIUM LYMPHOCYTE PROLIFERATION TEST

The Board recommends that the Department of Labor communicate to Congress the need for a technical amendment in the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) that will recognize that covered individuals as defined in The Act and who have three borderline beryllium lymphocyte proliferation test results, have beryllium sensitivity.

RATIONALE

Beryllium lymphocyte proliferation test Some individuals who have been exposed to beryllium develop an immune reaction to the metal, which can remain silent without symptoms or illness (beryllium sensitization) or can progress to cause persistent symptoms and organ damage (chronic beryllium disease). Beryllium sensitization is detected through testing the reactivity of cells (lymphocytes) that are contained in venous blood or, much less commonly, in the lungs. The blood beryllium sensitization test, called the beryllium lymphocyte proliferation test (BeLPT), is the most widely used, scientifically accepted means to determine if a person is immunologically reactive to beryllium and at risk for subsequent chronic beryllium disease. The beryllium lymphocyte proliferation test, like all medical tests, has both strengths and limitations as an indicator of immune system reactivity and as a predictor of progression to chronic beryllium disease. It can be falsely positive or falsely negative. The latter can occur when a truly sensitized person is on a medication that suppresses the immune system (e.g., steroids), causing the immune cells to fail to react to the beryllium challenge of the BeLPT. Even in the absence ofimmunosuppression, some people react to beryllium but in a manner that is only weakly abnormal, leading to a BeLPT test result that is labeled as "borderline" by the testing laboratory. However, whether a person has a falsely negative test result due to immunosuppression or a borderline BeLPT test result, they are still at risk of progressing to chronic beryllium disease and require access to diagnostic testing and ongoing monitoring.

Borderline BeLPT Uncommonly, persons have persistent borderline BeLPT test results on multiple BeLPT tests. A large study of 19,396 BeLPT tests among 7,820 DOE workers yielded 37 people (~0.5%) who had two consecutive borderline BeLPT test results (1). However rare, this group is important in applying an equitable definition of who has beryllium sensitivity. A widely recognized published study, using BeLPT test results from DOE workers, concluded that people who work in a beryllium-using environment with a reasonable population prevalence of chronic beryllium disease (2%) and have three borderline BeLPT test results are 91.2% likely to have beryllium sensitivity (2).

The virtual equivalence between repeated borderline BeLPT test results and frankly abnormal BeLPT test results have led professional organizations, beryllium disease experts, DOE contractor medical providers, and government agencies to conclude that a person with three borderline BeLPT tests should be treated as if their BeLPT test result was abnormal. These include the American Thoracic Society (3), National Jewish Health (4), Department of Energy (5), OSHA (6), Washington State (7), and the Energy Facility Contractors Group (4)

Gap in the EEOICP Act The EEOICP Act provides benefits for covered beryllium employees at a Department of Energy facility or beryllium vendor facility if they develop beryllium sensitization or chronic beryllium disease. The Act defines beryllium sensitivity as "established by an abnormal beryllium lymphocyte proliferation test performed on either blood or lung lavage cells." The Act provides for ongoing medical monitoring for covered employees with beryllium sensitivity and requires beryllium sensitivity as an element in diagnosing a covered employee as having "established chronic beryllium disease" after January I, 1993. The Act currently does not recognize or comment on the significance of a borderline BeLPT test result.

Proposed Act Modification A solution to this gap is a small modification in the language of the Act to the following: "The Act defines: "Beryllium sensitivity as established by an abnormal beryllium lymphocyte proliferation test performed on either blood or lung lavage cells ***or three borderline beryllium lymphocyte proliferation tests performed on blood cells."*** (The new text is added in bold) [Title 42, Chapter 84, Subchapter XVI, Part B, Section 73841, (8)]. The administrative, resource, and fiscal impact of the proposed change will be minor in that the number of DOE workers with three borderline LPT's is a small fraction of the number of workers tested for beryllium sensitivity or who have an abnormal BeLPT.

