



RELEASE - TRANSMISSION OF REVISED MATERIAL TO BE INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL: CHAPTER 2-0100 INTRODUCTION, CHAPTER 2-0200 RESOURCE CENTERS, CHAPTER 2-0300 INITIAL DEVELOPMENT, CHAPTER 2-0500 COVERED EMPLOYMENT, CHAPTER 2-0600 SEC STATUS, CHAPTER 2-0700 TOXIC SUBSTANCE EXPOSURE, CHAPTER 2-0800 WEIGHING MEDICAL EVIDENCE, CHAPTER 2-0900 CANCER AND RADIATION, CHAPTER 2-1500 CONSEQUENTIAL ILLNESSES, CHAPTER 3-0100 INTRODUCTION, CHAPTER 3-0200 MEDICAL BILL PROCESS, AND CHAPTER 3-0300 ANCILLARY MEDICAL SERVICES.

EEOICPA TRANSMITTAL NO.10-07

January, 2010

EXPLANATION OF MATERIAL TRANSMITTED:

These twelve chapters are transmitted for placement in the new Unified Procedure Manual (PM) binder. These chapters consist of the consolidation of updated information and guidance as it pertains to the Program's administration of Parts B and E of the EEOICPA. This is the final transmittal accompanying the release of the Unified Procedure Manual. All prior released chapters should now be associated with this publication in the Unified binder to serve as the official DEEOIC Procedure Manual, and all older Part B and E versions should be discarded.

New chapter 2-0100 replaces Part E chapter E-100.

New chapter 2-0200 replaces Part E chapter E-400.

- Chapter 2-0200 establishes guidelines for Resource Center use of ECMS, and provides guidance for Resource Center outreach to solicit impairment claims.

New chapter 2-0300 replaces Part B chapter 2-0100 and Part E chapter E-300.

- Chapter 2-0300 discusses the role of the Resource Centers in gathering claimant information for initial development, and establishes procedures for developing the claims of terminally ill claimants.

New chapter 2-0500 replaces Part B chapter 2-0400 and Part E chapter E-400.

- Chapter 2-0500 consolidates previous guidance for obtaining employment verification from four separate lists into a unified resource for employment verification known as the Employment Process Overview Document. Chapter 2-0500 also incorporates procedures from the following:
 - Bulletin 02-18: Use of ORISE database.
 - Bulletin 03-21: Coverage of Uniformed Members of the military.
 - Bulletin 03-26: Government Agency Employment.
 - Bulletin 03-27: Establishing covered subcontractor employment.
 - Bulletin 03-28: EEOICPA coverage of the citizens of the Marshall Islands.
 - Bulletin 06-09: Center to Protect Workers' Rights (CPWR) and its predecessor of the same name Bulletin number 04-09.
 - Bulletin 09-02: Subcontractor database for verification of contractual relationship at covered facilities.
 - Bulletin 09-10: Processing Social Security Administration Form SSA-581.

New chapter 2-0600 replaces parts of Part B chapter 2-0500 and 2-0600.

- Chapter 2-0600 incorporates existing procedures for handling SEC claims. This includes a listing of the specified cancers, instructions on calculating 250 work days, and roles of the claims staff including Branch of Policy, Regulations and Procedures in handling SEC claims.

New chapter 2-0700 replaces parts of Part E chapter E-400.

- Chapter 2-0700 includes information about the Site Exposure Matrices (SEM), and qualifies that under no circumstances is a claim for benefits denied solely due to a lack of information contained in SEM.

New chapter 2-0800 replaces Part B chapter 2-0300 and parts of Part E chapter E-500.

- Chapter 2-0800 has been revised to include an exhibit of a Statement of Accepted Facts (SOAF) and includes the general requirements for a proper Statement of Accepted Facts. The Chapter also instructs claim staff to use ACS web portal to select a second opinion physician.
 - Chapter 2-0800 includes revised ECMS coding to ensure prompt payment of medical bills from District Medical Consultants (DMC), second and referee physicians. This chapter includes an exhibit of approved ICD-9 codes and corresponding Procedure Codes, and has revised the Medical Consultant Referral Form to include more medical specialties.

New chapter 2-0900 replaces Part B chapter 2-0600.

- The revision of PM Chapter 2-0900 includes guidance on establishing causation for cancer under Part E.
 - The chapter also explains how a case "pending" or "pulled" by NIOSH during the dose reconstruction affects the dose reconstruction process and the procedures to resolve a case in "pulled" status.
 - Chapter 2-0900 includes detailed explanations of when rework of dose reconstruction is required and provides specific examples.
 - Chapter 2-0900 includes procedures for requesting a rework of dose reconstruction.

New chapter 2-1500 replaces Part B chapter 2-1000.

- Chapter 2-1500 clarifies the circumstances by which an illness will become compensable as a consequential illness of an accepted condition.

New chapter 3-0100 contains entirely new material.

New chapter 3-0200 replaces parts of Part B chapter 3-0100.

- Chapter 3-0200 consolidates guidance on payment for non-standard medical treatments and explains the procedure for approving organ transplants, and experimental medical procedures, among others.

New chapter 3-0300 replaces parts of Part B chapter 3-0100.

- Chapter 3-0300 incorporates guidance relating to approval of in-home health care services for claimants requiring such services.



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FILING INSTRUCTIONS:

File this transmittal behind EEOICPA Transmittal 10-06 in the front of the new Unified Federal (EEOICPA) Procedure Manual.

Distribution: List No. 3: All DEEOIC Employees
List No. 6: Regional Directors, District Directors, Assistant District Directors, National Office Staff, and Resource Center Staff.

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SUPERSEDED

1. Purpose and Scope. Part 2 outlines the policies, guidelines and procedures for developing, adjudicating and managing claims under the EEOICPA.

This chapter describes the structure of EEOICPA PM Part 2 and the responsibilities of the Claims Examiner (CE) in administering the EEOICPA. The reference materials listed at the end of this chapter are available to staff in each District Office (DO), Final Adjudication Branch (FAB) and National Office.

2. Structure of Part 2.

a. General Topics. The chapters in this section address intake of information at Resource Centers (2-0200) and initial development by CEs (2-0300). PM 2-0400 addresses services provided by representatives.

b. Employment and Exposure. The chapters in this section address the aspects of employment that must be established for coverage under the EEOICPA. They include covered employment (2-0500), Special Exposure Cohort status (2-0600), and toxic substance exposure (2-0700).

c. Eligibility. The first three chapters in this section address the medical aspects of entitlement. They include a chapter on developing and weighing medical evidence (2-0800), a chapter describing the criteria for cancer and radiation claims (2-0900), and a chapter describing the criteria for non-cancerous conditions (2-1000).

The last two chapters in this group address entitlement under the Radiation Exposure Compensation Act (RECA) (2-1100) and requirements for establishing survivorship (2-1200).

d. Entitlement. These chapters address ratings for permanent impairment (2-1300), computing compensation payments for wage-loss (2-1400), and consequential injuries (2-1500).

e. Decisions and Hearings. This section provides guidance on writing recommended decisions (2-1600), and is followed by two chapters about the work of the FAB. The first (2-1700) addresses the procedures used by FAB, while

2. Structure of Part 2. (Continued)

the second (2-1800) focuses on the decisions FAB issues. The final chapter in this group (2-1900) discusses reopening claims.

f. Codes. The last two chapters in Part 2 address coding under the Energy Case Management System (ECMS). PM 2-2000 describes the codes used in overall case processing, while PM 2-2100 describes the codes used to track decisions made within the Program.

3. Responsibilities of Claims Examiners. The CE develops and adjudicates claims, provides courteous and timely responses to requests for information, initiates compensation payments and monitors assigned caseloads.

a. Processing Claims. The CE is expected to exercise keen judgment, derived from experience, background, and acquired knowledge, tempered with compassion and common sense. This involves the ability to assess evidence, identify pertinent issues, and make well-rationalized judgments. Each case stands on its own merits and must be impartially judged based on the facts established in the case file. The decision cannot be based on conjecture, speculation, or unwarranted presumption.

4. Reference Materials for Claims Examiners. Each DO has resources containing the following items including, but not limited to:

a. Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000, as amended, 42 U.S.C. § 7384 *et seq.*

b. 20 CFR Parts 1 and 30 (Regulations) - Claims for Compensation Under the Energy Employees Occupational Illness Compensation Program Act, issued December 29, 2006.

c. Executive Order 13179, signed December 29, 2006.

d. EEOICPA Procedure Manual.

4. Reference Materials for Claims Examiners. (Continued)

- e. EEOICPA Bulletins, Circulars, Transmittals, and Program Memoranda. The Policy Branch issues these documents.
- f. Dorland's Illustrated Medical Dictionary, W.B. Saunders Co.
- g. Guides to the Evaluation of Permanent Impairment, 5th Edition, American Medical Association.
- h. Current edition of The Merck Manual, Merck & Co.
- i. Current directory of the American Medical Association for each state within the DO's jurisdiction.
- j. Current ICD-9 coding manual.
- k. NIOSH regulations on dose reconstruction and probability of causation (42 CFR Parts 81 and 82, Guidelines for Determining the Probability of Causation and Methods for Radiation Dose Reconstruction Under the Employees Occupational Illness Compensation Program Act of 2000; Final Rules).
- l. The most recent DO accountability review report.
- m. Road map or atlas covering the DO's geographical jurisdiction.
- n. The Federal Register publications listing covered facilities.
- o. Resource Center procedure manual.
- p. User's Guide for the Interactive RadioEpidemiological Program (NIOSH-IREP).
- q. Directory of Department of Energy records, contacts, and description of Department of Energy facilities.
- r. Shared Drive maintained by the National Office.

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1. Purpose and Scope. This chapter describes the policies and procedures governing the Division of Energy Employees Occupational Illness Compensation (DEEOIC) Resource Centers (RCs).

2. Resource Center Functions. The RCs are situated in key geographic locations throughout the United States to provide assistance and information to the EEOICPA claimant community and other interested parties. The RCs gather substantial information and documentation, but they do not perform adjudicatory functions. The RCs provide claim development support and program outreach as well as initial claim intake.

The District Office (DO) retains all adjudicatory and most additional development functions. The RCs perform only certain initial development and limited follow-up tasks as specifically outlined in these procedures. The RCs are staffed and managed by contractor staff. Each RC has a manager, and each manager reports to the RC Contractor Project Manager, who in turn, reports to the DEEOIC RC Coordinator located at the National Office (NO). The RC Coordinator is responsible for supervising the activities of all RC staff, nationwide.

The RC role as it pertains to initial employment verification and occupational history development includes the following:

a. Claim Intake. Most new Forms EE-1/2 are filed directly with the RC located in the geographical area where the claimant(s) reside. Forms EE-1/2 received directly in the DO undergo employment verification at the DO and such claims are referred to the RC only if the DO determines that an Occupational History Questionnaire (OHQ) is required.

Regardless of place of receipt, the date of filing for a claim is the earliest discernible date stamp or postmark of a claim form or words of claim. Words of claim are any written statements received without a claim form that indicate a claimant's intention to seek benefits under the EEOICPA.

2. Resource Center Functions. (Continued)

Whether filing by telephone or in person, RC staff relays information about the program to the claimant. The RC explains the eligibility requirements, asks about

conditions that the claimant has developed, and begins the process of gathering information for use in adjudication.

(1) Filing by Telephone. When a claimant files a claim telephonically with RCs but then either refuses or fails to sign an actual claim form, the RCs must proceed as follows:

(a) Two weeks after the call, the RC telephones the claimant, informing him or her that the claim form must be signed to complete the filing process, and then recording the contact in the Telephone Management System (TMS) Energy Case Management System.

(b) Two weeks after that initial follow-up call, the RC sends the claimant a letter telling him or her that the unsigned claim form will be forwarded to the DO assigned to adjudicate the claim, and places a copy of the letter in the case file, but that the DO Claims Examiner (CE) will administratively close the claim because of the lack of a signed claim form.

(c) The RC then prepares a memo to the file documenting the times, dates, and manner of the efforts made to get the form signed, and of the warning that the claim will be closed administratively.

b. Claim Status. Claim status requests regarding initial employment verification or occupational history development fall within the purview of the RC staff, who also field other claim status requests to

2. Resource Center Functions. (Continued)

assist claimants with general questions not requiring DO or Final Adjudication Branch (FAB) involvement.

The RC staff member reviews ECMS status codes and answers claimant inquiries, memorializing such activities into the TMS or Notes screen. If the claim status request is beyond the scope of the RC staff to address, the RC staff member determines the case file location in ECMS and directs the caller to the proper CE or FAB Hearing Representative (HR).

Inquiries received from a claimant or authorized representative seeking claim statuses are referred to the adjudicatory DO CE or the FAB HR as necessary. When referring a claimant or authorized representative to a DO or FAB, the RC provides the claimant/authorized representative with the toll-free number to the DO or FAB. All RC Managers have full read only access to ECMS in order to better assist claimants with inquiries. Any inquiries that cannot be addressed by the RC staff/Manager go to the CE or FAB HR, as appropriate.

c. Program Information. If a potential claimant calls for information and/or guidance and no claim is on file, the RC staff member informs the potential claimant of filing requirements and available benefits. No referral to a DO or FAB is necessary. As no claim exists in the system, a note memorializing the telephone conversation is not entered into ECMS.

Where a current claimant contacts the RC for guidance about the claims process (e.g., confirmation that a claim exists, questions about submitting new evidence or a new claim for benefits), the RC can provide guidance to the claimant as needed without referral to the DO or FAB. A TMS memorializing the telephone conversation is entered into ECMS

Also, RC staff may assist claimants in understanding the information being sought in DO development letters, explain the means by which such information may be obtained, and assist claimants in obtaining

2. Resource Center Functions. (Continued)

evidence. The RCs also assist claimants with medical bills/documentation and enroll/educate medical providers to join and navigate the automated medical bill pay system. A TMS memorializing the telephone conversation is entered into ECMS.

d. Initial Employment Verification. The RCs take initial employment verification steps for all new claims (Part B, E, and B/E) filed with the RC that are not covered under the Radiation Exposure Compensation Act (RECA). The DO conducts initial employment verification on claims filed directly with the DO (see section 5 below).

(1) Form EE-3 is the principal source for claimed employment information. However, if a claim is filed without a Form EE-3, the RC does not solicit it from the claimant. Rather, all claim materials are forwarded to the DO, where initial employment verification occurs.

(2) The RC uses DEEOIC tools, including procedures, bulletins, and employment verification updates and is given access to the DEEOIC Shared Drive to view these materials. The RC conducts initial employment verification on claims submitted by DOE contractor/subcontractor, Atomic Weapons Employer (AWE), and Beryllium Vendor (BV) employees for use in the adjudication of claims filed under EEOICPA.

e. Occupational History Questionnaire. RCs conduct occupational history development on all new Part E claims and some previously filed Part D/E claims, as discussed in section 6 below.

3. ECMS Usage in the Resource Centers. ECMS access is granted to the RCs to record claimant interaction and obtain claim status updates. Such interaction is recorded in ECMS Notes or ECMS TMS. RCs cannot input ECMS case status codes. Specific technical guidance regarding ECMS is provided in the ECMS User's Reference Guide.

3. ECMS Usage in the Resource Centers. (Continued)

Some RC activity occurs prior to case creation in the DO, and ECMS data input is unavailable. RCs make ECMS entries only on created cases. Where the case is not yet created, the RC maintains a written account of all claim-related activity, including the date on which such activity took place. All pre-case create actions at the RC are recorded in the RC memorandum to the DO discussed in section 5 below.

- a. ECMS Notes. The ECMS Notes field is used for all face-to-face contact with a claimant on a created case. For example, ECMS notes are used when a claimant appears at the RC to submit evidence or claim forms, to make an inquiry or raise a concern, or to complete the OHQ interview if the interview is done in person.

The RC staff member records the claimant's visit in the notes field in ECMS, providing a synopsis of the conversation and a description of any evidence or new claim filed during the visit. The Notes entry outlines the interaction with the claimant, including instructions or guidance the RC provides to the claimant. The RC discusses only information on a specific claim with the claimant in question. Once a note is placed in the system, a hard copy is printed and forwarded to the appropriate DO or FAB for association with the case file.

When creating an ECMS notes entry, the RC selects 'R - RESOURCE CENTER USE ONLY' entry in the "Note Type" section in the upper left hand box of the screen.

- b. TMS. The TMS feature in ECMS allows RC staff members to memorialize telephone conversations and to access telephone messages for calls received in the RC. TMS provides a mechanism to track and maintain telephone contacts on given case files.

RC staff members receive incoming telephone calls, return calls and place calls to claimants and others regarding questions and concerns arising out of the claims process.

3. ECMS Usage in the Resource Centers. (Continued)

(1) RCs receive various kinds of direct calls. Generally, incoming calls are from claimants (or their authorized representatives) seeking claim status or guidance, or from potential claimants seeking program information and guidance regarding the claims process.

(2) A RC staff member returns a telephone call received in the RC within two business days of receipt regardless of the issue at hand. All calls related to claims in ECMS are logged into the TMS and must be returned accordingly.

(3) Outgoing calls are those generated from the RC for a purpose other than returning a telephone call. The DO may request RC assistance in obtaining evidence from a claimant or conducting some additional follow-up on a case file. Many RC outgoing calls are generated in the course of conducting employment

verification and occupational history development, and are memorialized in ECMS only on created cases.

c. Calls from Claimants. Each telephone call to or from a claimant must be accurately entered into ECMS in accordance with the specific instructions contained in the ECMS User's Reference Guide and ECMS PM Chapter. If RC staff members conduct OHQ interviews (see below) by telephone, the OHQ interview must be memorialized in TMS in the same manner as the in-person interview.

The RC staff member handling the telephone call outlines the content of the discussion, the claimant request, if any, the guidance or solution offered, and the outcome of the call or resolution of the issue at hand. Entry of quality data is of the utmost importance, and the RC staff member strives to ensure accuracy and specificity of data input when telephone contact is noted in TMS.

3. ECMS Usage in the Resource Centers. (Continued)

As with ECMS notes, the RC prints a TMS record once completed. The printed TMS record is forwarded to the appropriate DO for association with the case file.

d. ECMS Entries. The RC ECMS user may change ECMS entries placed into the system by RC staff as needed to correct errors, or at the request of the RC manager upon his or her final review of claim file material before it is forwarded to the DO. However, the RC cannot delete ECMS entries, so RC staff and managers must ensure that the data entered into ECMS is of high quality and free of errors prior to saving the entries into the system.

Once an ECMS record is input at the RC level, only NO DEEOIC staff may remove it. No capability to add or alter ECMS claim status codes has been granted to the RCs, and all coding operations related to RC activity on a case (aside from activities related to input in TMS or ECMS Notes) are entered at the DO to correspond with the date of the activity, as noted on the RC memorandum that accompanies case file materials to the DO.

e. ECMS Security. Security measures govern access to the system due to the sensitive nature of the records available

in ECMS and other claim file documents (e.g., employment history, payment information, disease history, Social Security Numbers, and addresses).

When a RC staff member is hired, and ECMS access is required for that individual, access must be granted. Conversely, when an RC staff member's employment is terminated, that person's ECMS access must be disabled.

(1) To give a new RC staff member ECMS access, the RC manager prepares a memorandum to the RC Contract Project Manager requesting such access and providing all pertinent employee information. The RC Contract Project Manager sends a

3. ECMS Usage in the Resource Centers. (Continued)

memorandum to the DEEOIC RC Coordinator at NO, who reviews the request and advises Energy Technical Support of the need to grant access to an incoming RC employee.

(2) Upon termination or resignation of an employee, the RC Manager prepares a memorandum to the RC Contract Project Manager. The memorandum provides the former employee's name, title, employee number, and all other necessary information, including the date of the employee's termination or resignation. The memorandum requests that the former employee's access to ECMS be terminated on a specified date (i.e., date of termination or resignation).

(3) The RC Contract Project Manager then prepares a memorandum notifying the DEEOIC RC Coordinator advising of the RC former employee's scheduled departure. The DEEOIC RC Coordinator advises Energy Technical Support of the need to delete ECMS access to the outgoing RC former employee upon receipt of such notification.

4. Security, Privacy, Conflicts of Interest.

a. RC Staff Member with Interest in a Claim. A RC staff member may be a party to a claim under the EEOICPA or may have a personal or familial interest in the outcome of a claim.

(1) Resource Centers must avoid conflicts of interest in processing claims and should avoid even the appearance of impropriety in their work. Their staffs must work without any bias or influence that would affect their ability to render impartial service to the government in carrying out their duties.

Therefore, Resource Center staff cannot process claims or conduct either employment verifications or occupational histories for immediate family members (defined as spouses, children, siblings,

4. Security, Privacy, Conflicts of Interest. (Continued)

grandparents, parents, or first or second cousins) or for any other individuals with whom they would have so close a relationship as to affect their judgment.