REFERENCES

1. Stange AW, Furman FJ, Hilmas DE. The beryllium lymphocyte proliferation test: Relevant issues in beryllium health surveillance. Am J Ind Med. 2004 Nov;46(5):453-62.
2. Middleton DC, Mayer AS, Lewin MD, Mroz MM, Maier LA. Interpreting borderline BeLPT results. Am J Ind Med. 2011 Mar;54(3):205-9.
3. Balmes JR, Abraham JL, Dweilc RA, Fireman E, Fontenot AP, Maier LA, et al; ATS Ad Hoc Committee on Beryllium Sensitivity and Chronic Beryllium Disease. An official American Thoracic Society statement: diagnosis and management of beryllium sensitivity and chronic beryllium disease. Am J Respir Crit Care Med. 2014 Nov 15;190(10):e34-59.
4. Letter from Lisa Maier, Annyce Mayer, and Kalie Von Feldt to Rachel P. Leiton, February 22, 2018.
5. DOE Beryllium Rule
6. OSHA Beryllium Rule
7. Washington State Department of Labor and Industries
8. Newman LS and Maier LA. Chronic Beryllium Disease. UpToDate. **https://www.uptodate.com/contents/chronic-beryllium-disease-berylliosis?search=beryllium&source=search_result&selectedTitle=1~19&usage_type=default&display_rank=1** Accessed June 30, 2022

Advisory Board on Toxic Substances and Worker Health

July 11, 2022

Mr. Martin J. Walsh
Secretary of Labor
Department ofLabor
200 Constitution Ave.
Washington, DC NW 20210

Honorable Secretary Walsh:

On behalf of the Department of Labor Advisory Board on Toxic Substances and WorkerHealth, I submit the attached Advisory Board Recommendation that was adopted unanimously at the Board's meeting on June 29, 2022.

We sincerely hope that our advice is useful to the Department. We thank you for the opportunity to serve as Board members and wish the Program continued success in meeting the needs of the United States energy employees. Please let us know if there are questions.

Sinerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Advisory Board on Toxic Substances and Worker Health

BOARD RECOMMENDATION ON INDUSTRIAL HYGIENE REPORT LANGUAGE (ADOPTED JUNE 29, 2022)

The Board recommends that the Energy Employees Occupational Illness Compensation Program advise its staff and industrial hygiene contractor that claim-related industrial hygiene reports and opinions restrict comparisons of claimants' exposures to toxic substances at Department of Energy facilities to regulatory workplace exposure standards only to cases where sufficient industrial hygiene data exist that are relevant to the claim and that support the comparisons. Comparisons of exposures to regulatory standards must describe the available industrial hygiene data and the specific regulatory limit referenced, with preference for the most current standards. In the absence of specific industrial hygiene evidence, comparisons of claimants' workplace exposures to regulatory standards lacks objective support and may be prejudicial to an appropriate resolution of the claim.

RATIONALE

In the recent Board review of selected individual claims that were resolved in 2019-2021, Board members noted frequent inclusion in the industrial hygiene reports of conclusory language to the effect that there was no evidence found during the claim evaluation that exposures to toxic substances of said claimant exceeded regulatory standards. In addition, there is a footnote in these reports that exposures to specific toxic substances below regulatory standards will protect most workers against harm caused by the toxic substances in question.

The Board had a very fruitful discussion of these statements and their context with Mr. Jeffrey Kotsch and Mr. John Vance of the Energy Employees Occupational Illness Compensation Program at the Board meeting on May 10-11, 2022. They confirmed the general knowledge held by many Board members that relatively little industrial hygiene data are historically available from the Department of Energy sites and that, when such data are available, they mostly derive from incident-related short-term releases or exposures. While such episodes of exposure can lead to acute or, less commonly, persistent health problems, most chronic occupational diseases that are the subject of most EEOICP claims are due to ongoing exposure to toxic substances over months or years of employment. This applies to cancers, chronic lung diseases, chronic beryllium disease, Parkinsonism, and others. Ongoing exposures were uncommonly measured at DOE sites (and throughout U.S. industry), especially over the last decades of the 20th century. Thus, objective evidence of exposures to toxic substances at any level - low or high, or above or below regulatory standards – is mostly absent in the evaluation of EEOICP claims and attendant industrial hygiene evaluations of these claims.