In such cases, the RC notifies the DEEOIC RC Coordinator at NO in writing via e-mail memorandum and refers those cases to the nearest alternate RC. After the conflict review process is completed, the RC manager prepares a memorandum to the alternate RC manager asking that the occupational history development or other task(s) be conducted and forwarded to the next nearest DO that does not have jurisdiction over the RC in question.

The RC assigned this development action has 14 calendar days upon the receipt of the assignment to complete all these activities and to report to the DO.

(2) When a RC staff member has a claim of his or her own, or when the situation meets the definition of a conflict of interest due to a relationship as defined above, the DO case file in question is transferred to the nearest DO for handling.

For instance, a claim involving an RC staff member working at an RC within the jurisdiction of the Denver DO is transferred to the Seattle DO for handling, and vice versa. Claims involving a staff member working at an RC within the jurisdiction of the Cleveland DO are transferred to the Jacksonville DO, and vice versa.

b. Security and Individual Privacy Concerns. When interacting with claimants and other interested parties (e.g., authorized representatives) RC staff must remain aware of individual privacy concerns and maintain compliance with Privacy Act mandates. Except as discussed below, RC staff members may not provide information about an individual claim for benefits, or

4. Security, Privacy, Conflicts of Interest. (Continued)

any other personal information, to anyone other than the identified claimant or his or her authorized representative.

(1) For RC staff to release any information regarding a specific claim or claimant to an alleged authorized representative of that claimant, an authorization form signed by the claimant must be in the case file appointing such individual as the claimant's authorized representative regarding his or her claim for benefits under the EEOICPA.

A claimant may authorize other third parties to receive claims information, but may not authorize multiple authorized representatives.

(2) Where information is sought that exceeds the RC's ability to assist the claimant or authorized representative (e.g., specific development questions regarding the relationship between toxic substances and illness), the RC staff refers the matter to the proper DO CE or FAB HR, denoted in ECMS as the primary CE.

c. Multiple Worksites. In all instances involving multiple worksites, the RC closest to the residence of the claimant(s) performs the required development tasks. For instance, if employment is claimed at all three Gaseous Diffusion Plants, and the employee/claimant(s) reside in the Paducah, Kentucky area, the Paducah RC handles all required tasks with assistance from the other RCs as needed.

d. Multiple Claimant Locations. If claimants reside in different states and the claim as a whole can be better served by utilizing more than one RC, a RC will be assigned based upon the geographical locations of the claimants. In such cases the RC forwards documentation to the adjudicatory DO.

5. Employment Verification. Detailed guidance on Employment Verification is found in the PM Chapter covering

5. Employment Verification. (Continued)

this subject. Below is an overview of those employment verification tasks with associated resource center tasks.

a. Review of ECMS. When the RC is taking a claim and reviewing it for initial action (employment verification or OHQ), the RC reviews ECMS to determine whether a claim already exists in ECMS. If so, the RC contacts the adjudicatory DO CE for guidance as to whether employment or occupational history development is required. If documentation is present in the existing claim file to either confirm employment or document workplace exposure, the DO advises the RC accordingly and no action is needed by the RC. This is a case-by-case decision made by the DO.

b. Review of Case File. Upon receipt of a new claim, the RC staff member reviews the Forms EE-1/2, EE-3, and EE-4 and the DOE covered facility website to determine the type of facility claimed (e.g., DOE, BV, or AWE). The DOE website lists all major covered facilities, applicable time frames, a description of the site operations, and in certain instances, the names of the major contractors working at those facilities. This review also helps to determine the need for an OHQ, as AWE, BV and DOE (including DOE predecessor agency) federal employment is not covered under Part E and no interview is required.

c. Determining Appropriate Subpart. The claim may be filed under Part B, Part E, or both, depending upon the illness claimed and type of employment. The RC uses the DEEOIC case create worksheet (see EEOICPA PM 1-0300, Exhibit 1), and reviews the claim materials for a determination as to benefits being sought and conditions claimed to determine under which Part a claim is being filed. At any time the RC may consult the DO for guidance as to whether an OHQ is necessary.

(1) Claims submitted by AWE employees are excluded from Part E coverage unless their employment occurred during a time when the AWE was undergoing DOE remediation. DOE remediation periods can be ascertained by reviewing the DOE

5. Employment Verification. (Continued)

covered facility website, but the RC should seek DO guidance before conducting interviews about such claims.

(2) Claims filed by contractors or subcontractors of DOE or Section 5 RECA workers are always treated as Part E claims for the purposes of conducting an occupational history interview.

d. ORISE. If employment is claimed at a covered facility listed on the DOE website, the RC staff member determines whether employment can be verified through the Oak Ridge Institute for Science and Education (ORISE) database. This database, which is accessed via ECMS, contains employment information for over 400,000 employees who worked at certain facilities from the 1940s to the early 1990s.

Complete usage instructions regarding the ORISE database are discussed in the ECMS release notes dated April 6, 2005, version 1.8.2.0. Since ORISE is part of ECMS, the RC staff member obtains ORISE information by entering an employee's Social Security Number or name.

Resource Center staff determines whether appropriate data may be found in ORISE by checking the Employment Pathways Overview Document (EPOD). If the facility description includes the statement, "ORISE - yes," then RC staff first develops employment by accessing ORISE. If ORISE information is unavailable or inconclusive, additional development is pursued as outlined below.

In either case, the RC staff member prints the results found in ORISE as part of the evidence of file. If employment is listed at a facility not on the ORISE list, ORISE is not consulted for verification.

(1) If the ORISE matches claimed employment within six months, no additional development is required. The RC prints out the ORISE database

5. Employment Verification. (Continued)

query result, prepares a memorandum stating the date the ORISE action was taken, and forwards all available materials to the DO with an RC checklist (Exhibit 1).

If an OHQ is required on a Part E claim, the RC attempts to complete the OHQ to be forwarded with the RC checklist. The findings and associated memoranda are subject to CE review and can potentially serve as a basis for verifying and accepting claimed employment under the EEOICPA.

(2) If the claimed employment cannot be confirmed through ORISE, or is only partially confirmed, the RC prints the ORISE record and determines if other sources of employment verification are available as outlined through the Employment Pathways Overview Document as described in Chapter 2-0500.

e. The EE-5 Process/DOE POC. Employment under the EEOICPA is also verified using the EE-5 process. The EE-5 process is applicable to employment claimed at DOE facilities, including contractor and subcontractor employment, as well as Beryllium Vendor and Atomic Weapons Employer employees. The RC refers the EE-5 package according to instructions in the PM.

For those instances in which employment is claimed for which there is no applicable DOE operations office, the following steps are to be taken:

(1) Employment for which EPOD indicates that a corporate verifier is able to confirm employment. For those instances in which a corporate verifier has employment information, resource center staff prepares the appropriate correspondence to a corporate verifier. EPOD identifies the information needed by each specific corporate verifier in order for them to confirm employment. EPOD also contains the name and address for corporate verifier contact persons from whom verification should be requested.

5. Employment Verification. (Continued)

(2) If EPOD does not provide any pathway for employment verification at a claimed facility, the RC center staff informs the claimant that DOE does not possess employment records for the facility claimed and no other knowledgeable source exists to verify employment. In writing or by telephone, the RC advises the claimant to submit further evidence in support of his or her claimed employment directly to the DO. If the claimant is the employee or a clearly eligible survivor, the RC also asks the claimant to sign Form SSA-581 so that the DO may request SSA records. The RC does not forward Form SSA-581 to SSA, but sends it to the DO with the employment verification packet. The RC does not mail this form to a claimant.

(4) The RC prepares a memorandum documenting the dates on which employment verification actions were taken for each claimant. The memorandum is forwarded to the DO within seven days of receipt of Form EE-1/2. The memorandum is accompanied by the Resource Center Claim Checklist (Exhibit 1) listing all materials enclosed and further actions required.

(5) Each adjudicatory DO District Director (DD) designates primary and alternate RC employment verification Points of Contact (POCs) and provides the RC with their names and contact information. The DD must immediately inform the RC if a POC is replaced.

(a) Duties. The DO employment verification POC serves as the primary contact for all responses regarding initial employment verification requests made by the RCs. The POC reviews all employment verification responses, consults ECMS to determine the CE handling the claim in question, and forwards all employment responses to the handling CE within one business day of receipt of the response in the DO.

5. Employment Verification. (Continued)

(b) E-Mail Contact. Each POC has access to e-mail for use in verifying employment. The POC's e-mail address is copied on all e-mail requests for verification (where such request is the desired method of inquiry) and the e-mail from the RC provides the POC's name and contact information and requests that the employment verification response be forwarded to the attention of the POC.

(6) The RC prepares the claim package with the accompanying memorandum and checklist outlining the actions taken and forwards all documents to the adjudicatory DO. The RC includes a copy of the DOE Verification of Employment Memorandum, which serves to acknowledge that DOE has no employment information to provide.

(a) Later submissions to the DO do not require a formal memorandum, but should be accompanied by the Resource Center Claim Checklist. Any activity the RC took that needs to be captured by the DO in ECMS can be outlined either on the Checklist or on a separate sheet of paper.

(b) The RC manager verifies the contents of the referral package and signs the checklist. The RC manager is responsible for validating that the information in the referral package(s) reflects the RC actions taken and accurately reports the dates of all activities conducted.

(c) The DO sometimes grants extensions of time in the face of extenuating circumstances. When RC staff conduct large outreach events and take new claims, they cannot begin employment verification actions until they return to the RC. In this instance the RC may ask the DO for an extension of time. The RC manager e-mails

5. Employment Verification. (Continued)

the DO Employment Verification POC with all claim file information requesting an extension of time and outlining the reason behind the request.

f. SSA-581 and Other Evidence. The following evidence, while not exhaustive, may assist in evaluating the validity of a period of claimed employment. RC staff should use judgment to determine which of the listed items staff should request from claimants.

(1) Time and attendance forms; W-2 forms and other tax statements; wage and earnings statements; check stubs; correspondence from the employer addressed to the employee; notices of promotion, reassignment, layoff, etc; ID cards; minutes from employment related meetings; punch cards; sign in and out logs; security clearance applications; union records; letters and certificates of achievement or participation in a certain event.

(2) Also, Forms EE-4 (Employment Affidavit) from coworkers and others with firsthand knowledge may be acceptable to establish employment in conjunction with other evidence. The RC may assist the claimant in preparing Form EE-4, but only contacts employment verifiers as identified therein. The RC does not contact coworkers or other individuals or gather employment or other evidence on behalf of the claimant.

(3) If the claimant is a walk-in employee or a clearly eligible survivor, the RC asks the claimant to sign Form SSA-581 so that the DO may request SSA records for use as a tool in additional employment development. The RC does not forward Form SSA-581 to SSA, but sends it to the DO with the employment verification packet. The RC does not mail this form to a claimant.

5. Employment Verification. (Continued)

g. SEC/Newly Designated SEC. The Secretary of the Department of Health and Human Services (HHS) has approved additional designations to the SEC class, and other designations are anticipated in the future. Many new SEC designations are/will be employment-specific and date-specific. HHS defines SEC inclusion specifically in many instances, and it will be necessary to identify a person's job title, years of employment, place of employment, and other facts based upon the specific language defining the SEC.

Therefore, it is necessary to gather employment-specific information when verifying employment at these sites. The Policy Branch issues Bulletins outlining specific guidance for handling newly-designated SECs. The Policy Branch Chief ensures that the RCs receive all Bulletins related to SEC class inclusion.

Since Form EE-5 does not contain a section to list employment-specific information, the RCs use the cover letter to DOE for this purpose. In the DOE cover letter the RC requests specific duty station information to assist the DO when rendering determinations as to SEC class inclusion. The request is tailored to meet the exact definition of SEC employment as set out by HHS and defined in Bulletins issued by the Policy Branch.

6. Occupational History Development. In addition to initial employment verification, the RCs conduct initial occupational history development on Part E cases *only* regarding claims involving covered Part E employees and their eligible survivors. This is done in part by completion of the OHQ (Exhibit 2). There are two OHQs, one for RECA and one for non-RECA claims.

Whenever possible, this step occurs during claim intake at the RC, with the results forwarded to the DO within the seven day period in which the initial employment verification task is conducted. The RC may conduct the OHQ prior to receipt of the claim filing, but the OHQ is not to be sent to the DO until a signed claim form is received.

6. Occupational History Development. (Continued)

If no signed claim form is received, the RC returns the OHQ to the claimant with instructions to return to the RC with a signed claim form.

a. Time Frames. If the OHQ cannot be completed within the initial seven day period, the RC sends the claims package to the DO immediately upon completion of employment verification (within seven days of receipt of claim forms), and then conducts the occupational history development.

(1) The RC has a total of 14 calendar days from the date of receipt of the claim or receipt of the assignment from the DO to conclude the occupational history development steps.

(2) If all actions cannot be completed within that time frame, the RC advises the DO CE via e-mail of the reason for the delay and outlines a reasonable timeframe in which to finalize all necessary actions.

(3) If an additional seven calendar days elapse after the 14 calendar day due date, the RC telephones or e-mails the DO CE requesting a time extension and providing an action plan.

(4) As soon as the occupational history task is complete, and assuming that a signed claim form has been received, all documentation is immediately forwarded to the DO with a memo or Claim Checklist noting the date on which the interview(s) was conducted. The RC maintains a copy of all case file materials until the occupational history development process is complete.

(5) If the RC cannot conduct the OHQ within 30 days of receipt of assignment and/or filing of the claim, the RC suspends all activities and reports to the DO. No further action is taken. The DO CE sends a letter to the claimant requesting a response once all materials are

6. Occupational History Development. (Continued)

received in the DO. Depending upon the claimant's response, the CE can assign the OHQ task to the RC.

b. Occupational History Development Not Conducted.
Under the following circumstances, no OHQ development occurs:

(1) If beryllium illness or chronic silicosis is the only condition claimed, unless otherwise directed by the DO. In addition, no occupational history development is conducted where only ineligible survivors are claiming benefits. For a complete discussion of eligible survivors under Part E, see EEOICPA PM 2-1200.

In such instances, the claim file material is immediately forwarded to the DO upon completion of the employment verification portion, the DO reviews for necessity of further occupational history development, and assigns development tasks to the RC as needed.

(2) If benefits are approved under Part B, or a positive DOE physician panel finding exists that DOE accepted under the Part D program and the employee is a DOE contractor or subcontractor (not a federal employee) then the employee is also covered under Part E for those approved diagnosis. In all cases, the RC consults ECMS for the status of the Part B claim for acceptance and queries the DO for guidance if a question arises as to whether or not an occupational history development action is required.

(3) If the Department of Justice (DOJ) has accepted a RECA Section 5 claim, no occupational history development is necessary, unless the claim was filed by a survivor. All other RECA claims generally require independent adjudication and require an OHQ. Cancer claims submitted by Section 4 RECA claimants who do not wish to file

6. Occupational History Development. (Continued)

with DOJ require an OHQ. See Chapter 2-1100 for details.

d. Occupational History Questionnaire and Interview. The main function of the RC staff member in his or her occupational history development role is to conduct the OHQ interview. In cases with multiple survivors, all claimants are interviewed, unless one or more claimants have been designated to represent all of the claimants with regard to the interview process.

(1) Sometimes one claimant will know more about possible worksite exposure, or be more comfortable with a formal interview process, than the others. In such instances, a simple signed statement by the other claimants designating a certain claimant to be interviewed in his or her stead will suffice.

(2) Such a signed statement is not a designation of an authorized representative, and is only used in the interview process. Where an authorized representative has been appointed on a claim file with multiple claimants, there is no need to designate a claimant to participate in the questionnaire process. Authorized representatives may determine how the questionnaire process will be conducted.

(3) Much of the information gathered through occupational history development is sensitive in nature and is subject to Privacy Act mandates. Accordingly, the information developed may not be disclosed to any individual unless he or she is an authorized representative of the claimant or an authorized DEEOIC representative (see EEOICPA PM 2-0400).

e. Timeliness Goals. An interview must be scheduled and completed within the timeframes stated in this document, and all reworks and follow-up interviews must be conducted within seven days of receipt in the RC as noted above.

6. Occupational History Development. (Continued)

To properly conduct the interview, the RC staff must understand the work performed by DOE employees. Knowledge of the types of hazardous materials potentially present at DOE sites, the covered illness resulting from claimed exposures, the standard length of exposure for the illness to occur, and the medical diagnosis required to verify the illness is also necessary.

The RC staff must also possess sufficient knowledge of the EEOICPA, the DOE and RECA sites, and hazardous materials to record sufficient, valid data in occupational history questionnaires as well as ECMS and TMS notes.

f. Proper Use of OHQ. DEEOIC developed the DOE and RECA occupational history questionnaires for use by the RC staff, who must properly use them to obtain the information DEEOIC requires to evaluate a claim for causation. This chapter deals solely with the DOE OHQ; for further guidance regarding the RECA OHQ, see EEOICPA PM 2-1100.

The interview may be conducted in person or by telephone. On created cases, all telephonic activity regarding occupational history development is captured in the ECMS TMS screen, while all in-person activity is placed in the ECMS Notes screen. All required ECMS coding is input at the DO once the occupational history development task is complete and all documentation is returned to the DO.

g. Use of Script. When conducting interviews, the RC adheres to the script prepared by the DEEOIC. It is of the utmost importance that all interviews follow the prepared script, but flexibility is allowed for follow-up questions that logically flow out of the results of the interview.

If the interviewee has little or incomplete knowledge about a particular subject, the RC notes such deficiencies so that the DO is aware that information-gathering efforts were made.

6. Occupational History Development. (Continued)

Each interview takes approximately two to three hours to complete. It is possible that multiple claimants will require an interview for one case file.

(1) Overall, the RC interviewer is responsible for the proper conduct of the interview and for producing a complete, comprehensive questionnaire, including correct grammar and spelling.

(2) The RC makes certain to comply with specific requests for information from the CE. For instance, if the CE wants specific exposure information regarding solvents (e.g., benzene exposure) the RC follows up with a line of questioning to satisfy the CE's request.

(3) Once the interview is completed, the RC staff member gives the claimant the interview confirmation letter (Exhibit 3) verifying that the interview took place, and its date. A copy is sent with the OHQ for inclusion in the case file.

(4) All information is saved to the OHQ exactly as presented by the interviewee without alteration, duplication, or summarization by the RC interviewer, and the original paper version of the OHQ and a saved copy on a CD is forwarded to the appropriate DO within two days of completion.

(5) The RC interviewer in no way interprets the information presented by the interviewee. The OHQ is a stand-alone document and only the CE may interpret its meaning when using it as a development tool.

h. No RC Action Required. Neither initial employment verification nor occupational history development is undertaken where there is no eligible survivor under the statute. Where it is obvious that no eligible survivor exists (especially in the case of

6. Occupational History Development. (Continued)

adult children under Part E) no additional RC action takes place.

(1) Since occupational history development is conducted exclusively on Part E claims, no action is necessary where Part E employment is not claimed or confirmed. If employment is claimed or confirmed at an AWE, a BV, or the employee is a DOE (or predecessor agency) federal employee, no occupational history interview is conducted.

(2) AWE contractors/subcontractors are not afforded coverage under the EEOICPA, and such claimed employment does not require occupational history development by the RC.

(3) The RC does not conduct initial employment verification on claims submitted by RECA claimants. However, occupational history development is necessary on most RECA claims and should be attempted upon receipt of Form EE-1/2 in the RC.

Since the DO must begin employment verification with the DOJ, all RECA claim forms are sent to the DO on the date of receipt in the RC for case create at the DO. Since the RECA claim forms are not held for seven calendar days, as in most other cases, whenever possible the RC attempts to conclude the occupational history development on the date of receipt of the RECA claim forms prior to shipment to the DO.

Where occupational history development cannot be completed at the RC on RECA claims upon the date of filing, the RC copies the RECA claim form documents

and maintains a file at the RC while conducting occupational history development actions. In such instances the RC has 14 calendar days from the date the claim is received in the RC to

6. Occupational History Development. (Continued)

conclude the occupational history development actions.

The RC prepares a list of all materials being submitted on a transmittal sheet outlining the material being sent, separated by the claim number. All such documentation is associated with the proper case file upon receipt in the DO.

i. Materials Destroyed. Once all employment verification and occupational history development actions are finalized and the CE confirms by telephone or e-mail that the DO does not require further assistance, the RC destroys its file copy.

j. Follow-Up or Reworks of Complete OHQs. Upon review of a completed OHQ, the DO may determine that additional information is required or identify an error that requires remedy.

(1) Follow-up interviews are conducted when the DO identifies additional issues through further development of the claim for causation that require RC assistance. The CE makes follow-up assignments directly to the RC manager with an accompanying memo outlining instructions as to the required additional development needed.

(2) Reworks arise when an error is found in the final product from the RC. Interview reworks are conducted only where the CE identifies a deficiency (i.e., incomplete or inaccurate data). Reworks must be approved by a CE and are forwarded to the RC manager by the DO DD with a memorandum outlining specific instructions as to the deficiency found and the required remedy.

(3) The RC must complete all follow-up and rework assignments from the DO within seven calendar days of receipt in the RC.

7. Transfer of Cases. Once all possible initial employment verification/occupational history development

7. Transfer of Cases. (Continued)

actions are complete, the RC sends all claim forms, associated documents, and the RC checklist to the DO with a memorandum outlining RC activities to that point.

Upon receipt of the initial submission, the case is created as set out in EEOICPA PM 1-0300. Once the case is created and the claim assigned to a CE, the CE reviews all claim file materials and employment verification/occupational history development materials for ECMS coding.

- a. Codes. The CE inputs coding in ECMS to correspond with the date on which the action occurred at the RC.
- b. CE Review. The CE reviews the initial submission to determine whether additional tasks are necessary at the RC level. As noted above, the DO may return any part of the package if a deficiency is identified or an additional interview is deemed necessary.

The CE uses the information obtained during the occupational development as a tool for establishing causation (based upon employment and the claimed covered illness) in the adjudication process. Also, the CE proceeds to develop the claim.

- c. Receipt of Materials in the RC After Initial Seven Day Memo. Any such materials are sent to the DO with the occupational history development package if they cannot be included with the seven day memo submission. All other materials received at the RC after all development is concluded (including printouts of TMS and ECMS Notes records) are submitted without a memo or checklist.

- d. Receipt of Material in the DO Prior to Case Create. In some cases the DO receives documentation from the RC prior to receipt/filing of a claim form. The DO maintains all such information in a dummy folder and retains it until the claim form is received. When the case is created, RC actions are coded to correspond with the day upon which they actually occurred, regardless of claim filing date.

7. Transfer of Cases. (Continued)

ECMS coding must reflect the true date a RC action was taken.

8. Part D/E Claim Files. In the past, Part D/E claims potentially required occupational history development at the RCs. The CE evaluates the older Part D/E claims on a case-by-case basis to determine whether a referral to the RC is needed.

a. Exposure Evidence. The CE examines the case file for the existence of DAR records, other DOE exposure records, and other employment records that might provide exposure evidence and eliminate the need for an OHQ.

Also, the CE consults the Site Exposure Matrices (SEM) in conjunction with the case file material to determine the need for further development by the RC. The CE must make the OHQ assignment to the RC unless he or she can establish the plausibility of exposure to a toxic substance by other means [e.g., the SEM, Document Acquisition Request (DAR) records, other employment evidence indicative of exposure].

(1) If the CE determines that an OHQ is required due to a lack of other exposure and employment evidence, an assignment to the RC is made. The RC has 14 calendar days from the date of receipt of the assignment from the DO to complete the occupational history development tasks outlined by the CE.

(2) The CE prepares a memorandum to the RC requesting that the OHQ be completed. The CE lists any specific information (e.g., toxic exposure, employment) that needs development. Any relevant case file material (e.g., claim forms, employment and exposure records) is attached for RC review. The CE includes precise instructions as to the information being sought. The Senior CE or Supervisor reviews the memorandum and approves the assignment before it is sent to the RC.

8. Part D/E Claim Files. (Continued)

Upon receipt in the RC, the assignment is logged into ECMS Notes. Date of receipt in the RC is the first day of the 14 calendar day period.

(3) Once the CE identifies the need for an OHQ and tasks the RC with an assignment to conduct the interview, the DO sends a letter to the claimant. The letter advises the claimant that the interview is conducted on behalf of DOL, that it is different from any other prior interview the claimant may have given, and that it is intended to provide the claimant with a thorough and timely adjudication of his or her claim.

(4) The CE also "closes out" the OHQ assignment (or follow-up or rework) in this manner if the RC attempted to complete the OHQ, but was unsuccessful because the claimant could not be reached or refused to complete it. The status effective date in this situation is the date of the RC memo to the DO explaining why the OHQ could not be completed.

9. Resource Center File Retention. Depending upon the circumstances and the need for additional follow-up regarding a task described in this chapter, RCs retain or destroy file materials as necessary.

a. Office of Worker Advocacy (OWA) Files. There is no need to retain materials related to old OWA claim files. The RCs may destroy any OWA materials on hand.

b. Part D Files without Employment Verification (EV) or OHQ Information. This material is disseminated from the DOs as necessary based upon DO review and identified assignments to the RC. Any such material on hand at the RC can be destroyed unless it is being used in the process of a DO assignment. Once completion of the assignment is confirmed via the method outlined below, all materials are to be destroyed.

9. Resource Center File Retention. (Continued)

c. New Incoming Cases. Where only EV is conducted, the RC destroys case file material upon completion of the EV task and DO confirmation of receipt of all documents. Case file materials regarding Part E claims that require an OHQ are retained either until the OHQ process is complete and the DO confirms receipt of the transmitted materials, or in cases where the OHQ cannot be conducted, as described above.

d. DO Transmittal. Upon receipt of the EV/OHQ and/or all other pertinent documentation required of the RC, the DO checks off each item listed on the transmittal and then faxes the transmittal to the appropriate RC instructing it to destroy its case file materials. Upon receipt of the DO transmittal, all such materials are destroyed. The transmittal may be sent by the DD or any individual designated by the DD for such purpose.

e. Receipt of Documents in the NO or FAB. If NO or FAB receives a Resource Center transmittal containing information for association to a case file at NO or FAB, the Policy Analyst/Hearing Representative/CE (or designee at the discretion of management) confirms receipt via fax to the appropriate RC, instructs the RC to destroy their copy of the transmitted material, and associates the materials to the case file. The faxed instruction sheet is also placed in the case file for record keeping purposes.

If NO or FAB receives a transmittal from a Resource Center, but the case file is no longer at NO or FAB, the Policy Analyst/Hearing Representative/CE (or designee at the discretion of management) immediately forwards the materials and transmittal sheet to the appropriate DO. When the DO receives the transmittal, the DO follows the instructions above.

10. Wage-Loss and Impairment Outreach. Due to the complex nature of the Part E benefit structure and the requirements necessary to qualify for lump-sum compensation, selected Resource Centers (RCs) have been tasked to engage in an outreach effort to educate claimants on the requirements of

10. Wage-Loss and Impairment Outreach. (Continued)

filing for and obtaining impairment and/or wage-loss benefits.

a. Outreach. To facilitate communication with eligible claimants who are also the covered employee or worker (hereafter referred to as employees) certain DEEOIC RCs are assigned responsibility for contacting identified employees by telephone to explain the benefit provisions available under Part E. Assignments are as follows:

Jacksonville DO and FAB	Savannah River RC
Cleveland DO and FAB	Portsmouth RC
Denver DO and FAB	Espanola RC
Seattle DO and FAB	Hanford RC

b. RC Referral. There are two types of Part E cases that are to be identified and referred to the designated Resource Center (RC) to initiate employee communication:

1. Cases at the Final Adjudication Branch where a positive Final Decision has been issued to a living employee and there has not been a prior claim for impairment and/or wage-loss.

2. Cases at the District Office where a positive Final Decision has been issued to a living employee and initial development is underway for impairment and/or wage-loss.

c. Referral from FAB. For Part E cases at the Final Adjudication Branch, when a final decision is issued to a living employee with a positive causation determination, a copy is to be prepared and forwarded to the designated RC. This should be done **only** in situations where there is no indication that a claim has been made for impairment and/or wage-loss. Decisions that pertain strictly to survivors of a deceased employee are not to be referred to the RC, but processed in the normal fashion. The Washington, DC FAB sends final decisions that meet these

10. Wage-Loss and Impairment Outreach. (Continued)

guidelines to the appropriate RC, based on which DO issued the recommended decision on Part E.

d. Development. For any case at the DO that contains a final decision with a positive finding on causation issued to a living employee and where there has been no claim for impairment and/or wage-loss, an initial development letter for impairment and/or wage-loss benefits is completed and sent to the employee with a copy of the letter sent to the assigned RC. An example of an initial development letter for impairment benefits is included in EEOICPA PM 2-1300. Examples of the initial development letters for wage loss benefits are included in EEOICPA PM 2-1400.

e. Records. Upon receipt of a final decision or a development letter in the RC, the RC should take appropriate action to record its receipt. The RC is responsible for ensuring that an appropriate system for recordkeeping is developed to track referrals, and subsequent actions in accordance with the guidance provided here. The RC uses a spreadsheet to record the date the final decision or development letter(s) was received in the RC, the employee's name, claim number, the date outreach was completed and whether or not the employee intends to pursue impairment and/or wage-loss. In addition, the RC will also report on the disposition of all referrals on a weekly basis to the DEEOIC RC Coordinator. This data should be incorporated into the routine weekly RC activity report already generated by the RC manager.

f. Contacting the Claimant. The RC staff should carefully review Procedure Manual Chapters 2-1300 and 2-1400, which explain the eligibility requirements for compensation benefits and the procedures DEEOIC follows for developing impairment and wage-loss benefit claims. For each referral, the RC initiates a telephone call to the employee identified. It is necessary for the RC to access ECMS to obtain contact information for the employee. The purpose of this call is to provide information about the potential

10. Wage-Loss and Impairment Outreach. (Continued)

impairment and/or wage-loss benefits available, respond to questions, and solicit claims.

A script (Exhibit 4) has been developed for use by the RC staff in explaining impairment and/or wage-loss benefits to the employee at a general level. It is important the RC staff adhere to the script. Given the complexity of the benefit structure under Part E, it is likely that the employee will have questions. The RC staff may respond to general follow-up questions; for example, eligibility requirements or program procedures to develop a claim for impairment and/or wage-loss benefits. To help the RCs anticipate and answer some of the most common questions regarding impairment and wage-loss benefits, DEEOIC has developed a Q & A Sheet (Exhibit 5) for use by the RCs.

Claim-specific questions or questions that exceed the RC's ability to assist the employee must be referred to the assigned CE or FAB hearing representative/claims examiner, per ECMS. No attempt should be made by the RC representative to offer opinion or conjecture as to the likelihood of entitlement. All adjudicatory functions are solely the responsibility of the assigned CE.

g. Statement from the Claimant. During the telephone call, if the employee expresses the intention to pursue impairment and/or wage-loss benefits or in cases where the RC staff member believes the employee may qualify for these benefits, the RC advises the employee to submit a signed statement or letter to the appropriate DO stating his or her intention to pursue benefits.

h. Claimant Information. In cases where the employee expresses the intention to pursue impairment and/or wage-loss benefits, the RC must also mail the brochures titled "How Do I Qualify for an Impairment Award" (available on the DEEOIC website at http://www.dol.gov/esa/owcp/energy/regs/compliance/brochure/ESA_how_do_I_qualify.pdf)

10. Wage-Loss and Impairment Outreach. (Continued)

and/or "Wage-Loss Benefits" (available at the DEEOIC website at http://www.dol.gov/esa/owcp/energy/regs/compliance/brochure/ESA_wage_loss.pdf) with an appropriate cover letter to the employee. These brochures were developed to explain these two types of benefits and the requirements that must be met to qualify for benefits.

i. TMS. All discussions with the employee about wage-loss and/or impairment is memorialized into the ECMS via the TMS screen. In general, each TMS entry contains a synopsis outline of the discussion; the employee's question or request, if any; the guidance or solution offered; and a notation as to whether the employee intends to pursue impairment and/or wage-loss. The TMS screen is printed and the paper record of the activity is forwarded to the appropriate DO/FAB daily for association with the case file.

j. Special Instructions for Terminal Claimants. Designated RCs are responsible for immediately notifying via email the DO POC and the assigned CE or FAB HR (as denoted in ECMS), on any case needing prioritization, such as a terminally ill employee who wants to claim impairment and/or wage-loss. The designated DO POC is the same individual who handles the RC employment verification process. The RC staff member still submits the printed copy of the telephone contact in TMS to the appropriate DO/FAB for association with the case file. For easier identification, these TMS records must be marked "Priority" on top of the page.

k. Follow Up with the Claimant. The designated RC has seven calendar days from the RC's receipt of the employee's final decision or initial development letter(s) to initiate telephone contact. In cases where the RC is unable to contact the employee within seven calendar days, the RC continues to follow up with the employee and documents the contact attempts in TMS until contact is successful or the RC makes a reasonable determination that further attempts will not be productive. The RC representative may use his

10. Wage-Loss and Impairment Outreach. (Continued)

or her discretion to determine when to cease further contact attempts with the employee, but as a general rule, after three recorded attempts in as many days has failed to garner employee contact, the RC may cease outreach effort.

1. Disposing of the Decision. The RC is to shred the final decision and/or development letter after the employee has been successfully contacted or after the RC has ceased outreach effort with the employee.

RC Checklist Cover Sheet

Date: _____

To:

<input type="checkbox"/>	DOL Jacksonville District Office	→ Attention: _____
<input type="checkbox"/>	DOL Denver District Office	
<input type="checkbox"/>	DOL Cleveland District Office	
<input type="checkbox"/>	DOL Seattle District Office	

The attached claim forms are submitted with supporting documentation.

Employee: _____ SSN: _____

Survivor: _____ SSN: _____

Enclosed documents include:

<input type="checkbox"/>	EE-1/EE-2	<input type="checkbox"/>	Birth Certificate
<input type="checkbox"/>	EE-3	<input type="checkbox"/>	Marriage License/Certificate
<input type="checkbox"/>	EE-4	<input type="checkbox"/>	Death Certificate
<input type="checkbox"/>	Authorization for Representation	<input type="checkbox"/>	Divorce Decree
<input type="checkbox"/>	EE-5 (s)	<input type="checkbox"/>	Power of Attorney Document
<input type="checkbox"/>	ORISE Printout	<input type="checkbox"/>	Adoption Records
<input type="checkbox"/>	Copy - Appendix H or 02-34 letter	<input type="checkbox"/>	SSA-581
<input type="checkbox"/>	Copy - Letter to DOE OPS Center	<input type="checkbox"/>	Social Security Records (brought in by claimant)
<input type="checkbox"/>	Copy - Letter to Corporate Verifier	<input type="checkbox"/>	Medical Records/Pathology Report
<input type="checkbox"/>	Claimant Employment Records	<input type="checkbox"/>	Other
<input type="checkbox"/>	Occupational History Questionnaire	<input type="checkbox"/>	Other
<input type="checkbox"/>	Occupational History Thank You Letter	<input type="checkbox"/>	Other

Resource Center Manager _____

**Energy Employees Occupational Illness Compensation
Program Act (EEOICPA)
Occupational History Interview**

DOE Facility

Section 1: INTRODUCTION			
Employee SSN	Employee Name	DOL District Office	Interview Date/Time
Interviewer Name	Interviewee Name:	Relationship to Employee	
Do I have your consent to conduct this interview?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2: EMPLOYEE PERSONAL HEALTH HISTORY				
Please <input checked="" type="checkbox"/> the appropriate response. If yes, indicate relationship.				
	Yes	No	Unsure	Relationship (S-Self, P-Parent, G-Grandparent)
Heart disease or Heart Attack				
High Blood pressure				
Anemia or Blood Disorders				
Diabetes				
Stroke				
Memory Problems				
Kidney Disease*				
Liver Disease*				
Skin Disease*				
Arthritis				
Sterility/Infertility**				
Lung Disease				
Specify Type (i.e., Asthma, Emphysema):				
Cancer				
Specify Type(s):				
Other:				
(Specify Diagnosed Condition):				

* Note that we are asking about diseases other than cancer. If you have been diagnosed with a cancer of this organ, please refer to question, 'Cancers,' and note the organ involved in the space provided for "Specified Type".

** Does not mean loss of sexual activity with old age.

Section 3: TOBACCO AND ALCOHOL HISTORY		
Did the Employee Ever Use Tobacco products? (Cigarettes, Cigars, Pipe, Snuff, Chewing Tobacco)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:
	Age began:	Age Stopped:
	Average number used per day	
Did applicant Ever consume Alcoholic Beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:
	Age began:	Age Stopped:
	Average number drank per day	

Section 4: NON-DOE WORK HISTORY

1. Please list jobs held before or after the employee worked at the DOE Facility.
2. Please list the jobs in employer order, starting with the most recent.

Employer	Job Title(s)/Description(s)	Beginning (mm/yy)	Ending (mm/yy)

**Section 5A → Section 8
 MUST be Completed for
 EACH claimed DOE
 Facility**

Section 5 (A): DOE FACILITY (Please complete Section 5 (A)–Section 8 for each DOE facility)

1. DOE Facility:

2. Name of Contractor or Subcontractor and Claimed Employment Dates:


(List all employers and corresponding dates of employment)


Contractor/Subcontractor	Claimed Employment Dates (mm/yy)

Section 5 (B) DOE FORMER WORKER SCREENING PROGRAM

Was the employee a participant in a DOE screening program? if yes, please site and note worker population screened (production vs. construction) (* denotes “New” program)

<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Amchitka <input type="checkbox"/> Rocky Flats <input type="checkbox"/> Idaho National Labs (Production __ Construction* __) <input type="checkbox"/> Nevada Test Site <input type="checkbox"/> Los Alamos Nat. Labs <input type="checkbox"/> INEEL (Production __ Const* __) <input type="checkbox"/> Portsmouth (Production __ Const __) <input type="checkbox"/> SRS (Production __ Const __) <input type="checkbox"/> Oak Ridge K25 (Production __ Const __) <input type="checkbox"/> Oak Ridge Y-12 (Production __ Const __) <input type="checkbox"/> Iowa Army Ammunition Plant. <input type="checkbox"/> Paducah Gaseous (Production __ Const __) <input type="checkbox"/> Pantex <input type="checkbox"/> Hanford (Production __ Const __) <input type="checkbox"/> Mound* (Production __ Const __) <input type="checkbox"/> Fernald* (Production __ Const __)	<input type="checkbox"/> Fermi National Accel.* <input type="checkbox"/> Argonne National Lab* <input type="checkbox"/> Ames Laboratory* <input type="checkbox"/> Kansas City Plant* (Production __ Construction __) <input type="checkbox"/> Lawrence Livermore* <input type="checkbox"/> Lawrence Berkley * <input type="checkbox"/> Pinellas* (Production __ Constuction __) <input type="checkbox"/> Princeton Plasma Physics* <input type="checkbox"/> Sandia Nat. Labs* <input type="checkbox"/> Brookhaven Nat. Labs* <input type="checkbox"/> Supplemental Care Program* <input type="checkbox"/> Fernald Settlement Fund <input type="checkbox"/> Rocky Flats Former Radiation Worker <input type="checkbox"/> Former Beryllium Worker Medical Surveillance Program <input type="checkbox"/> Former Beryllium Vendor Employee Medical Screening Program (remember: MUST ALSO BE Designated as DOE facility)
---	--

Section 5 (C): LABOR CATEGORY (While employed at a DOE Facility)		
<input checked="" type="checkbox"/> Any that apply		
	Work Category	Approximate dates of Employment (Example: 11//59 – 02//65)
<i>Crafts</i>		
	Carpenter	
	Electrician	
	Heating, Ventilating, Air-conditioning maintenance	
	Machinist	
	Mason	
	Mechanic, Instrumental	
	Mechanic, Maintenance	
	Mechanic, Vehicle	
	Millwright	
	Painter	
	Plumber and/or Pipefitter	
	Structural and Metal Worker	
	Tool and Die Maker	
	Welder	
<i>Engineers</i>		
	Chemical Engineer	
	Civil Engineer	
	Construction Engineer	
	Electrical Engineer	
	Industrial Engineer	
	Mechanical Engineer	
	Quality Control Engineer	
	Safety Engineer	
<i>General Managers, Supervisors, and Project Managers</i>		
	First line supervisor	
	General manager or Executive	
	Project or Program Manager	
<i>Laborers and General Service Workers</i>		
	Change House Attendant	
	Decontamination /Decommissioning (D&D) worker	
	Firefighter (includes HAZMAT, firefighter/paramedic)	
	Food Service Worker	
	Janitors and Cleaners	
	Laundry Workers	
	Landfill worker	
	Locksmith	

	Work Category	Approximate dates of Employment (Example: 11//59 – 02//65)
	Handler, Helper, and Laborer (General)	
	Light Vehicle Driver	
	Security Officer	
	Security Specialist	
	Truck Driver	
<i>Operators</i>		
	Chemical System	
	Component	
	Driller	
	Explosive Storage Operator	
	Material moving equipment operator	
	Production Systems	
	Utilities operator	
<i>Scientists</i>		
	Chemist	
	Environmental Scientist	
	Geologist	
	Materials Scientist	
	Social Scientist	
<i>Technicians</i>		
	Computer Repair and/or Setup	
	Drafter	
	Engineering Technician	
	Environmental Sciences Technician	
	Fire Systems Testing Technician	
	Industrial Safety and Health Technician	
	Laboratory Technician	
	Quality Control Technician	
	Test Fire Technician	
	X-Ray Technician	
<i>General Administrative and Professional Administrative</i>		
	Accountant or Auditor	
	Buyer, Procurement and Contracting Specialist	
	Compliance Inspector	
	Industrial Hygienist	
	Lawyer	
	Physician	
	Nurse	
	Security Specialist	
	Administrative Assistant	
	Office Clerk	
	Secretary	

<input checked="" type="checkbox"/>	Work Category	Approximate dates of Employment (Example:11//59 – 02//65)
	Typist or Word Processor	
Other (List all other positions held)		

Section 5 (D): UNION AFFILIATION

Please All Unions to which you belonged.