It is thus, at a minimum, incomplete and, perhaps more correctly, misleading to state that there is no evidence of toxic exposures in excess of regulatory standards when the plain facts of the claim are, in most cases, that there is none to minimal industrial hygiene evidence concerning the relevant exposures.

In the absence of industrial hygiene evidence, it would be equally truthful to state that there is no evidence that the claimant's exposures were **below** the regulatory standards, implying that exposures may have routinely exceeded such standards. Such a statement would be objectionable for the same reasons.

A critical problem with the current text about not exceeding regulatory standards in industrial hygiene reports is that the medical consultants (or claims examiners if a medical consultant is not used in the case) who are asked to address causation and are given the industrial hygiene reports are very likely to use the conclusions of the industrial hygiene reports in formulating their causation opinions. Whether these physicians are provided with all of the exposure information or not (occupational health questionnaire, employment history, DOE records, and others), the fact is that the physicians will in many, and perhaps most, cases rely on the industrial hygiene expert in the case, whose opinion is expressed in the industrial hygiene report. If the industrial hygiene conclusion is that no evidence exists that regulatory standards (which protect most workers, as also stated in the industrial hygiene reports) are exceeded, many physicians will use such a conclusion to decide that there is no causation, leading ultimately to claim denial.

For these reasons, the Board believes that the industrial hygienist evaluation should adhere to the known facts of the claim combined with the application of their expert opinion regarding activities at DOE sites, but that interpreting the claimant's exposure experience in terms of regulatory standards when no or insufficient industrial hygiene data exist is improper, unfairly tilts the scales against the claimant, and should not be employed.

Advisory Board on Toxic Substances and Worker Health

December 21, 2022

Mr. Martin J. Walsh
Secretary, U.S. Department of Labor
Frances Perkins Building
200 Constitution Ave.
Washington, DC

Dear Mr. Walsh:

I am pleased to transmit a recommendation of the Department of Labor Advisory Board on Toxic Substances and Worker Health in relation to the Board's advisory capacity to the Energy Employee's Occupational Illness Compensation Program (EEOICP). It was adopted unanimously at our meeting on December 1, 2022. It is:

Exposure Evaluations for Claimants Who Worked Widely Within a Department of Energy Site

The Board hopes that our input is useful to EEOICP. It remains an honor for the Board to be cousulted on important issues that face the Program. I would be pleased to answer any questions.

Sincerely,

Steven Markowitz MD, DrPH
Chair
Advisory Board on Toxic Substances
and Worker Health

Exposure Evaluations for Claimants Who Worked Widely Within a Department of Energy Site

ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH RECOMMENDATION

(Adopted by the Advisory Board on Toxic Substances and Worker Health, December 1, 2022)

RECOMMENDATION

The Board recommends that the Department of Labor provide instruction to claims examiners, industrial hygienists, and contract medical consultant reviewers that, if there is evidence that a claimant's employment led to their routine duties being performed widely across a site, this be specifically noted in the claim file and that consideration be given in establishing toxic substance exposure and causation for exposures that are sitewide and not just limited to their work area of record.