- | | | |
|---|---|---|
| <input type="checkbox"/> Carpenters' Union | <input type="checkbox"/> OCAW | <input type="checkbox"/> Teamsters' Union |
| <input type="checkbox"/> IBEW | <input type="checkbox"/> Operating Engineers' Union | <input type="checkbox"/> Other Union |
| <input type="checkbox"/> IGAN (Guards' Union) | Painter's Union | Name of Union: _____ |
| <input type="checkbox"/> Ironworkers' Union | <input type="checkbox"/> Plumbers' and Pipefitters' Union | |
| <input type="checkbox"/> IAM | <input type="checkbox"/> Sheet metal workers' Union | |
| <input type="checkbox"/> Laborers' Union | | |

Section 6: WORK AREAS (Building Name and Function)

Please note, the building, work activity, years of employment and frequency in which the employee was performing type of work activity in the identified location. If building name of number is unknown, please mark "unknown" and provide description of activities occurring in building.

Use the following key to fill in the "Frequency" box:

- 5 Daily or most days per week
- 4 2-3 days per week
- 3 1-2 days per week
- 2 Few times per month
- 1 Once per month or less

Building Number/Name or Description	Work Activity	Years of Employment	Frequency Pick 1-3
<i>Example: C200 or Process Bld</i>	<i>Maintenance</i>	<i>1952-58</i>	<i>3</i>

Building Number/Name or Description	<i>Work Activity</i>	Years of Employment	Frequency Pick 1-3
Additional Information:			

Section 7: PERSONAL PROTECTIVE EQUIPMENT (PPE)

Description	Please <input checked="" type="checkbox"/> if utilized	Please <input checked="" type="checkbox"/> frequency of use		
		Often /Always	Sometimes	Infrequent/Never
Apron or lab coat				
Respiratory Protection				
Supplied air or SCBA (Self Contained Breathing Apparatus)				
Face mask with filter/cartridges				
Type:				
Disposable mask				

Gloves Type:				
Eye Protection				
Safety Glasses				
Face Shield				
Goggles				
Full protective suit				
Radiation monitoring badge (including film badge)				
Pencil/Pocket dosimeter				
extremity (finger or wrist) monitor				
none worn				
other (describe):				
Uniform or Company provided Clothing laundered by plant or third party				
Own clothing and own laundering				
Please describe the work situations and exposures where employee used PPE noted above:				
Were there times when you felt you should have worn any of the above protective equipment but did not? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, Please explain:				

Section 8: EXPOSURE INFORMATION

1. For each section please review the identified agent and indicate if the employee is aware of exposure
2. Indicate the approximate number of years known to be exposed
3. Indicate if the employee "processed" the agent (i.e. machined, polished, mixed or poured)

METALS			
Agent	Please <input checked="" type="checkbox"/> if you were exposed to this metal	Approximate numbers of years exposed	Please <input checked="" type="checkbox"/> if you ever processed (machine, drill, grind, polish) this metal
Beryllium			
Cadmium			
Chromium			
Lead			
Manganese			
Mercury			

Nickel		
Zirconium/Zircalloy		
Other		
In what job titles were you exposed to metals? (select job titles from Section 5C--Labor Category)		
1.	2.	3.
4.	5.	6.

HIGH EXPLOSIVES			
Agent	Please <input checked="" type="checkbox"/> if Exposed	Approximate Numbers of Years Exposed	Please <input checked="" type="checkbox"/> if Employee Processed (melt, mix, pour) the Agent
A-6			
Baritol (barium nitrate+TNT)			
Boracitol (TNT+boric acid)			
CH6			
Comp B (TNT+ RDX)			
HMX			
LX-04-1 , LX-07-2(HMX+Viton A)			
LX-09 (HMX+ pDNPA+ FEFO)			
Octol			
PETN			
PBX			
RDX			
TNT			
XTX (PETN+ silicone rubber)			
Other explosives			
In what job titles were you exposed to explosives? (select job titles from Section 5C--Labor Category)			
1.	2.	3.	
4.	5.	6.	

RADIOLOGICAL		
Agent	Please <input checked="" type="checkbox"/> if Exposed	Approximate Numbers of Years Exposed
Cesium		
Californium		
Cobalt machine		
Plutonium		
Polonium		

Tritium		
Uranium		
Depleted Uranium		
X-ray machine		
Other radiation Source:		
1. Where you ever involved in a major accident or incident at the site? Describe incident include approximate dates and locations if possible:		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did you ever have your urine tested to measure radiation exposure?		<input type="checkbox"/> Yes <input type="checkbox"/> No
In what job titles were you exposed to radiation? (select job titles from Section 5C--Labor Category)		
1.	2.	3.
4.	5.	6.

PLASTICS / ADHESIVES/ RESINS			
Agent	Please <input checked="" type="checkbox"/> if Exposed	Approximate Numbers of Years Exposed	Please <input checked="" type="checkbox"/> if Ever Processed or otherwise Directly Handled
Adiprene			
MOCA			
Isocyanates (TDI)			
Foams			
Other			
Did you ever have urine or other medical tests for MOCA exposures? 4,4'-Methylene-bis(2-chloroaniline)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
In what job titles were you exposed to plastics or binders? (select job titles from Section 5C Labor Category)			
1.	2.	3.	
4.	5.	6.	

DUSTS / FIBERS		
Agent	Please <input checked="" type="checkbox"/> if Exposed	Approximate Numbers of Years Exposed
Asbestos (pipe wrap, asbestos board)		
Silica (sand blasting, masonry, concrete)		
Coal dust		
Fiberglass / glass wool / mineral fibers		
Other, metal dusts		
In what job titles were you exposed to dusts or fibers? (Select from list of job titles listed in Section 5C-- Labor Category):		
1.	2.	3.
4.	5.	6.

Other Toxic Substances		
Agent		Approximate Numbers of Years Exposed
Do you believe all information relevant to your occupational history was addressed? Yes No If no, please provide explain:		

THANK YOU

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATIONS
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION



Date: _____ / _____ / 200__

Dear Claimant,

Thank you for your participation in the Occupational History Interview today. Your input will aid the Claims Examiner at the DOL District Office in the development of your claim. The information gathered during this interview will be used in developing the most up to date information regarding the possible exposures that _____ may have come into contact with while working at a Department of Energy (DOE) site(s). It will also provide the physicians who may be reviewing your case or performing an evaluation with a more complete picture of the worker's exposures, medical condition and history.

If you have any questions regarding the information gathered, or if you come upon other relevant information that you want to share with this program, please contact the District Office at

- 1-877-336-4272 Jacksonville
- 1-888-805-3401 Seattle
- 1-888-805-3389 Denver
- 1-888-859-7211 Cleveland

Thanks Again,

_____ (Print Name)

Resource Center Staff

File Number:

Claimant Name:

Date of telephone call:

IMPAIRMENT TELEPHONE SCRIPT

Good Morning/Afternoon, my name is _____ and I am calling from the _____ Resource Center. May I please speak with Mr./Ms. _____?

Hello Mr./Ms. _____, I am calling regarding your claim under the Energy Employees Occupational Illness Compensation Program Act. Our records indicate that your Part E claim was already accepted by the Department of Labor (DOL) in a decision issued on _____.

If you have a few moments I would like to tell you about additional monetary benefits that you may also be entitled to. Is this a good time to talk? *(If they say no, ask them when would be a good time to call them back. Make note of a more convenient time to call back)*

Before we start, I would like you to confirm some information we have on file. We have your mailing address as: (state address we have on record). Is that correct?

Did you receive a _____ (final decision or letter) from the Department of Labor, regarding possibly filing a claim for impairment and/or wage loss benefits? That _____ (final decision or letter) was sent to find out if you want to file a claim for additional compensation, specifically monetary benefits based on impairment and/or wage loss.

Each percentage of whole body impairment equals \$2,500 in compensation. The overall rating shows how much of your entire body's function is impaired due to your covered illness. An impairment rating may be performed once your covered condition has reached maximum medical improvement (MMI). MMI means that your covered condition is unlikely to improve with additional medical treatment. A qualified physician can determine whether or not you are at MMI.

The first step is to apply for benefits by providing a written, signed statement to DOL that you wish to claim impairment benefits.

Once the district office receives your written request, a claims examiner will send you a letter describing what information is necessary for the impairment rating.

When you receive this letter, please call me at _____ and I will be more than happy to assist you further.

****if claimant received "option letter" from the district office, continue with script****. If not, go to ### wage loss section

Impairment ratings are based on the evaluation of specific medical tests (i.e. pulmonary function tests, liver function tests, etc.) that can be done by any qualified physician. In other words, medical evaluations that are necessary to evaluate the degree of loss of function of body parts that are affected by your covered condition.

The evaluation can be performed by a physician of your choice. The physician must hold a valid medical license and Board certification/eligibility in the appropriate field of expertise (i.e. toxicology, pulmonary, occupational medicine, etc.) to perform such an evaluation. The physician must also possess the necessary professional and medical background in interpreting the AMA's Guidelines to provide such ratings.

You will need to provide the name, address, and telephone number of the physician you have selected to perform your impairment evaluating. The _____ District Office will send the physician a letter outlining the specific requirements for performing your evaluation.

Also, DOL can arrange for a qualified physician to review the medical information provided by your physician to determine the degree of impairment. You will not be sent to a physician for this review. If necessary, the physician may request medical tests to establish the degree of impairment.

DOL will pay the cost for obtaining the required medical tests and the cost for one impairment evaluation.

###Before I let you go, I'd like to ask you a few additional questions. Did your covered illness cause you to stop working for any period? Did it cause you to accept a lower paying job or work less hours?

If yes, continue:

If prior to your age for full Social Security retirement you lost wages as a result of your covered illness, you may be also eligible to receive additional compensation. Wage loss benefits are separate from what we were just talking about (impairment). It is entirely your choice whether or not you want to claim compensation for impairment and/or wage loss.

How old were you when you stopped work or lost wages? [If they respond that they were 65 or over (if born in xxxx or earlier, the age varies with the year of birth) they are probably not eligible for wage loss benefits. If under that age, they may be).

If you wish to apply for wage loss benefits, again, please send a written and signed request to the _____ district office and state that you are applying for wage loss benefits. You should also show the date (month and year) when your covered illness started causing you to lose wages. Once the district office receives your written request, a claims examiner will contact you to help you complete the claim with all appropriate documentation. Compensation for wage loss ends when you reach normal retirement age (per Social Security), but each year of qualifying wage loss can pay you \$15,000 if your covered illness caused you to earn no more than 50% of your previous average annual wages, or \$10,000 if it caused you to earn no more than 75% of your previous average. The DOL looks at wages in each calendar year, and even factors-in inflation.

If you want to file a claim for impairment and/or wage loss, and it's easier for you, please feel free to bring your request to this Resource Center and we will help you submit it to the district office.

Do you think that you are interested in filing a claim for impairment

[record response]

Do you think that you are interested in filing a claim for wage loss? [record response] **ONLY ASK IF APPLICABLE!**

Mr./Ms. _____ do you have any questions at this time?

Please do not hesitate to give me a call at _____ should you require assistance with filing a claim for these benefits or to get answers to any of your questions.

It has been a pleasure speaking with you.

Resource Center Outreach Effort Impairment and Wage Loss Frequently Asked Questions

Impairment

1. What is an impairment award?

An impairment award is monetary compensation for the permanent loss of function of a body part or organ, due to an illness covered under the EEOICPA.

2. Who is eligible for impairment benefits?

Employees who have received positive causation determinations under Part E of the EEOICPA.

3. What proof do I need for DOL to establish impairment?

In general, impairment is a decreased function in a body part(s) or organ(s) established by medical evidence. Impairment ratings are based on the evaluation of specific medical tests (i.e. pulmonary function tests, liver function tests, etc.) that can be done by any qualified physician. In other words, medical evaluations necessary to evaluate the degree of loss of function of body parts that are affected by the covered condition.

4. What is considered when determining percentage of impairment?

DOL considers the following:

- Loss of function (whole person) as a result of a covered illness
- Standards applied from the American Medical Association's (AMA's) Guides to Evaluation of Permanent Impairment, Fifth Edition
- Whether the condition has reached maximum medical improvement (MMI), i.e. well stabilized and unlikely to improve with treatment. DOL will award impairment ratings for chronic conditions without the need for those claimants to wait for a recovery that is unlikely to occur.

5. How is impairment compensation calculated?

Each one percent of impairment=\$2500

Example: 3% impairment rating = \$7500 award

6. How do I apply for impairment benefits?

You apply for benefits by providing a written, signed statement to DOL that you wish to claim impairment benefits. No particular form is needed.

7. How does DOL determine impairment?

DOL determines impairment ratings based upon a physician's evaluation. The evaluation can be performed by a physician of the claimant's choice.

DOL can arrange for a qualified physician to review the claimant's medical records and make an impairment evaluation. The claimant will not be sent to a physician for this review. The physician will use the information provided by the claimant's physician to determine the degree of impairment. DOL can also seek an additional evaluation when necessary.

8. What requirements are necessary for a physician to be qualified?

The physician must hold a valid medical license and Board certification/eligibility in the appropriate field of expertise (i.e. toxicology, pulmonary, occupational medicine, etc.) to perform an evaluation.

The physician must also show that he/she meets at least one of the following criteria:

- certified by the American Board of Independent Medical Examiners (ABIME) and/or American Academy of Disability Evaluating Physicians (AADEP)
- possesses knowledge and experience in using the AMA's *Guides* to conduct impairment ratings.

Wage Loss

9. What are wage loss benefits?

Covered employees may receive compensation for wage loss if the loss was caused by a covered illness. Wage loss compensation is payable for years of wage loss prior to regular Social Security Administration (SSA) retirement age (usually 65 years). The wage loss can be total or partial.

10. Who is eligible for wage loss benefits?

Claimants who have received positive causation determinations under Part E of the EEOICPA, and experienced wage loss prior to Social Security Administration regular retirement age as a result of the covered illness.

11. What type of proof will I be required to submit to prove my wage loss?

In addition to medical evidence, various types of documentation may be submitted to establish earnings, such as:

- Social Security earnings statements
- Social Security disability records
- Pay Stubs
- Union records
- Tax Returns
- Pension Records

12. What type of medical evidence is needed to support loss of wages?

- Medical reports showing an inability to work
- Physician's office notes
- Return-to-work slips

- Physician's signed statement explaining a relationship between covered illness and period(s) of wage loss
- District medical consultant's evaluation report

13. How is wage loss compensation computed?

Covered employees may be eligible to receive compensation for wage loss for each qualifying year (prior to normal SSA retirement age) in which their earnings fell a specific percentage below their average annual earnings (AAW) for the 36-month period before they suffered a wage loss (not including periods of unemployment) as a result of the covered illness:

- \$10,000 for any year in which wages were greater than 50% but less than 75% of the calculated average annual wage earnings as a result of a covered illness.
- \$15,000 for any year in which wages were less than 50% of their calculated average annual wage earnings as a result of a covered illness.

14. What is considered when determining wage loss?

DOL considers the following:

- When initial wage loss began
- Dates of wage loss claimed
- Number of years of wage loss prior to SSA retirement age
- AAW amount prior to the first wage loss

15. How do I apply for wage loss benefits?

If you have never claimed wage loss benefits, a written and signed statement that you wish to claim wage loss benefits is enough to establish a claim. The statement should be sent to the District Office that handles your claim. If you have already made an initial wage loss claim, Form EE-10 is used to claim additional calendar years of wage loss..

16. How often can I apply for additional wage loss?

Additional wage loss claims can be filed on a yearly basis.

17. I am currently receiving SSA disability benefits due to a problem unrelated to my DOE work. How will you determine if I have a wage loss due to my accepted illness?

Medical evidence that wage loss is related to a covered illness must be submitted in order for wage-loss benefits to be afforded. Wage loss due to an unrelated condition that is not approved under Part E is not compensable.

18. Will employees whose onset of illness occurs after retirement be eligible for compensation based on wage loss?

They can be if they were unable to work due to the illness and the inability to work began prior to regular SS retirement age.

19. Are wage loss benefits available to survivors of covered employees?

Yes, in addition to the basic \$125,000 survivor benefit, a survivor may receive additional compensation in increments of \$25,000 based on the employee's years of qualifying lost wages. For example, if there are no qualifying lost wages, the survivor receives \$125,000. If the employee had qualifying wage loss for a period of time of at least 10 years but less than 20 years, the survivor will receive an additional \$25,000, for a total of \$150,000. If the employee had at least 20 years of qualifying wage loss, the survivor will receive an additional \$50,000 for a total of \$175,000.

20. If an employee dies before retirement age, do those years qualify in determining additional survivor benefits?

DOL will presume that the deceased employee (in a Part E claim only) experienced qualifying wage loss for each calendar year after the calendar year of his or her death up to and including the calendar year when he or she would have reached his or her normal retirement age under the Social Security Act (SSA).

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1. Purpose and Scope. This chapter explains the procedures to be used by the Claims Examiner (CE) for the review and initial development of a Part B claim, a Part E claim, a Part B/E claim, and for a Part D claim that has been developed by the Department of Energy (DOE), after receipt by the designated District Office (DO) and entry in the Energy Case Management System (ECMS).

2. Resource Center Actions. Resource Center (RC) staff conduct initial employment verification on most non-Radiation Exposure Compensation Act (RECA) claims filed with the RC and occupational history interviews on all new Part E claims with covered employment and eligible survivors. The DO conducts initial employment verification only on claims filed directly with the DO. However, the CE closely reviews all initial development actions taken at the RC and determines what additional and follow-up measures are necessary.

3. Review by the District Office for Potential Development. Regardless of the type of claim (i.e., B only, E only, B and E, or a Part D claim developed by the DOE), the CE first reviews the claim to determine what development is required to issue a recommended decision. Key items the CE needs to review to determine whether sufficient evidence exists are listed below. These three factors are applied differently for each claim type.

a. Medical Condition(s).

b. Employment History. Information provided by the RC will assist the CE in determining what additional development is required.

c. Survivorship Eligibility, When Appropriate. This excludes employee claims and RECA claims for Part B only.

4. Reviewing a New Claim. The initial review takes place upon the DO's receipt of the new claim from Mail and Files (see EEOICPA PM 1-0200). The CE reviews the claim as a whole, weighing employment, medical, and survivorship eligibility to properly categorize the claim and determine what development is required. The information contained in

4. Reviewing a New Claim. (Continued)

the RC packet assists the CE in planning additional development.

When a deficiency in the evidence is identified, the CE must notify the claimant and request evidence needed to resolve the deficiency. The CE may also assist the claimant with his or her claim by requesting evidence from other sources.

a. Medical Development. The CE reviews the claimed medical condition(s) on Forms(s) EE-1/2 and the completed Case Create Worksheet to determine whether the claim is applicable under Part B, Part E, or both. Refer to Chapter 2-0900 covered occupational illnesses under Part B and to Chapter 2-1000 for covered illnesses under Part E.

For example, the claimed condition of prostate cancer is applicable under both Part B and Part E but the claimed condition of asbestosis is applicable only under Part E.

(1) The CE must ensure that the condition claimed is covered under Part B, Part E, or both, based upon the claimed employment and the different criteria used to determine covered employment under each Part.

(2) The CE develops the medical condition(s), as needed, in accordance with EEOICPA PM 2-0800, Developing and Weighing Medical Evidence.

b. Employment Development. At the same time, the CE reviews Form EE-3 and any employment verification request forms or evidence received from the RC to determine whether the claimed employment is applicable under Part B, Part E, or both.

(1) Under Part B, the applicable facility types include DOE, atomic weapons employers (AWE), beryllium vendors (BV), and RECA mines or mills. AWE subcontractors are not covered under Part B or Part E.

4. Reviewing a New Claim. (Continued)

(2) Under Part E, the only applicable facility type is DOE or a covered RECA Section 5 facility. Only DOE contractors/ subcontractors are covered; federal DOE employees at such sites are not covered Part E employees.

AWE and BV employees are not covered under Part E. However, if employment is claimed at an AWE or BV during a time in which such facility was designated a DOE facility for remediation, the case file is forwarded to the National Office (NO) for review. EEOICPA PM 2-0500 discusses DOE remediation in detail.

(3) The CE looks at the claimed facility types(s) (i.e., DOE, AWE, BV, and covered RECA mines or mills), time period(s), job title(s), and ORISE printouts, if available. The CE then determines whether the claimed employment is applicable under Part B, Part E, or both, and then develops any employment evidence needed.

c. Eligible Survivor Development. When Form(s)EE-2 is received, the CE reviews the claim and determines whether all eligible survivors have been accounted for and given the opportunity to apply for survivor benefits. Also, the CE reviews the claim for sufficient evidence to support the relationship between the survivor and the employee.

(1) Under Part B, the eligible survivors are the surviving spouse, children, parents, grandchildren, or grandparents at the time of payment.

(2) Under Part E, the eligible survivors are the surviving spouse and certain eligible children at the time of the employee's death (see EEOICPA PM 2-1200).

The RCs do not develop for employment or occupational history if it is *clear* that no eligible survivor exists (which occurs primarily in cases involving

4. Reviewing a New Claim. (Continued)

adult children under Part E). The CE must review the evidence of record to confirm the absence of an eligible survivor before issuing a recommended decision based upon RC determination, because the RCs do not perform any adjudication functions.

d. Verifying ECMS Accuracy. After reviewing the claim, the CE reviews the New Claims Review Checklist and ECMS to ensure that the claim was entered correctly in ECMS (see EEOICPA PM 2-2000).

5. Sources of Evidence. Decisions are based on the written evidence of record. Evidence may include (but is not limited to) forms, reports, letters, notes, personal statements, and affidavits. Most of the evidence required under the EEOICPA may be obtained from the following sources:

a. Claimant. Any claimant filing for benefits under the Act is responsible for submitting the necessary evidence required for the Office of Workers' Compensation Programs (OWCP) to adjudicate the claim.

b. Department of Energy (DOE). The DOE, a federal agency, had contractual arrangements with employees, contractors, subcontractors, AWEs and BVs with respect to the United States Atomic Weapons Program. The Act requires DOE to provide the Department of Labor (DOL) with information relevant to EEOICPA claims. The DOE conducts medical screening of former DOE facility employees through its Former Worker Program (FWP). The procedures for obtaining employee-specific FWP records are set forth in Paragraph 12 of this Chapter.

c. Corporate Verifiers. While it produced atomic weapons, the DOE maintained relationships with a wide variety of external entities such as contractors and subcontractors, BVs and AWEs. The CE may need to contact these entities to obtain information about a claim for compensation.

d. Oak Ridge Institute for Science and Education (ORISE). Oak Ridge maintains the ORISE database,

5. Sources of Evidence. (Continued)

which may be accessed via the Internet. The ORISE database, which contains information for over 400,000 employees from the 1940s until the early 1990s, is an effective source for verifying employment for individual claims. ORISE is accessible via ECMS, and the initial ORISE search is generally conducted at the RC when a claim is filed.

e. The National Institute for Occupational Safety and Health (NIOSH). NIOSH is an agency within the Department of Health and Human Services (HHS) that is responsible for estimating the radiation exposure to DOE employees, contractors, subcontractors and AWE employees during the production of atomic weapons.

NIOSH researches site information for covered facilities and sends dose reconstruction reports to EEOICPA DOs. The DOs use the dose reconstruction reports to determine the probability of causation between a claimed cancer and exposure at a covered facility, based on the criteria established by NIOSH.

f. Medical Sources. These sources include reports from doctors and hospitals providing examination and/or treatment to covered employees. By signing Form EE-1 or EE-2, the claimant authorizes OWCP to collect medical documentation pertinent to his or her case.

g. Center for Construction Research and Training. The Center for Construction Research and Training is a research, development, and training arm of the Building and Construction Trades Department (BCTD) of the AFL-CIO.

CPWR has direct access to 15 building and construction trade international unions, signatory contractors, and union health, welfare and pension funds. CPWR also has access to employment records, union rosters, and dispatch records.

CPWR researches and provides employment information for construction and trade worker claims where DOL has

been unable to obtain reliable information from other resources (e.g., DOE, corporate verifiers).

h. Site Exposure Matrices (SEM). The SEM database may be accessed via the Internet. SEM is a source for obtaining evidence of potential exposures to toxic substances at many DOE facilities.

i. Other Sources. The OWCP may receive evidence from other sources, such as individuals completing employment affidavits, claimant representatives, and other state and federal agencies.

6. Advising the Claimant of Deficient Evidence. When the CE determines that additional development is required, the claimant must be advised of the deficiency and afforded an opportunity to respond.

a. Initial 30-day Period. If the CE identifies a deficiency in the evidence that requires development, a letter is prepared which describes the deficiency and additional information necessary to overcome it. The CE thoroughly reviews the evidence in the file before writing the letter and tailors the letter to the individual case. Often 30 days will be sufficient time to allow for submission of additional evidence.

For example: If a claimant submits a claim for a non-covered condition and the evidence does not support a covered condition under the EEOICPA, the CE advises the claimant that a covered condition has not been claimed and that he or she is allowed 30 days to claim such a condition and to provide supporting medical evidence. [If the claimant does not claim a covered condition and does not provide supporting evidence, the CE proceeds with a Recommended Decision for denial.]

b. Final Notice. If the claimant fails to submit the requested evidence within a 30-day period, in most instances the CE sends a follow-up letter advising the claimant that OWCP has not received the requested evidence and that he or she will be provided with additional time to submit the evidence.

6. Advising the Claimant of Deficient Evidence. (Continued)

For example: If a covered condition is claimed, but the file is lacking medical documentation, the CE allows a reasonable period of time for submission of the appropriate evidence. In cases such as this, the CE makes at least two requests for medical documentation.

c. Setting Deadlines. As the EEOICPA is non-adversarial, the CE uses care when setting deadlines. The information requested is not always easily obtained because most employees were exposed many years ago. Thus the CE must be as flexible as possible and advise the claimant that additional time will be granted if the claimant requests a reasonable extension of time.

7. Requesting Evidence by Telephone. The CE may also use the telephone to gather evidence. Person-to-person contact often succeeds in obtaining information, addressing specific concerns, and defusing contentious situations. Any use of the telephone is to be conducted in a professional and courteous manner.

a. Documenting Phone Calls. CEs document each call in the Telephone Management System (TMS) in ECMS and place a copy of the automated telephone record in the case file. It is vital to enter a call summary into the TMS right after the call, while the information is still fresh in the CE's mind. For more information on TMS, see EEOICPA PM 0-0400.

8. Initial Exposure Development. RC staff conduct occupational history interviews on most new Part E claims filed after August 1, 2005, and on certain Part D/E claims filed before that date. In conjunction with this step, the CE queries the Site Exposure Matrix (SEM), and prepares the Document Acquisition Request (DAR) and forwards it to the proper DOE Operations Center or corporate verifier requesting exposure information to complement the RC findings. A DAR is not always necessary; the CE completes a DAR request based upon what medical evidence and exposure documentation is already contained in the case file.

8. Initial Exposure Development. (Continued)

a. Occupational History Interview. Exposure information is partially obtained through the occupational history interview conducted at the RC. Two separate interview scripts (one for DOE employment, one for RECA) are available, and the findings outlined in these documents assist the CE in clarifying what further exposure development is needed as it relates to causation.

b. Review of Evidence. The CE reviews the claimed employment, exposure documentation, the SEM (see EEOICPA PM 2-0700), and the claimed condition to determine the proper course of development for causation.

c. Assignment to RC. The CE reviews all former Part D cases, new Part E cases filed before August 1, 2005, and claims filed directly with the DO to determine whether an occupational history interview is required. Such evaluations are made on a case-by-case basis by reviewing the evidence in the file as a whole and the exposure evidence in particular.

(1) If the evidence in the file is insufficient to develop for exposure, the CE assigns an occupational history development task to the RC via memo to the RC manager.

(2) Upon receipt of such assignment, the RC has 14 calendar days to complete the occupational history interview and return the findings to the DO with a cover memorandum outlining all tasks and stating when they were conducted.

9. Former Part D Claims. Former Part D claims have been incorporated into the existing Part B EEOICPA files. DOE may have gathered documents that are relevant to DEEOIC's current development needs. The CE must review these claims for medical, employment, and survivorship information (if applicable).

The case file may contain copies of records from a Part B claim (e.g., medical records, development letters, Forms

9. Former Part D Claims. (Continued)

EE-5, a NIOSH dose reconstruction report, a recommended decision, a final decision) and/or records that were gathered by the DOE Office of Worker Advocacy (OWA).

As noted above, should an occupational history interview be required, the CE assigns the task to the RC. Any employment development is conducted at the DO; no RC assignment is necessary. The evidence in these claims may include:

a. Claim Forms.

(1) Form EE-1, EE-2, or EE-3.

(2) Form 350.2, Employee Request for Review by Physician Panel. This is the primary application form for current or former DOE contract employees under Part D.

(3) Form 350.3, Survivor Request for Review by Physician Panel. This is the primary application form for a survivor of a former DOE contract employee under Part D.

(4) Form KK-1, KK-2 - OWA1-7/6/01 Request for Review by Medical Panels. DOE used these forms initially for filing claims by the employee and by the survivor, respectively, and for the claims review by the Medical Panels. These were internal forms used by OWA only.

Once the Office of Management and Budget (OMB) approved these forms, they became known as Form 350.2, Employee Request for Review by Physician Panel, and Form 350.3, Survivor Request for Review by Physician Panel, respectively.

If no DOE/OWA forms are located, the CE reviews the file for any correspondence from the claimant that may contain words of claim. As with Part B, any correspondence referring to a request for benefits or a request for review by a physician panel will be considered a claim filed under Part E.

9. Former Part D Claims. (Continued)

b. Highlight Sheet. This form provides a chronological description of adjudicative actions, follow-up information, and documented phone calls by the OWA. This information was entered in OWA's Case Management System (CMS).

c. Medical Records. These records include medical narratives, pathology reports, clinical reports, and diagnostic reports.

d. Survivorship Evidence. This includes marriage certificates, divorce decrees, birth certificates, adoption papers, death certificates, obituaries, and school records.

e. Employment Evidence. This includes a Document Acquisition Request (DAR), which in turn includes employment records such as job position descriptions, personnel information, security clearance information, employment dates, medical records, accident/incident reports, radiation records, and dosimetry records.

f. Occupational Medical Questionnaire. This form is in the case file if completed by an RC staff member and/or by an OWA staff nurse based on conversations with claimants.

g. Physician Panel Report. Some case files may contain this report, which consists of the OWA physician's discussion, rationale, and conclusion as to whether a toxic substance aggravated, contributed to, or caused the claimed condition(s). Additional guidance as to the proper evaluation of these reports as they relate to causation is outlined in Paragraph 10 of this Chapter.

h. Former Worker Program (FWP) Documents. As discussed in greater detail in Paragraph 12 of this Chapter, DOE medically screens former DOE facility workers. The resulting studies document claimed illnesses and exposure. The CE may encounter DOE FWP documentation in the case file. The CE reviews DOE

9. Former Part D Claims. (Continued)

FWP findings together with all other evidence in file when evaluating for causation.

i. Authorized Representative Release Form. The claimant may have designated a representative to act on his or her behalf in the adjudication process with DOE. The CE contacts the claimant to determine whether this designation is still valid (see EEOICPA PM 2-0400).

j. Duplicate Records. The CE may find duplicate copies of records in the Part D case file. The CE maintains the integrity of the Part D case file by keeping it in the order that it was received in the district office. The CE does not remove any duplicate copies of individual records unless it is obvious that there is an exact duplicate photocopy of the entire case record in the file. In this instance the CE shreds the duplicate photocopy.

10. Positive DOE Panels.

a. Official Positive DOE Panels. If a positive DOE physician panel finding is present in a Part D case file and the DOE approval letter is signed by a DOE official, the physician panel finding is considered an official positive determination from DOE. Generally, such claims are in posture for acceptance of causation under Part E, but further development of survivorship and potential coordination and offset issues may be required of the CE before issuing a recommended decision:

(1) Eligible Survivor. In survivor claims the CE needs to determine whether the claimant is an eligible survivor under Part E and whether the accepted covered illness aggravated, caused, or contributed to the covered Part E employee's death (see EEOICPA PM 2-1200).

(2) State Workers' Compensation Benefits/Tort Offset. Also, the CE needs to determine whether the claimant received any compensation from a

10. Positive DOE Panels. (Continued)

state workers' compensation plan (see EEOICPA PM 3-0400 and 3-0500).

b. Unofficial Positive DOE Panels. If a positive DOE panel finding is present in the case file, but no accompanying approval letter signed by a DOE official is present, the case is not in posture for possible acceptance. In such a case, the physician panel report has not been sent to the claimant and the CE does not consider it an official positive determination from DOE. Therefore, the CE reviews the claim to determine if further development is needed concerning survivorship, medical, employment or exposure issues, as with any other claim.

11. Reviewing Part B/E Claims. A claim accepted under Part B is also accepted for causation under Part E for the accepted Part B covered occupational illness, if all other appropriate criteria under Part E are met.

Unlike a Part E claim with an accepted Part B claim, a claim that has been accepted under Part E is not automatically accepted under Part B.

In developing these cases, the CE needs to be alert to the differences in medical, employment, and survivorship requirements between Part B and E claims (including RECA claims), since these differences can result in the need for additional development and/or non-approval of the claim under Part E, even though it has been approved under Part B.

a. Medical Differences Between Part B and E Claims. Covered illnesses under Part E include all the covered occupational illnesses under Part B (i.e., beryllium sensitivity, chronic beryllium disease, chronic silicosis, and cancer) plus additional covered illnesses (e.g., asbestosis).

However, the covered occupational illnesses under Part B do not include all the covered illnesses under Part E (for example, asbestosis, peripheral neuropathy, and anemia).

11. Reviewing Part B/E Claims. (Continued)

b. Employment Differences in Facility Sites Between Part B and E Claims. Covered employment under Part B includes all covered employment under Part E (i.e., DOE contractor/ subcontractor, RECA).

However, covered employment under Part E does not include all covered employment under Part B. Part E covers employment at a DOE or RECA Section 5 facility. It also covers employment at AWE and beryllium vendor facilities only during a period when they were designated as DOE facilities or during DOE remediation periods. Part E does not cover employment for beryllium vendors or AWE facilities outside of the time they were considered DOE facilities.

c. Survivorship Differences Between Part B and E Claims. These issues are addressed in the Survivorship Chapter of the PM.

d. RECA Differences Between Part B and E Claims.

(1) An eligible survivor who is the child of the covered employee under RECA and under Part B is not an eligible survivor under Part E unless he or she meets the definition of "covered child."

(2) An employee who does not meet the employment and other requirements under RECA section 5 (and therefore under Part B) may be eligible under Part E.

(3) An employee who does not meet the medical criteria for covered conditions under RECA section 5 (and therefore under Part B) may still be eligible under Part E (i.e., all cancers, asbestosis, etc.)

e. Requirements for New Part E Claim Filing. If a former Part D claim exists, a claimant does not need to file a new claim under Part E. If there is a Part B acceptance on record, a claimant does not need to file a new claim for benefits under Part E. However, if a Part B denial is on record, or a Part B claim is

11. Reviewing Part B/E Claims. (Continued)

pending a decision, the claimant must file a new claim form seeking benefits under Part E.

12. DOE Former Worker Program (FWP). The FWP began in 1996 and is designed to evaluate the effects of DOE's past operations on the health of workers employed at DOE facilities. The program documents medical conditions and workplace exposures that may help the CE develop and adjudicate claims. Additional information about the FWP is available at <http://www.eh.doe.gov/health/>.

In some instances, FWP records will appear in the Part D case file. If no records exist there, or a new Part E, B/E claim is filed, the CE requests FWP documents during initial development.

The CE reviews FWP records in light of the evidence in the file as a whole when evaluating a claim. EEOICPA PM 2-0700 explains how the CE uses FWP records in assessing causation.

a. Medical Component. FWP records contain valuable information about medical conditions and can help the CE develop for a covered illness.

(1) The FWP is a screening program and does not provide a final diagnosis for the medical conditions detected. If the screening tests identify a potential disease, the employee is referred to his or her treating physician for further medical workup and diagnosis.

(2) Results of medical tests conducted by the FWP (e.g., pulmonary function tests, beryllium lymphocyte proliferation tests, blood tests, X-rays with B reader interpretations, etc.) are valid when interpreted by certified medical professionals. Therefore, the CE may use such test results in evaluating records for a covered illness, provided a physician's interpretation of the test result is present.

12. DOE Former Worker Program (FWP). (Continued)

b. Exposure Component. FWP medical screening is conducted to evaluate former DOE workers for adverse health outcomes related to occupational exposures to substances such as beryllium, asbestos, silica, welding fumes, lead, cadmium, chromium, and solvents. Therefore, these records contain valuable exposure information. The CE reviews FWP screening records along with the evidence in the file as a whole when evaluating claimed exposure.

Also, the FWP asks the former DOE employee to undergo a Work History Interview, which examines workplace exposure at DOE facilities. The CE uses the results of the interview when assessing work history and exposure.

c. Existence of FWP Records. The CE must review the case file/claim forms to determine whether FWP records exist.

(1) Part D Cases. As indicated, some former Part D cases will contain FWP records. The CE searches the case file for cover memos or medical records provided by the FWP. The CE should also refer to DOE Form 350.2, Employee Request for Review by Physician Panel, question 11, or Form 350.3, Survivor Request, question 11, to determine if the employee participated in the FWP. If records are not present, but there is some indication that they may exist, the CE obtains them as outlined below.

(2) New B/E Claims. With regard to new claims, the CE must review Form EE-3 and/or section 5(B) of the DOL Occupational History Interview (see EEOICPA PM 2-0200) to determine if the employee participated in a FWP screening program at the claimed work site. If so, the CE prepares a request package to be sent to the appropriate FWP.

d. Obtaining FWP Records. Where no records exist in a former Part D case, or a new Part E claim is filed,

12. DOE Former Worker Program (FWP). (Continued)

the CE requests the records from the appropriate FWP Point of Contact (POC). The complete POC list is available for viewing on the shared drive by accessing the Part E folder, Former Worker Program subfolder. If the records are unavailable at a POC, the POC cannot be determined, or a new Form EE-3 is required (see below), the CE requests assistance from the claimant.

(1) POC Request. After determining that FWP records must be requested, the CE reviews the POC list to identify the appropriate POC. The CE prepares a package and a cover letter to the POC (Exhibit 1). The package includes a letter to the FWP, a cover memo, Form EE-1 or EE-2, and *the new* Form EE-3.

The CE should state in the memo that an EEOICPA claim has been received for the named DOE employee, the employee participated in the specified FWP, and DOL is requesting a copy of all FWP records. The memo and package are faxed or mailed to the designated POC.

(2) New Form EE-3. FWPs will accept only a new Form EE-3 as a release. If the case file contains an old Form EE-3, the CE writes to the claimant asking the claimant to complete and sign a new Form EE-3. Once the new form is received, the CE prepares the request package as outlined above.

(3) No FWP Records. When the CE cannot locate FWP records, the CE contacts the claimant in writing to determine if the employee participated in a FWP at the claimed work site. The CE includes a new Form EE-3 with the letter and instructs the claimant to complete, sign and return the new Form EE-3 to the DO *only* if the employee participated in the FWP.

e. Building Trades National Medical Screening Program Database. This database contains work history

12. DOE Former Worker Program (FWP). (Continued)

and medical test results for certain employees who worked at Amchitka Island, Savannah River, Oak Ridge, and Hanford and who filed Part D claims with DOE from 2000-2004.

(1) The CE views medical data and work histories contained in the database by accessing the Shared Drive, Part E folder, Former Worker Program subfolder. The "read me" file in the FWP subfolder contains detailed instructions for navigating the database and retrieving information.

(2) The CE searches the database for medical information and prints the results. The medical results generated from the database do not contain a physician's signature.

(a) A letter from the Building Trades FWP Medical Director, Dr. Laura Welch, describing the information obtained in the database search and attesting to its validity is located on the Shared Drive, Part E folder, FWP subfolder.

(b) The CE prints Dr. Welch's letter and attaches it to the search results. The CE places these documents into the case file and weighs the information with the evidence on file as a whole.

13. Terminally Ill Claimants. OWCP strives to process claims fairly and expeditiously for all claimants. However, claimants who are end-stage terminally ill must have priority processing. These claims should be handled swiftly and compassionately.

a. Claims Actions. DO and FAB CEs and hearing representatives (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

13. Terminally Ill Claimants. (Continued)

evidence stating that the claimant is at the end-stage of an illness, or telephone calls or letters from RCs, congressional offices, authorized representatives, family members, or medical providers regarding the claimant's illness. Upon receipt of information concerning the end-stage of the claimant's illness, the District Director (DD) or Assistant District Director (ADD) or FAB Manager (depending on where the file is located) must be notified immediately.