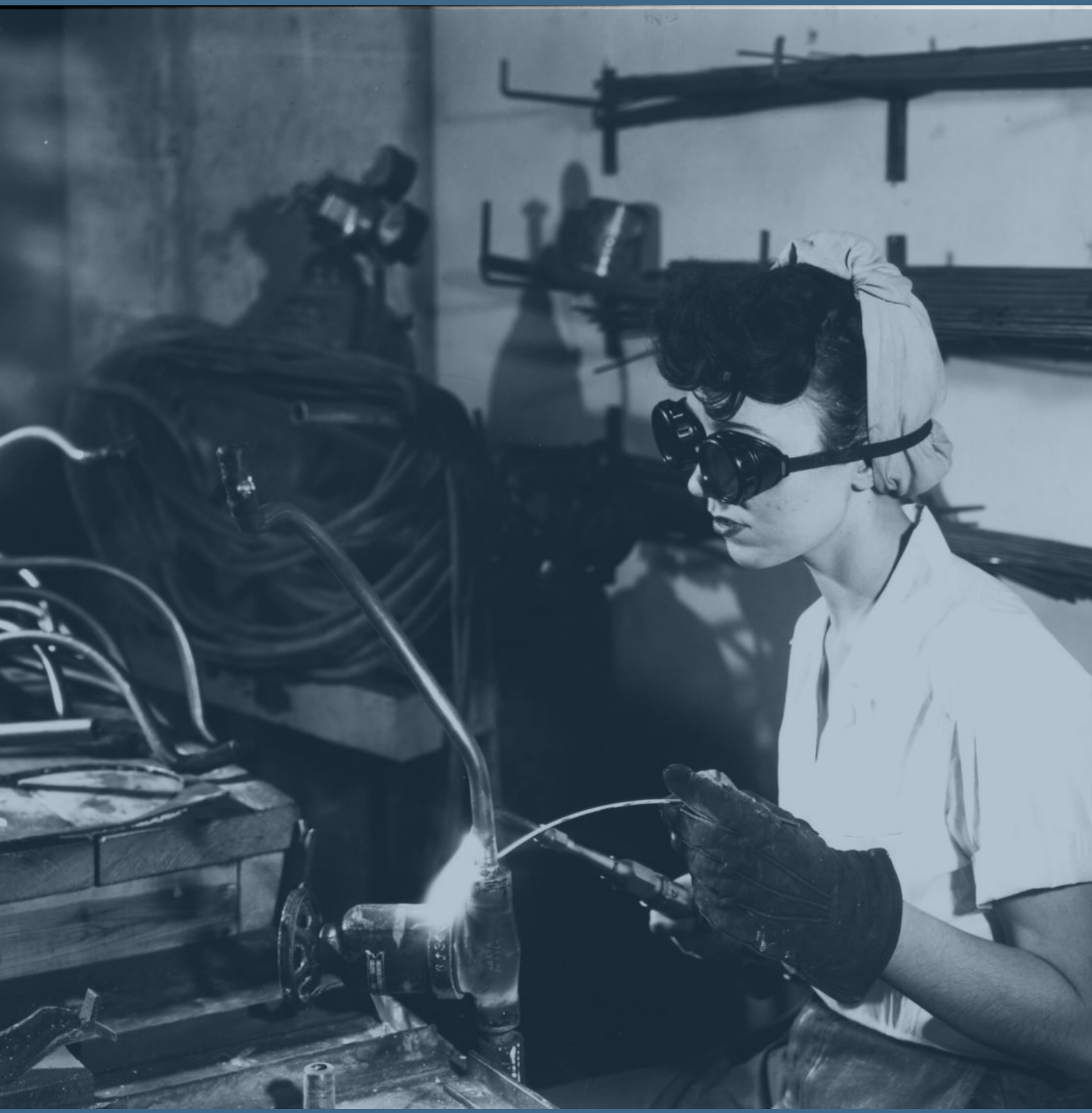
RATIONALE

The Board recognizes that the Site Exposure Matrices is a very useful tool for identifying some potential exposures to toxic substances at Department of Energy sites in relation to claims for compensation. However, there is broad agreement that, due to the incomplete nature of historic data or other evidence concerning potential exposures that occurred at Department of Energy sites, the Site Exposure Matrices provide only a partial view of such potential exposures. This limitation is in part mitigated by other sources of exposure information that are used in the claims' evaluation process.

This limitation in the Site Exposure Matrices is most conspicuous for occupations whose work tasks routinely require that they work in many areas and buildings at a Department of Energy site. These occupations include, for example, security guards, firefighters, health physics technicians and others. We have noted very considerable variation in the number and types of toxic substances associated with these job titles at different sites with the Department of Energy complex.

To address the limitation in the Site Exposure Matrices for these occupations, the claims examiners can ensure a more informed and fairer evaluation of potential exposures for a defined and finite set of these occupations through identifying their claims and through the routine referral of their claims for an industrial hygiene evaluation, indicating in the request that it is accepted that the claimant may have had a broader profile of exposure to toxic substances than the Site Exposure Matrices indicates. Such a communication should also be made to any contract medical consultants who are providing evaluations of these claims.

OFFICE OF THE OMBUDSMAN
UNITED STATES DEPARTMENT OF LABOR



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