The DD/ADD or FAB Manager must use sound judgment in determining if priority handling is warranted. If medical documents or other information indicate that the claimant is in the end-stage of his/her illness, or that death is imminent, priority handling of the case is required. If the claimant's medical status is unclear, a medical report that establishes that the claimant is in the end-stage of a disease or illness must be obtained. Once this information is obtained, the DD/ADD or FAB Manager will determine whether priority handling is warranted.

Once it is determined that a claimant is in the end-stage of his/her illness, the DD/ADD or FAB Manager must enter the appropriate status code in ECMS and prepare the case file in accordance with EEOICPA PM 2-2000.

Priority handling for terminally ill claimants requires that the entire adjudication process be expedited. Whenever the file changes hands, the person receiving the file should be notified, verbally or in writing, of the claimant's terminal status. The supervisor or DD/ADD should facilitate the expedited adjudication of the claim by requesting priority processing from any other agencies involved, such as the DOE, Department of Justice (DOJ), and NIOSH.

If a case requires referral to the NO for reopening or policy clarification, the DO or FAB must identify the claimant as terminally ill in the memo to the Director. Procedures for expediting payment processes

13. Terminally Ill Claimants. (Continued)

for terminally ill claimants can be found in the
EEOICPA PM 3-0600.

DOL Letter to DOE Former Worker Program

Dear FWP POC Name:

(Survivor/Employee name) has submitted a claim for benefits under the Energy Employees Occupational Illness Compensation Program. (Mr/Ms/ name) has claimed that he/she (his spouse/Father/Mother Full Name) participated in the {Site Name} Former Worker Screening Program.

The Department of Labor is requesting copies of all records you have for (employee name) to assist us in the adjudication of the claim.

Attached is the signed EE-3 which authorizes the FWP to release records to the Department of Labor.

If you have any questions regarding this request, please contact me directly at (phone number).

Thank you for your assistance in this matter

Sincerely,

Claims Examiner

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1. Purpose and Scope. The EEOICPA lays out a set of employment criteria which must be satisfied before a claim can be considered for compensability. These criteria, taken together, form the basis of covered employment. This section of the EEOICPA Procedure Manual lays out the guidance to be followed by the Claims Examiner (CE) for gathering and evaluating evidence to determine whether a claimant meets the necessary employment criteria specified in EEOICPA.

2. Facility Coverage. The EEOICPA provides facility definitions that serve as the basis for determining covered employment. The following summaries provide a general definition of each type of facility covered:

a. Atomic Weapons Employer (AWE) Facilities. An AWE facility means a facility, owned by an atomic weapons employer that is or was used to process or produce, for use by the United States, material that emitted radiation and was used in the production of an atomic weapon, excluding uranium mining or milling. Coverage at the facility may be further extended after the period of processing or production of radioactive material for use in a weapon, if there is a finding in a NIOSH report on residual radioactive contamination that the potential exists for residual radioactive contamination at that facility. AWE facilities are designated by the Department of Energy (DOE).

(1) Coverage extends only to the employees who worked directly for the AWE at the facility. Contractor or subcontractor services provided on-site or off-site for an AWE are not covered.

(2) Atomic weapons employees are covered under Part B of the EEOICPA for cancer only. No coverage is afforded these employees under Part E.

(3) Designating additional AWE facilities is the responsibility of DOE; however, applicable time frames for AWE production activities at a particular facility are determined by DOL.

(4) Determinations on whether an AWE facility has a period of residual radioactive contamination and the length of that period are the responsibility of

2. Facility Coverage. (Continued)

the NIOSH. Periodic reports are issued listing affected sites. Facilities with residual radioactive contamination are covered as AWE facilities even if there is a change in the owner or operator of the facility.

b. Beryllium Vendor (BE Vendor) Facilities. Be Vendor facilities are companies which are either named in the Act or DOE has determined that they processed or produced beryllium for sale to, or use by DOE. The Act names several beryllium vendors by corporate name and these are known as statutory beryllium vendors. Any employee of a statutory beryllium vendor who worked for the vendor during periods when the company was engaged in activities related to the production or processing of beryllium for sale to or use by DOE, has covered employment, regardless of work location. Other beryllium vendors, which are location-specific, were designated by DOE through publication in the Federal Register. The final list of designated beryllium vendors was issued on December 27, 2002.

(1) Beryllium vendor coverage extends to direct employees of the vendor, its contractors or subcontractors, or any Federal employee who may have been exposed to beryllium at a facility owned, operated or occupied by the vendor.

(2) Coverage for beryllium vendor employment is limited to those benefits available under Part B of the EEOICPA for beryllium sensitivity and chronic beryllium disease.

c. Department of Energy (DOE) Facilities. A DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located in which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and with regard to which the DOE

2. Facility Coverage. (Continued)

has or had either (A) a proprietary interest; or (B) entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services.

(1) The extent of benefits available to those who worked at DOE facilities is dependent on the type of employment, specifically whether the employee was a DOE federal employee or an employee of a DOE contractor or subcontractor. Under Part B, coverage extends to both DOE federal employees and contractor or subcontractors employees working at the site, while under Part E coverage is only extended to contractor or subcontractor employees.

(2) The definition of DOE includes its predecessor agencies including:

(a) Manhattan Engineer District (MED)(August 13, 1942-December 31, 1946)

(b) Atomic Energy Commission (AEC)(January 1, 1947 - January 18, 1975)

(c) Energy Research and Development Administration (ERDA)(January 19, 1975-September 31, 1977)

(d) Department of Energy (October 1, 1977 - present)

(3) Designations of DOE facilities or changes in DOE facility time frames are the responsibility of DOL. Further information regarding how DOL assesses claims for DOE facility status is discussed later in this chapter.

- d. Remediation Employment. At many AWE facilities, there is a DOE period of remediation designated sometime after the years of active processing ended. In those
2. Facility Coverage. (Continued)

instances when a facility is designated as a DOE facility for remediation only, in order to have covered employment at that location, the employee must have been employed by the contractor performing the remediation work. Such remediation workers are eligible for the full range of benefits under both Parts B and E of EEOICPA.

e. Facilities with multiple designations. Many facilities covered under the EEOICPA have multiple designations. There can exist any combination of AWE, Beryllium Vendor and DOE facility designation at the same facility. For those instances in which an employee works at such a facility during periods separately designated for different facility types, the employee will have eligibility for every category for which he/she has verified employment.

f. RECA Section 5. This is a special category of employment that involves miners, millers and ore transporters at uranium mining facilities. For the purposes of this chapter, RECA Section 5 employees are not addressed. For information regarding handling these types of claims, please refer to Chapter 2-1100 of the EEOICPA Procedure Manual.

3. Comparing initial claimed employment to the covered facilities database. The first step the CE takes in assessing covered employment is determining which claimed employment on the EE-3 Employment History form corresponds with a known covered AWE, Be Vendor or DOE facility. The CE does this by comparing what is written on the EE-3 with the facilities identified on a web utility located at: <http://www.hss.energy.gov/HealthSafety/FWSP/Advocacy/faclist/findfacility.cfm>

When performing the comparison between the claimed employment and the facility database, the CE must be diligent in assessing the evidence. While in many instances, employment at a particular location or facility will be obvious, in other situations it may not. Evidence presented by a claimant must be scrutinized against the database to assist in determining the location where employment occurred. In 3. Comparing initial claimed employment to the covered facilities database. (Continued)

some situations, the claimant may use various words, phrases or other descriptors to identify a work location. Moreover, the CE must be mindful that often the name of a facility is different from the employer name provided by the claimant. Given these realities, the CE must cross reference the data provided by the claimant with the information in the facility database. This can involve searching by facility name, state or location, or key word. The "Find this Keyword" search feature is particularly helpful as it is the broadest possible way to look for potential covered employment based on claimant statements.

a. Certain employers should be screened out of the review process if it is clearly discernable that there is no affiliation to the atomic weapons industry. For example, employment as a clerk at a shoe store or cashier at a department store would not require action on the part of the CE to further consider as part of the review for potentially covered employment.

4. Matching claimed employment. The outcome of the initial employment facility screening will result in either part or all of the claimed employment having possibly occurred at a covered facility, or none of the claimed employment being linked to a facility. In any instance where all claimed periods of employment are linked to a location identified on the facility database, the CE is to proceed to employment verification as discussed later in this chapter. Alternatively, if the CE is only able to match a portion of the claimed employment to a facility listed in the facility database, or there is no match found, action must be taken to communicate the findings to the claimant. The CE is to contact the claimant to notify him or her as to which employment can form the basis of a claim and which does not appear linked to a covered facility. The claimant is to be afforded the opportunity to provide clarifying evidence. The process for this action is further discussed in paragraphs 17 and 18 of this chapter. It should be noted that this development may occur concurrently with other actions being taken in conjunction with the claim such as requests for additional medical or factual evidence.

4. Matching claimed employment. (Continued)

When there is sufficient evidence to conclude that employment may have occurred at a covered facility, the CE may then proceed with the verification of employment as described later in this chapter. If the claimant does not respond to the inquiry or does not provide any type of clarifying evidence, the CE may proceed with adjudication of the claim based on the evidence of record. If there is no match between any claimed employment and a covered facility, the CE may proceed to deny the claim. In any instance where claimed employment is not verified, it must be described in any recommended decision.

5. Resource Center Actions. As outlined in Chapter 2-0200, resource center staff take initial employment verification steps for those cases originating at a resource center. This includes matching claimed employment to covered employment and initiating action outlined in paragraphs 6 through 12, below, as appropriate.

6. Verification of Employment. Once matches are established between claimed employment and a covered facility, the next step is employment verification. Employment verification is the process by which the CE establishes the factual accuracy of the claimed employment history. Evidence must be collected that establishes that:

- a. The employer qualifies for consideration under the law as an AWE, Be Vendor, DOE, or DOE contractor or subcontractor.
- b. The employee worked for claimed employer.
- c. The employee performed duties at that covered AWE, Be Vendor or DOE facility.

The process of employment verification is recognized as a difficult and challenging hurdle in many cases. Because the atomic weapons program dates back to the early 1940s, the large number of public and private organizations involved, the high level of security involved, and the sheer scope of the industrial process, locating pertinent individual employment records can be difficult. Moreover, it is also a

6. Verification of Employment. (Continued)

reality that records are missing, degraded, lost or destroyed. This imperfect situation presents particular difficulties to the CE when attempting to establish the factual accuracy of claimed employment.

As the statute allows latitude in the assessment of evidence, it is not necessary for the CE to collect evidence that establishes that the claimed employment is proven beyond a reasonable doubt, but merely that a reasoned basis exists to conclude that the employment occurred as alleged. This ensures that the claimant receives favorable treatment during the employment verification process. Once the CE has conducted an examination of the available factual evidence in support of the claimed employment, he or she must decide whether a sufficient basis exists to verify that each of the three elements of covered employment are satisfied.

a. SEC employment. In matching claimed employment to covered employment, the CE is to be mindful that there are numerous classes in the Special Exposure Cohort (SEC), described in Chapter 2-0600. It is important that the CE always consult the most current list of SEC classes so that claims fitting into the class can be promptly adjudicated, without overdevelopment of covered employment.

7. Employment Pathways Overview Document (EPOD). The EPOD is a document that has been created to assist the resource center staff and CEs in identifying the appropriate pathway(s) to be taken as part of the employment verification process. This document lists every facility published in the Federal Register that is covered under the Act (except RECA facilities) and provides an outline of the identified methods for verifying claimed employment at each location. EPOD is initially available on the shared drive in the Employment Verification Folder within the Policies and Procedures Folder.

The pathways listed in the EPOD are not intended to provide an exhaustive list of means to verifying employment at a facility, but rather represent what constitutes best practices for verifying employment most efficiently given the

7. Employment Pathways Overview Document (EPOD).
(Continued)

programmatic experience gained since passage of the Act in 2000. The CE should locate the facility(ies) identified on the EE-3 in EPOD and ascertain the programmatic implications based upon the claimed employment.

Specifically, EPOD identifies which methods, or combinations thereof, described below are appropriate to pursue to verify covered employment in the most expeditious manner possible. The recommended sequence for utilizing resources follows the numbered items 8 through 13 in this chapter.

EPOD replaces lists 1, 2, 3 and 4 from previous guidance. It also replaces the "CE Employment Verification Referral Sheet." If EPOD is silent on verification at a facility, the CE is to utilize Social Security Records (Paragraph 11, below) and "other employment evidence" (Paragraph 13, below).

The facilities in EPOD are listed alphabetically by state. On the first page of EPOD there is a list of states and, for those states with a large number of facilities, there are additionally letters after the state name. These letters provide a rough index of the facilities in that state. The state names and letters allow the user to navigate through the document. For example, to navigate to South Carolina the user places the cursor on South Carolina and presses "Cntrl + right click" at the same time and the utility will jump to South Carolina. Alternatively, if a user wants to view the S-50 plant in Tennessee, the most expeditious method would be to move the cursor over the letter S after Tennessee and then press "Cntrl + right click" at the same time and the utility will jump to S-50.

For many claims, DOE can provide employment information for employees covered under the Act. Since this is not always the case, it is necessary to include in the case file in every instance in which there is no appropriate referral to DOE, a letter from DOE so stating. (Exhibit 1) Therefore, for every facility in EPOD in which there is no referring DOE contact information, the CE is to place a copy of the DOE letter in the file.

8. Using the ORISE database. For every EEOICPA-covered facility for which there is some employment data in ORISE, EPOD will indicate "ORISE - yes." When this occurs, resource center staff and/or the CE conduct an ORISE search in ECMS as

outlined below. If there is no mention of ORISE in EPOD for the facility, the resource center staff or CE proceeds to the next recommended method for verifying employment noted in the facility description in EPOD or in this chapter.

- a. Resource center staff and/or the CE logs into ECMS as described in Chapter 2-2000, and chooses the "Inquiry" tab and selects "Search ORISE data." A screen appears which provides fields for the first name, last name, and social security number of the employee. To conduct a search, the CE must enter, at a minimum, a partial last name, or social security number for the employee.
- b. Once resource center staff and/or the CE enters the employee's name and/or social security number, the system searches the database and provides the results at the bottom of the page under ORISE Search Results. If the database finds a match, the name and social security number appears. The resource center staff and/or CE select the result to review the employment data.
- c. ORISE categorizes information in two rows of data. The first row categorizes the information by Facility and lists all the facilities or employers (for which data exists in ORISE) where the employee worked. The second row categorizes information in columns by Facility, Hire/Terminate Date, Dept. Code, Job Title, and Badge Number. ORISE was not created for the purpose of adjudicating claims, so information therein may be incomplete. In some cases it provides the name of the employer with a notation in the "HT" column, which provides "H" for hire and "T" for termination, with the numbers in the adjacent columns representing the corresponding dates for hire and termination.

8. Using the ORISE database. (Continued)

The translations for the codes in the "pay" column are as follows:

H = Hourly
W = Weekly
M = Monthly
O = Operations (hourly)
S = Salaried
C = Construction

- d. Because ORISE was not created for the purpose of adjudicating claims, resource center staff and/or the CE must consider the context of the information. For example, there may be data in ORISE confirming that an employee worked at a facility in 1949, but the resource center staff and/or CE must ensure that the covered time period for this facility includes 1949. Additionally, for many employees, the information in ORISE is incomplete. For example, for some employees the database may show the employee's name and facility, but does not include specific hire and termination dates. If this is the case, the CE develops hire and termination dates using alternate methods described in paragraphs 9 through 13 in this chapter.
- e. If the information from the ORISE database is used to verify any portion of employment, a copy of the ORISE employment results is printed and placed in the case file along with the memorandum from DOE stating that the data contained in the ORISE database is reliable (Exhibit 2). These documents may be used as affirmation of employment and are placed in the case file.
- f. The absence of data from ORISE may not be used as the basis for stating that an employee did NOT work at a given facility either for the entire time period claimed or for portions of claimed employment.
- g. There are some employers and/or facilities in ORISE that are not covered under the EEOICPA. Resource center staff and/or the CE need to carefully review the ORISE results for any non-covered employers. For example, the Puget Sound Shipyard for which ORISE ascribed the
8. Using the ORISE database. (Continued)

acronym PSSY is contained in ORISE, but is not covered under the EEOICPA. In the event that ORISE "confirms"

such non-covered employment, it does not render such employment as covered. If an employer is not covered, no degree of verification that a person worked there will serve to extend EEOICPA coverage to that facility. All decisions on adding facilities are made by the National Office through the process described in paragraphs 17 and 18 of this chapter.

9. Contacting DOE. When claimed employment can not be verified in ORISE, the resource center staff/CE use the Form EE-5, found in Exhibit 2 (Forms) of Chapter 0-0500 of this Procedure Manual to obtain employment information. To determine whether the claimed employment is such that an EE-5 referral to DOE is appropriate, resource center staff and/or the CE look up the name of the facility(ies) and/or employers in EPOD. If there is a notation in EPOD signaling "EE-5 Referral to (contact information)" next to the facility, resource center staff and/or the CE proceed with the EE-5 procedures specified in this paragraph. If the employee was employed at multiple work sites for which different DOE operations offices are responsible, resource center staff and/or the CE send separate employment verification packets to each unique DOE operations office that is appropriate given what is claimed on the EE-3.

a. EE-5. The resource center staff and/or the CE complete the top portion of the EE-5 by providing the employee name, SSN, claimed employer, and named claimed facility. Resource center staff and/or the CE also write a cover letter to the appropriate DOE operations office or offices, make a copy of the EE-1 or EE-2, as appropriate, and a copy of the EE-3 to be included in the package with the EE-5. The completed package is then submitted to every appropriate DOE contact listed in EPOD for each facility requiring such a referral. It may be necessary to submit separate employment verification packets to each responsible DOE operations office.

b. Subcontractor employment indicated. Resource center staff and/or the CE review the EE-3 and make a preliminary determination of whether the employee is claiming DOE subcontractor employment. If so, resource

9. Contacting DOE. (Continued)

center staff and/or the CE note this in the cover letter to DOE and request any information the DOE might have to help substantiate that the company was hired by the DOE or a DOE contractor to provide a service on-site during the time period when the employment is claimed. Questions regarding subcontractor employment are referred to the same operations' offices as the EE-5 package, and not to DOE Germantown.

c. Upon receipt of an EE-5 from DOE, the CE reviews it for completeness. DOE is responsible for selecting one of three options provided on the form and attaching any relevant information. In addition, the DOE representative completing the form must certify its accuracy. The CE returns any form that does not meet these requirements to DOE for correction. The three options available to DOE and the appropriate procedural responses are as follows:

(1) For any of the claimed employment in which DOE selects "Option 1 - Verified Employment," the CE accepts this time period as verified and no further action needs to be taken to establish this fact.

(2) If DOE selects "Option 2 - No verification is possible, but other pertinent evidence exists," this indicates that DOE has some information on the employee, generally suggesting that the individual was on site or somehow associated with the facility, but the information is insufficient for the DOE to provide verification. If Option 2 is selected, the CE develops the case further for employment as outlined in this chapter.

(3) If DOE selects "Option 3 - No evidence exists in regard to the claimed employment," it indicates that DOE has no evidence at all regarding the claimed employment. If Option 3 is selected, the CE develops the case further for employment as outlined in this chapter.

9. Contacting DOE. (Continued)

d. Timeframes. If the CE does not receive a completed form from DOE within 30 days of the initial submission,

the CE prepares a second request for the completed EE-5. If DOE is ultimately unable to verify employment, the CE is to utilize other procedures as outlined in this chapter.

e. No Response from DOE. If the CE does not receive a response from DOE within 60 days from the initial request, additional development is necessary.

(1) Contact DOE by telephone. If no response is received, the CE contacts the appropriate Operations Office by telephone. The CE asks the contact person identified in EPOD whether a response to employment verification is forthcoming. If DOE responds via telephone that they have no records to verify employment, the CE documents this to the case file with a memo outlining DOE's response. This serves as the "EE-5" for purposes of a DOE response.

(2) Contact the claimant. After 60 days with either no response or a response that no records are available from DOE, the CE contacts the claimant for additional employment information.

f. Document Acquisition Request (DAR) Processes. For cases involving DOE contractor employees, the CE or resource center makes a request to DOE for records useful for developing information regarding toxic exposures. Although DAR records are predominately used in the adjudication of the toxic exposure component of Part E cases, DAR records can also contribute to the evidence of covered employment, especially in cases involving DOE subcontractor employment, which is further described in paragraph 14 of this chapter. DAR records can include site medical records, job descriptions, radiological records, incident or accident reports and others. Generally, a request for DAR records is only made of DOE once employment is confirmed. However, some DOE operations offices have stated that they prefer to receive the DAR request at the same time as they receive

9. Contacting DOE. (Continued)

the EE-5. If resource center or district office staff are aware of such a situation, they include the request

for DAR records in the EE-5 package. The point of contact at DOE for DAR records is also included in EPOD. For more details on the DAR process, refer to Chapter 2-0700 of this manual.

g. Dosimetry Records. It is general program policy for NIOSH to obtain dosimetry records from DOE as part of the dose reconstruction process. The dosimetry records become associated with the file when the district office receives NIOSH's dose reconstruction report. Nevertheless, in instances in which dose records may be useful for confirming that an individual was on site or was monitored for radiation exposure the CE may request such records from DOE as part of employment development.

10. Contacting Corporate Verifiers. Many of the facilities designated under EEOICPA are operated by private companies and neither DOE nor any of its predecessors have possession of the employment or personnel records. However, many of these companies are still in business, or have been bought by other companies which have maintained records of past employees. Many of these companies have agreed to provide employment verification for purposes of adjudicating claims under EEOICPA. These companies are referred to as corporate verifiers. For each facility that has been identified as having a corporate verifier, EPOD provides the name and contact information for the corporate verifier. The CE is to follow the instructions listed in EPOD to obtain such employment information. General procedures for handling corporate verifiers include:

a. It is not necessary for the CE to submit a copy of documentation from the case file to the corporate verifier. Instead, a cover letter providing the details of the request is to be submitted. In most cases, the cover letter includes the employee's name, SSN, date of birth, employer name and the dates of claimed employment.

10. Contacting Corporate Verifiers. (Continued)

b. Once the CE has received a response from the corporate verifier, the CE reviews it to determine if it

is sufficient to verify the claimed period of employment. If the corporate verifier affirms the entire period of employment being claimed, the CE accepts the period as factual. The CE must obtain the verification from corporate verifiers in writing. While an employment verification can be *initiated* through a phone call, there must be documentation from the verifier in the case file to substantiate a finding of covered employment. If the corporate verifier is unable to substantiate the claimed period of employment or can substantiate a portion of it, the CE requests additional information. The CE can proceed with a request to the Social Security Administration (SSA) for information as described in paragraph 11 of this chapter, and should also ask the claimant for additional information, as outlined in paragraph 13 of this chapter, as appropriate.

c. If verification is for a beryllium sensitivity or chronic beryllium disease (CBD) case, the CE need not verify all employment, only enough employment sufficient to substantiate the exposure at any time during a covered time period. For additional information regarding development of a beryllium claim, refer to Chapter 2-1000.

d. Corporate verifiers sometimes change. If a CE learns of a change in contact information or locates new contact information, this information should be sent to the National Office Employment Contact in the Policy Branch.

11. Verifying Employment through the Social Security Administration (SSA). Absent confirmation of employment through ORISE, DOE or a corporate verifier, the CE requests additional information from SSA. Also, for those facilities for which EPOD does not provide any suggested employment verification pathway, the resource center and/or CE requests records from SSA by following the procedures outlined below.

11. Verifying Employment through the Social Security Administration (SSA). (Continued)

a. Obtain a release from the claimant. Once the resource center and/or CE determine that SSA information is required to verify employment, the CE prepares a letter to the claimant for his or her release of SSA information. The claimant is advised that additional employment verification is necessary. A Form SSA-581, "Authorization to Obtain Earnings Data from SSA," should be enclosed (Exhibit 3). The following information is required on the SSA-581:

(1) For Employee Claims: The employee, the resource center staff or CE complete the following sections of the SSA-581: name; social security number; date of birth of employee; and other name(s) used. The employee or his or her authorized representative must also fill in his or her address/daytime telephone number and sign and date the form.

(2) For Survivor Claims: The survivor, resource center staff or CE complete the following sections of the SSA-581 form: name of social security number holder (employee); employee's social security number; date of employee's birth; date of employee's death; and other name(s) used. The survivor writes in his or her address/daytime telephone number; indicates the appropriate box and shows relationship; signs and dates the form and prints his or her name in the requested space.

The resource center staff or CE explains to the survivor that he or she must provide proof of the employee's death and his or her relationship to the employee. Proof of death includes: a copy of the death certificate, mortuary or interment record, or court-issued document. Proof of relationship includes: marriage certificate, birth certificate, adoption papers, or other court-issued document(s). SSA requires that these documents be submitted in order to process requests from survivors.

11. Verifying Employment through the Social Security Administration (SSA). (Continued)

b. Timeframes on the SSA-581. The resource center staff or CE complete the form with the years deemed necessary to verify employment and/or establish wage-loss on the "Periods Requested" line. The CE or resource center staff identify this time period by reviewing the EE-3 and all the related documentation in the file, as well as a review of ECMS.

In the box titled, "Requesting Organization's Information," the CE or resource center staff sign the section, "Signature of Organization Official," and provides the district office toll free telephone and fax numbers.

The resource center staff or CE must ensure that the upper right hand corner of the form allocated for "Requesting Organization" indicates the correct district office where SSA's response should be sent.

c. The original (signed) SSA-581, and supporting documents (if the request is submitted by a survivor) must be submitted via Federal Express to the SSA, Wilkes Barre Data Operations Center (WBDOC), at the following address:

Social Security Administration
Wilkes Barre Data Operations Center
PO Box 1040
Wilkes Barre, PA 18767-1040

d. Once the claimant's release has been obtained, the CE or resource center staff prepare a package for SSA referral. The package to SSA includes a cover letter requesting SSA to perform an earnings search on the named employee. Attached to the cover letter is Form SSA-581 that indicates the name of the employee, employee SSN, and the years of employment to be researched. Upon release of the package to the SSA, the CE or resource center staff will input code "SS" into ECMS.

11. Verifying Employment through the Social Security Administration (SSA). (Continued)

e. Following submission of a Form SSA-581, the CE (or designee) is responsible for determining if SSA has received the earnings request (Form SSA-581) and for obtaining a status update on the employment verification request.

(1) If there has been no response from SSA within thirty (30) calendar days of the date of the submission to SSA, the CE calls to obtain a status update. The telephone call should be documented in the TMS section of ECMS and a printed copy placed in the case file. If SSA indicates that no SSA-581 form has been received, the CE must resubmit the form. Otherwise, the CE obtains the status and monitors for further follow-up.

(2) Inquiries to SSA are made by calling one of ten phone numbers (Modules) depending on the last four digits of the relevant SSN. (Exhibit 4)

(3) In response to the SSA-581, SSA provides a statement of earnings, known as an SSA-L460. If the CE does not receive a completed SSA-L460 within thirty (30) days of the first inquiry call to SSA (the 60th day), the CE follows-up with a call to determine the status of the request and proceeds as necessary. After 60 days, it is necessary to obtain a newly signed SSA-581 from the claimant and resubmit the form to SSA as outlined above.

f. Tracking SSA requests and costs. After the completed SSA-581 form is sent, and a copy is placed in the case file, a SSA Point of Contact (POC) designated by the District Director ensures that the form is logged into a tracking spreadsheet. Each district office is responsible for developing a system of logging and tracking each claim, but the spreadsheet should contain, at a minimum, the case number and the date sent to SSA.

g. Response from SSA. Depending on the response from the SSA and the circumstances of the employment, the CE does one of three things. The CE either accepts the

11. Verifying Employment through the Social Security Administration (SSA). (Continued)

period of employment as verified; develops for additional information, such as work location or the other elements needed for subcontractor employment, as appropriate; or denies the claimed period of employment. The CE documents receipt of the SSA response by entering code "SR" into ECMS.

12. CPWR. The Center for Construction Research and Training, formerly known as the Center to Protect Workers' Rights (CPWR), and which continues to utilize the acronym CPWR, is a research, development, and training arm of the Building and Construction Trades Department (BCTD) of the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO). DEEOIC has contracted with CPWR to research and provide employment information for construction/trade worker claims where DEEOIC has been unable to obtain reliable information elsewhere. It is especially useful for obtaining information on DOE subcontractors and on workers employed in the trades. Instructions for development of subcontractor employment are provided in paragraph 13 of this chapter. Any time subcontractor employment is suggested on the EE-3, the subcontractor worksheet described in paragraph 14 must be completed. Once that is completed, there are essentially two pathways by which information from CPWR can be obtained for the use of EEOICPA claims adjudication:

a. Web-accessible database. If the resources already covered in this chapter do not provide sufficient documentation for a finding of covered employment, the CE can utilize CPWR, if appropriate. With regard to locating information to substantiate the existence of a contract between DOE and a company, CPWR has created a web-accessible database which the CE can use in identifying and confirming the existence of contractor or subcontractor employers at certain covered facilities. Facilities for which CPWR has contractor and subcontractor information have been identified in EPOD as "CPWR." If the CE determines that the claimed employment involves subcontractor employment at a facility in which EPOD indicates "CPWR has contractor/subcontractor information," the CE first

12. CPWR. (Continued)

reviews the EE-5, the DAR request and any material received from DOE. If this information is insufficient for a finding of covered employment, the CE reviews the CPWR database for any information therein linking the claimed employer to the claimed DOE facility, by following these instructions:

- (1) The CE goes to www.btcomp.org. A log-on screen appears. Each district office has been assigned one original user name and password.
- (2) Upon access to the web site, a disclaimer notes the database is a general information resource tool. It is not intended to nor does it contain all of the documents that relate to DOE contractors and/or subcontractors. However, the DEEOIC considers the information available in the database to be accurate and correct. Once the CE accepts the disclaimer, the database opens into basic search mode. The database allows various ways to search for information: by subcontractor name, by site, or by scrolling down the subcontractor master list.
- (3) To search by contractor/subcontractor name, the CE enters the name of the company identified in the evidence from the case record. The company name may be the current recognized employer name, an acronym for the employer, or a previous version of the name. The CE searches the database using various combinations of spellings or aliases for the employer name. This increases the likelihood of a positive outcome and reduces the number of false negative results. For example, if a CE enters the name "Bowles Construction Company" the database returns a negative result. However, if the CE enters "Bowles" or "Bowles Construction" the employer appears in the return.
- (4) To search by site, i.e. covered facility, the CE clicks on the list box labeled "by site" on the left hand side of the screen and selects the facility for which he or she is seeking contractor

12. CPWR. (Continued)

or subcontractor information. This returns all employers known by CPWR linked to that facility. It may be necessary for the CE to scroll down to view all named employers. To view detail for a named employer, the CE merely needs to access the "view" link under the options category. In some instances, a contractor or subcontractor name might be linked to multiple covered facilities. In these instances, the detailed return for the employer is separated into sections by covered site.

(5) It is also possible for the CE to search the comprehensive listing (master list) of all contractor employers listed in the database which appears if no name or site search criteria are applied or if the option "show all" is selected. A unique document identification (Doc Id) has been assigned to each contractual finding. The Doc Id is used by CPWR as a means of tracking and is not accessible by the CE.

(6) After the CE has accessed the database and conducted appropriate research to locate a contractor/subcontractor, the CE documents the case file. In the case of a positive result, the CE prints a copy of the screen for the case file. The printout must show all the results of the database search including the employer name, site name, contractual relationship indicator, dates verified, type of work performed, description of evidence, document ID, and date of database update. Generally, this information must be printed based on a "landscape" print mode setting. The printout should also list the date of the database search, the date of the latest update of a facility and any of the pertinent facts. In the situation where a database search does not return any result, the CE completes a "Memorandum to the file" noting the lack of information in the database for the claimed contractor/subcontractor. The memorandum is dated and signed by the CE. Caution: The database contains records on employers linked to DOE, but for which no probative documentation has been

12. CPWR. (Continued)

located. Any employer found in the database that does not have the "contractual relationship" indicator checked cannot be used to confirm that the employer is a valid contractor or subcontractor and should not be printed out for the file.

(7) The purpose of the database is solely to show a relationship between a DOE facility and a contractor or subcontractor employer. A positive result may return varying levels of information about an employer linked to a facility. For example, a database return may merely list that a contractor or subcontractor was linked to a particular facility, but not when. In addition to the database results, additional development may be needed independent of the database to ensure that such evidentiary gaps are filled.

(8) If the contractor or subcontractor is not listed in the database, additional development is necessary. The CE is not to assume that a search of the database that does not return any results establishes that the claimed employer was not a contractor or subcontractor. The CE must use all other resources that may potentially establish a contractual relationship.

b. Referrals to CPWR. If information beyond that which is listed in the CPWR database is needed, CPWR can be asked to provide certain types of information to assist in these cases. The types of information CPWR can provide includes proof of a contractual relationship between DOE at a covered facility and an identified employer (contractor or subcontractor) during a specific time period, evidence that an employee worked for a specific employer during the claimed time period and, as appropriate proof that the employee worked on the premises of a DOE facility during a covered time period. CPWR is not permitted to offer an opinion as to the validity of the evidence presented to substantiate a claim. Weighing and evaluating the evidence is solely the responsibility of DEEOIC, with guidance provided in

12. CPWR. (Continued)

this chapter. Procedures for handling requests for information from CPWR are as follows:

(1) For any of the claimed contractor or subcontractor employment at a DOE facility for which CPWR has information, the CE is to determine whether the employee worked in an occupation for which CPWR has information. CPWR has information about the following:

- Asbestos Workers (can include those who worked with insulators and pipe coverings)
- Boilermakers (includes Riggers)
- Bricklayers (can also be called brick mason, mason, stone mason, tile layer, tile setter, terrazzo worker)
- Carpenters (can include latherers, millwrights, pile drivers, drywall hangers, framers and finishers)
- Electrical Workers (can include electricians, line men, power installers, wireman, telephone workers, instrument mechanic, telephone installer)
- Elevator Constructors
- Iron Workers (can include erectors, structural steel erectors, ornamental erectors, glaziers, welders, connectors and rodmen)
- Laborers (can include flaggers, miners/tunnel workers, shaft drillers at the Nevada Test Site & Amchitka, and machinists and janitors)
- Machinists
- Operating Engineers (includes heavy equipment operators such as operators of bulldozers, graders, cranes and front end loaders, also includes well drillers, mechanics and stationary engineers who operate boiler rooms, electrical generators and heating and cooling systems)
- Painters (can include glaziers, drywall finishers)

12. CPWR. (Continued)

- Plasters and Cement Masons (can include masons, cement finishers, concrete pourer)
- Plumbers and Pipefitters (can include fitters, sprinkler fitters, gas welders, instrument mechanics and steamfitters)
- Roofers
- Security Guards
- Sheet Metal Workers (includes duct worker, shop worker)
- Teamsters

(2) If the employee worked at a facility for which CPWR has information and in a trade for which CPWR has employment information, the CE is to confer with the district office Point of Contact (POC) for CPWR referrals. The POC is selected by each district office to serve as the principal liaison between DEEOIC and CPWR. There is one POC per district office who is responsible for all communication between the district office and CPWR. Also, the POC is responsibility for certifying outgoing referrals and reviewing incoming responses.

(3) If the POC agrees that the claim requires a CPWR referral, the POC or CE prepares three forms. These forms are a Subcontractor Worksheet (guidance for use is in paragraph 14 of this chapter), a CP-1 Referral Sheet (Exhibit 5) and a CP-2 Employment Response Report (Exhibit 6). The subcontractor worksheet apprises CPWR of the established documentation on record relevant to establishing covered employment. The CP-1 provides general information concerning the employee's case file. The CP-2 is a form CPWR uses to respond to employment data requests.

(4) The CE or POC complete the CP-1. Section 1 requires information concerning the case to be listed, such as employee name, claim type, file number and Social Security Number. In Section 2, the referring District Office is to be identified

12. CPWR. (Continued)

along with the number of attached CP-2 Employment Response Reports. Any special requests or other relevant information for CPWR is to be listed in the comment section.

(5) For each claimed employer at a facility where CPWR can provide assistance, the CE or POC prepare a separate CP-2 Employment Response Report. The CE or POC may prepare as many copies of the form as necessary. The CP-2 contains two sections. The CE or POC completes Section 1 and describes the employment to be researched by CPWR. It is important that the information specify both the periods of employment requiring verification and the type of evidence being requested, such as evidence of a contractual relationship, proof of employment with the claimed employer, or evidence of employment on the premises of the claimed facility. Section 2 of the CP-2 is reserved for CPWR to report any findings pertaining to the claimed employment.

(6) Upon completion of the DEEOIC portions of the CP-1 and CP-2, the POC reviews all the material. He or she ensures that the information contained on the referral forms is reported accurately and satisfies all of the requirements for submission to CPWR. Once the review is complete and the POC is satisfied that the forms are completed correctly, he or she signs and dates the CP-1. The CP-1 Referral Sheet is certified on the day the referral is mailed out of the district office.

(7) A copy of the completed package is kept for the case file. The original package, to include the CP-1, CP-2 and the subcontractor worksheet is express mailed to CPWR.

(8) On the same day that the referral package is mailed to CPWR, all claimants and/or the authorized representative in the case are to be notified of CPWR involvement. The CE or POC must prepare a letter for each claimant that describes CPWR's

12. CPWR. (Continued)

involvement in the case (Exhibit 7) and send it to each of the claimants and/or authorized representative in the case.

(9) CPWR is able to accept a minimum of 2500 through a maximum of 6000 CP-2's annually. Once the POC or backup person determines the number of cases to be sent to CPWR during a given week, he or she is to batch all the referrals and express mail (initial request should not be e-mailed) them weekly to:

Anna Chen (achen@zenithadmin.com)
Zenith Administrators
201 Queen Anne Avenue, North
Suite 100
Seattle, WA 98109
1-800-866-9663

(10) The POC or the backup person is the ultimate arbiter of all issues involving the CPWR referral process. He or she is not to certify for submission any referral package that does not meet the requirements for referral. Any incomplete or inaccurate referral package must be returned to the CE. The POC notifies the CE of any deficiency and the steps necessary to correct the problem. CPWR is permitted to contact claimants directly. However, any request for claimant contact must be submitted to the POC, who then provides the necessary contact information.

(11) The POC is responsible for tracking all CPWR referrals and responses. For each referral, the district office must track the following information:

- (a) case number
- (b) facility name(s)
- (c) employer name(s)

12. CPWR. (Continued)

- (d) number and date of referral(s) to CPWR,
- (e) number and date of response(s) received from CPWR,
- (f) CE initiating request
- (g) Target due date (40 days from the date of referral).
- (h) Number of overdue referral (s) (41 or more dates from the date of referral).

By the tenth day of each month, the DO POC sends the National Office an email summarizing the total number of CPWR referrals and responses for the preceding month, the number of outstanding requests (>40 days), the number of referrals determined to be eligible, the number of referrals determined to be ineligible, and the total number of referrals to date. The number of referrals determined to be eligible is defined as the number of referrals that CPWR determined as valid requests. The number of referrals determined to be ineligible is defined as the number of referrals that CPWR determined as invalid requests, e.g. the name was incorrect, the social security number was incorrect, the subcontractor was not a part of their database, etc. Contractually, CPWR can process a limited number of claims during the contracted time period. The report assists the National Office in tracking the number of requests by each district office on a monthly basis.

(12) In instances in which CPWR needs additional CP-2's subsequent to their preliminary research and requests such from the POC, the CE and POC must confer on the requests and determine if additional CP-2s are needed. If they agree with CPWR's assessment, the POC forwards via email or fax the appropriate number of additional CP-2s to the aforementioned address. If they do not agree with

12. CPWR. (Continued)

CPWR's assessment, the POC provides an explanation to CPWR.

(13) CPWR has 30 calendar days from receipt of a referral to conduct appropriate research into the claimed employment, complete each CP-2 based on the evidence gathered, and express mail the response to the appropriate POC. Responses are bundled according to case file number.

(14) District office mailroom staff date stamp incoming responses according to established procedures and forward them to the designated POC. The POC enters the receipt date in the tracking database and immediately forwards the CPWR response to the appropriate CE.

(15) When reviewing the CPWR response, the CE or POC is responsible for carefully assessing the relevance of any evidence or information submitted by CPWR. In instances where additional action is needed subsequent to a CPWR response, the CE must further develop the case. For example, if the evidence provided by CPWR confirmed that the employee was employed by a covered employer, yet failed to place the employee on the premises during a covered period, then additional development is necessary to place the employee on the premises. Additionally, if CPWR provided the names and addresses of individuals that may have known the employee, yet this information was not previously contained in the factual evidence, the CE requests an affidavit (as outlined in Paragraph 13, entitled, "Other Evidence," of this Chapter) from individuals identified by CPWR.

13. Other Employment Evidence. Evidence of employment by DOE, a DOE contractor, beryllium vendor, or atomic weapons employer may be made by the submission of any trustworthy contemporaneous records that on their face, or in conjunction with other such records, establish that the employee was so employed, and the location and time period of such employment. No single document noted in this section is

13. Other Employment Evidence. (Continued)

likely to provide all elements needed for a finding of covered employment, but rather each piece of evidence can contribute valuable elements needed to make a finding of covered employment.

Documentation from the following sources may be considered:

- a. Records or documents created by any federal government agency (including verified information submitted for security clearance and dosimetry badging), any tribal government or any state, county, city or local government office, agency, department, board or other entity or other public agency or office.
 - b. Records or documents created as a byproduct of any regularly conducted business activity or by an entity that acted as a contractor or subcontractor to DOE.
 - c. DEEOIC internal resources. The DEEOIC district offices each have gained experience with the facilities covered under this program. As part of adjudicating claims, each office has accumulated documentation substantiating various subcontractor relationships. Once such a relationship has been established at a facility for a given time period, the CE can use this information in the adjudication of other cases in which the same subcontractor employment is claimed during the same time period.
 - d. Affidavits or other types of signed statements attesting to the accuracy of a claim. The CE requests that the claimant use the EE-4 Employment History Affidavit to collect statements from knowledgeable parties. Statements provided by way of an affidavit are considered in conjunction with other evidence submitted in support of a claim. Affidavits are considered particularly appropriate as a means of demonstrating that an employee worked at a particular location and are best used with other information, such as SSA records. Affidavits alone are usually insufficient to prove the existence of a contractual relationship between DOE and a company.
13. Other Employment Evidence. (Continued)

Additionally, the CE has the discretion to assign different probative weight to different affidavits. For example, the CE may find that an affidavit from a former CEO of an employer has significantly more probative value than that of one from a relative who may benefit from any award granted. The CE must use his or her own judgment to ascertain what weight to give to any given piece of evidence, including affidavits.

14. Subcontractor Employment. Subcontractor employment at beryllium vendors and DOE facilities is covered under the Act, provided that certain developmental elements are met.

a. Definitions.

(1) Contractor. An entity engaged in a contractual business arrangement with DOE to provide services, produce material or manage operations.

(2) Subcontractor. An entity engaged in a contracted business arrangement with a contractor to provide a service on-site.

(3) Service. In order for an individual working for a subcontractor to be determined to have performed a "service" at a covered facility, the individual must have performed work or labor for the benefit of another within the boundaries of the facility. Examples of workers providing such services include janitors, construction and maintenance workers. The delivery and loading or unloading of goods alone is not a service and is not covered for any occupation, including workers involved in the delivery and loading or unloading of goods for construction and/or maintenance activities.

(4) Contract. An agreement to perform a service in exchange for compensation, usually memorialized by a memorandum of understanding, a cooperative agreement, an actual written contract, or any form of written or implied agreement is considered a

14. Subcontractor Employment. (Continued)

contract for the purpose of determining whether an entity is a "DOE contractor."

b. Standard. Mere presence on the premises of a facility does not confer covered employment. There are **three** developmental components that must be met before a decision of covered subcontractor employment can be reached. These elements are:

- (1) the claimed period of employment occurred during the covered time frame as alleged, and
- (2) a contract to provide "covered services" existed between the claimed subcontractor and a contractor at the facility or the identified vendor (during the covered time frame), and
- (3) the employment activities (work or labor) took place on the premises of the covered facility.

c. Subcontractor employment at beryllium vendor facilities. Under the Act, persons providing a service on the premises of beryllium vendors during covered time periods are entitled to the same benefits as employees of the beryllium vendor during those same covered time periods. For some beryllium vendors, the corporate verifier for the vendor at which the subcontractor performed work has records of subcontractor employees, and therefore in verifying beryllium vendor subcontractor employment the CE first contacts the corporate verifier for any information they have on the individual and his or her subcontractor employer. In those situations in which an employee is alleging beryllium sub-contractor employment and the beryllium vendor is unable to confirm employment, the CE is to use SSA records, affidavits and other evidence as described in this chapter.

d. Subcontractor employment at DOE facilities. Because DOE generally did not keep records of employees of subcontractors, particular evidentiary challenges are involved in proving subcontractor employment. To prove

14. Subcontractor Employment. (Continued)

each of the elements needed, it is generally necessary to gather and evaluate documentation from multiple sources, including DOE, SSA and CPWR. To assist the CE in making determinations on subcontractor employment and to ensure that all the developmental elements are met for any period that is ultimately accepted as covered employment, a Subcontractor Worksheet (Exhibit 8) has been created that the CE completes in all subcontractor situations, as described in this item. Once completed, this worksheet is kept in the case file as aid to understanding the basis used to make subcontractor employment determinations.

(1) The subcontractor worksheet has two parts, claimed and verified employment. The claimed section refers to the information provided by either the employee or survivor on Forms EE-1, EE-2 and EE-3, including claimed employment dates, facility(ies) and subcontractor (employer).

(2) The verified section refers to the documentation on record that supports the information reported on the Forms EE-1, EE-2 and EE-3. Verified contract/employment identifies the source that confirms the employer's link to the DOE; verified earnings identifies documents which support that the employee was employed by a specific subcontractor and verified premises identifies documents used to support the employee's presence at a covered facility during the covered time period.

(3) In completing the subcontractor worksheet, the CE will likely use an assortment of documentary evidence from different sources to make a finding of covered subcontractor employment. For example, SSA records may show that the employee worked for Sentell Brothers, thus establishing verified earnings. Documentation from CPWR may show that Sentell Brothers was a subcontractor during the period of verified earnings at K-25, X-20, Y-12 and Oak Ridge in general. DOE may also provide documentation showing that the employee had a

14. Subcontractor Employment. (Continued)

clearance to work at K-25 doing construction or DOE provides dosimetry badging information specific to K-25. In this situation, the CE has sufficient documentation to make a determination that the employee worked as a K-25 subcontractor employee during the time period for which the earnings, the contractual information and the presence on the premises requirements are all met. For all instances in which the CE is required to evaluate potential subcontractor employment, the CE writes a memo to the file outlining the findings for each period, providing a narrative evaluation of the evidence for each of the developmental elements of the subcontractor standard and an explanation of why the standard was or was not met.

15. Researcher Employment at DOE Facilities. A DOE contractor employee is also defined as "An individual who is or was in residence at a Department of Energy facility as a researcher for one or more periods aggregating at least 24 months." In order for an employee to meet the "researcher" provision under the Act, the following criteria must be met:

a. Research. There needs to be probative evidence in the file that the individual was actually performing research on the premises of the DOE facility. Visiting the site, obtaining medical tests on site or similar non-work related reasons that people may have for going on site at a DOE facility do not qualify under this provision. Evidence that can be used to document that an individual was performing research on site include published journal articles, affidavits or some other documentation affirming that the individual was engaged in research.

b. Living on-site not required. Although some DOE facilities provide dormitory-style accommodations which often house researchers, "in residence" can be satisfied by working "on the premises," and the individual need not have been living on the premises of the DOE facility.

15. Researcher Employment at DOE Facilities. (Continued)

c. Research can be unpaid. There is no requirement that the researcher is/was paid for the work.

16. Employees of Federal or State governments other than DOE and its predecessors. Employees of federal and state governments, (other than direct employees of DOE, ERDA, the AEC or MED) can be DOE contractor employees, as outlined in this paragraph.

a. Standard. A civilian employee of a state or federal government agency can be considered a "DOE contractor employee" if

(1) the government agency employing the individual is found to have entered into a contract with DOE for the accomplishment of one or more services on the premises of that DOE facility that such government agency was not statutorily obligated to perform, and

(2) DOE compensated the agency for that service.

b. Proof of contract. The district office contacts the federal or state agency directly in an effort to obtain the desired information. The District Director designates an individual in the district office to be responsible for coordinating and contacting federal and state agencies. This approach facilitates better communications with the agencies, especially for agencies with numerous requests. The point of contact is to provide copies of contracts and contacts to the National Office for development of a database. The CE should not pressure a state or federal agency to produce employment or contractual records.

c. If the evidence is unclear as to whether employment by a state or federal agency can be determined to be DOE contractor employment using the guidance in this paragraph, the CE obtains clarification from the claimant. The CE reviews any documentation submitted by the claimant and undertakes any additional development necessary to clarify the individual's employment status.

16. Employees of Federal or State governments other than DOE and its predecessors. (Continued)

Upon finding that the employee does not meet the definition of a "DOE contractor employee" who worked for a state or federal agency, and this is the sole employment listed on the form EE-3, the CE denies the claim. The CE issues a recommended decision denying the claim on the basis that the employment by the state or federal agency does not qualify the claimant as a "DOE contractor employee" as defined in EEOICPA.

d. Uniformed members of the Military. A claimant cannot obtain EEOICPA benefits based upon service in the military. If the claimant provides information or identifies himself/herself as military personnel, the CE sends a letter to the claimant stating that uniformed military personnel are ineligible for benefits under the EEOICPA. Only civilian employees who performed services on the premises of DOE facilities via contracts are considered DOE contractor employees.

17. Evaluating Evidence to Verify Employment. Once all evidence from appropriate sources has been received, the CE determines if the evidence is sufficient to verify the three components of covered employment listed in paragraph 6 of this chapter. The CE evaluates all evidence carefully in making this determination and uses discretion regarding documentation that reasonably establishes the presence of the employee at a particular facility during certain periods of time. Additionally, with regard to subcontractor employment, the evidence must reasonably satisfy all the components necessary to establish covered employment, as discussed in paragraph 14 of this chapter.

In weighing the evidence submitted in support of covered employment, the CE considers the totality of the evidence and draws reasonable conclusions.

18. Developing non-covered employment. As mentioned in paragraph 4, there will be instances in which the CE is only able to match a portion of the claimed employment to a facility and/or employer listed in the facility database, or there is no match found. In these instances the CE

18. Developing non-covered employment. (Continued)

communicates this to the claimant. The CE prepares a letter to the claimant explaining which employment is covered under

the Act and which is not, including any pertinent dates. A description of what constitutes an AWE, BE Vendor or DOE (as explained in paragraph 2) should be included in the letter. In the event that the claimant believes some of this non-covered employment should be covered, the CE requests that the claimant supply any pertinent evidence substantiating that the employment should be covered during specific years. Namely, the CE asks the claimant to provide evidence demonstrating that the place of work met the definition of an AWE, BE Vendor or DOE facility during the years the employee worked there. For example, the claimant can be asked to submit evidence such as contractual documents, business reports, internal memos, purchase orders, news articles, affidavits, etc. A period of 30 days is granted to the claimant to submit evidence in support of extending covered employment to additional facilities/employers and/or years.

After appropriate development, the CE decides whether any evidence submitted warrants a referral to the National Office. If the claimant has submitted pertinent evidence in regard to adding a facility/employer and/or years of coverage, the CE prepares a brief memo to the file explaining the circumstances of the situation and requests a review of the case file by the National Office which asks the National Office to make a determination regarding the new evidence of an additional covered facility/employer or years.

19. Additions or modifications to facility status. While EEOICPA defines what constitutes an AWE, Be Vendor or DOE facility, updates are periodically made to facility designations as new information becomes available. In instances when a claimant submits information in response to the request outlined in paragraph 18, the National Office takes a number of steps outlined in this paragraph to make a determination regarding whether the facility status should be modified. Depending on the facility type, authority rests with either the DOL or DOE to make modifications. Facility modifications or additions are dependent on the collection of probative evidence satisfying the legal definition of the facility.

19. Additions or modifications to facility status.
(Continued)

a. Atomic Weapons Employer. New designations are the responsibility of DOE. Accordingly, requests for new AWE designations are referred to DOE.

(1) Time frame changes relating to specific years of processing at an AWE are the responsibility of DOL. Evidence must be presented clearly demonstrating that the AWE processed or produced material that emitted radiation and was used in the production of an atomic weapon.

b. Beryllium Vendor. The statutory deadline for adding additional beryllium vendors was December 31, 2002 and therefore no additional beryllium vendors can be designated under the Act.

(1) Time frame changes relating to Be Vendors are the responsibility of DOL. Evidence must be presented clearly demonstrating that the Be Vendor had a contractual agreement involving beryllium with DOE, or its predecessors, and that the company is performing/or did perform those beryllium-related contractual tasks in the years to be added to coverage.

c. Department of Energy facility (DOE). Facility or time frame changes relating to DOE facility listings are the responsibility of DOL. Evidence must be presented clearly demonstrating that the facility meets the definition of a "Department of Energy facility" under the Act. Under the EEOICPA, a DOE facility means any building, structure, or premise, including the grounds upon which such building, structure, or premise is located in which operations are, or have been, conducted by, or on behalf of, the DOE (except for buildings, structures, premises, grounds, or operations covered by Executive Order 12344, dated February 1, 1982, pertaining to the Naval Nuclear Propulsion Program); and with regard to which the DOE has or had either (A) a

19. Additions or modifications to facility status.

(Continued)

proprietary interest; or (B) entered into a contract with an entity to provide management and operation,

management and integration, environmental remediation services, construction, or maintenance services.

Interpreting and applying the definition of a DOE facility is within the adjudicatory authority of DEEOIC. To determine whether a facility is a DOE facility under the Act, certain parameters must be met.

(1) Operations. To show that operations were performed on behalf of DOE, the evidence must demonstrate that DOE paid for operations at that location. These operations are not limited to those involving radiation or weapons. Everyday operations such as providing library services in a technical library are sufficient to meet this statutory requirement.

(2) Proprietary Interest. To show that DOE had a proprietary interest, evidence that DOE owned the building, structure or premises, such as a deed or affirmative statement from DOE acknowledging ownership. DOE ownership of intellectual property or equipment, regardless of size, does not fulfill the proprietary interest definition.

(3) Contracts. To show that DOE entered into a contract with an entity to provide management and operation, management and integration, environmental remediation services, construction, or maintenance services, the best possible evidence is to produce the contract. Typically contracts with DOE or its predecessors identify the contract type on the first page, so in those cases in which contracts are located, it is generally not difficult to discern contract type. The contracts identified in this portion of the law are among the

19. Additions or modifications to facility status.

(Continued)

more common and significant contracts used throughout the DOE complex in the following ways:

(a) Management and Operation (M&O) contracts are those contracts DOE often had with major companies to manage and operate large DOE

facilities, such as Union Carbide and Carbon at K-25 and Y-12.

(b) Management and Integration (M&I) contracts were also used by DOE to run major DOE sites, but an M&I contractor generally had numerous smaller site contractors for which the M&I's job was to "integrate" the work of the smaller companies. The Idaho National Laboratory is an example of a DOE facility which has been run from time to time by M&I contract. Companies holding M&O and M&I contracts at DOE facilities are generally considered the "prime contractor" for that facility, though sometimes facilities will change from the M&O model to the M&I model.

(c) Contracts for environmental remediation services, construction, or maintenance services are also common throughout the DOE, but are generally smaller in size than the major M&O's and M&I's. Remediation contracts were also utilized by DOE to clean up radiation at numerous AWE facilities. In these instances the locations are designated as DOE facilities for the period of remediation under DOE contract and the remediation workers are covered.

(d) Some common types of contracts issued by DOE that do not meet the statutory definition include research & development, output, and procurement.

20. Special Circumstances. There are some special circumstances regarding eligibility for benefits pertinent to the Naval Nuclear Propulsion Program and EEOICPA claims from citizens of the Republic of the Marshall Islands, as outlined below.

a. Naval Nuclear Propulsion. As noted in the section above, the statutory definition of a DOE facility specifically excludes, "buildings, structures, premises, grounds, or operations covered by Executive Order No. 12344, dated February 1, 1982 (42 U.S. C. 7158 note) pertaining to the Naval Nuclear Propulsion Program." As

a consequence of this exclusion, DEEOIC is unable to provide covered employment to those AEC employees and AEC contractors who worked at locations devoted to Naval Nuclear Propulsion operations.

b. Marshall Islands. DEEOIC has received claims for compensation under EEOICPA from citizens and nationals of the Republic of the Marshall Islands (RMI). The Marshallese base their claims on employment related exposure arising from the United States' nuclear weapons testing program conducted in the RMI. The DOE facility known as the Pacific Proving Ground was a weapons test site in the South Pacific from 1946 to 1962.

In 1986, the United States and the Marshall Islands terminated their trust territory relationship through enactment of the Compact of Free Association (Compact). The Compact is a comprehensive document encompassing a variety of agreements, including a number of socio-economic, agricultural, and monetary compensation programs. Under the Compact, the RMI became an independent sovereign nation and U.S. laws ceased to apply unless otherwise specified.

For the purposes of the administration of the EEOICPA, this Compact has been interpreted as precluding coverage for RMI citizens and nationals. If the CE determines that a claim for benefits is from a citizen or nationals of the Marshall Islands, the CE explains, in the conclusions of law portion of the recommended decision, that there is no provision under EEOICPA for coverage of

20. Special Circumstances. (Continued)

claims based upon employment in the RMI by citizens or nationals of the RMI. The CE inserts the following wording in the conclusions of law as a summary of the DEEOIC policy:

Since interpreting EEOICPA to apply to claims by Republic of the Marshall Islands (RMI) citizens or Nationals based upon employment in the RMI would constitute an invasion of the sovereignty of the RMI, the presumption against applying a statute extraterritorially is invoked. Furthermore, there appears to be

no contrary intent by Congress to rebut the presumption and, to the extent that Congress has expressed any intent, its approval of the Compact of Free Association between the United States and the RMI suggests that it did not intend for EEOICPA to apply extraterritorially in this situation.

Superseded

**Department of Energy**

Washington, DC 20585

January 11, 2010

Ms. Rachel P. Leiton
Director
Division of Energy Employees
Occupational Illness Compensation
U.S Department of Labor
200 Constitution Avenue, NW, Room C-3321
Washington, DC 20210

Dear Ms. Leiton:

The Department of Labor (DOL) regulations implementing Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provides, at title 20, Code of Federal Regulations, part 30.105, that after a claimant files a claim under EEOICPA, the Department of Energy (DOE) shall complete and transmit to DOL a Form EE-5 in which DOE certifies that it concurs with the employment information provided by the claimant, that it disagrees with such information, or that it can neither concur nor disagree after making a reasonable search of its records and a reasonable effort to locate records not in its possession.

This letter is to be used in lieu of the Form EE-5 for any claim alleging employment at a facility for which DOE does not have records that would allow it to concur or disagree with allegations concerning employment at such facilities. The list of these facilities is contained in the DOL Employment Pathways Overview Document (EPOD). EPOD is a tool DOL has created that contains a list of all covered EEOICPA facilities and the appropriate contact for site employment records. If no information is available from DOE for a particular site in the EPOD, DOL will use this letter in place of the Form EE-5.

Sincerely,

A handwritten signature in black ink, appearing to read "Patricia R. Worthington".

Patricia R. Worthington, PhD
Director
Office of Health and Safety
Office of Health, Safety and Security



Printed with soy ink on recycled paper

**Department of Energy**

Washington, DC 20585

April 30, 2002

MEMORANDUM FOR: **SHELBY M. HALLMARK**
Director
Office of Workers' Compensation Programs
U.S. Department of Labor

FROM: **BEVERLY A. COOK** *Beverly A. Cook*
Assistant Secretary
Office of Environment, Safety and Health
U.S. Department of Energy

SUBJECT: Verification of Employment

The Department of Labor (DOL) regulations implementing the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) provide, at 20 CFR § 30.105, that after a claimant files a claim under the EEOICPA, the Department of Energy (DOE) shall complete and transmit to DOL a Form EE-5 in which DOE certifies that it concurs with the employment information provided by the claimant, that it disagrees with such information or that it can neither concur nor disagree after making a reasonable search of its records and a reasonable effort to locate records not in its possession. The purpose of this memorandum is to comply with this requirement by informing DOL of certain resources that may be used for employment verification.

This memorandum will serve as DOE's Form EE-5 for any claim alleging employment where verification is confirmed by the Center for Epidemiological Research (CER) of the Oak Ridge Institute for Science and Education (ORISE). The CER database contains information on over 420,000 current and former employees within the nuclear weapons production complex. This data can be used to significantly improve and speed the employment verification process for many claimants.

In addition, ORISE-CER maintains other data resources, both electronic and hard-copy, that can be used to verify employment. This memo also serves as DOE's Form EE-5 for verifications performed using these data resources.

Form Approved
OMB No. 0980-0602

Social Security Administration

**Authorization to Obtain Earnings Data from the
Social Security Administration**

Mail completed form to: Social Security Administration Wilkes Barre Data Operations Center PO Box 1040 Wilkes Barre, PA 18767-1040	Requesting organization: RA PENF 09 8015 U S DEPARTMENT OF LABOR 719 SECOND AVE STE 601 SEATTLE WA 98104
--	--

Number Holder's Information

First Name:	<input type="text"/>	Middle Initial:	<input type="text"/>
Last Name:	<input type="text"/>		
SSN:	<input type="text"/>		
Date of Birth:	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year
Date of Death:	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year
Other First, Middle Initial, and Last Name Used to Report Earnings	<input type="text"/>		
Periods Requested	<input type="text"/>	through	<input type="text"/>
	Month	Year	Year
	<input type="text"/>	through	<input type="text"/>
	Month	Year	Year

I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature of Number Holder (or authorized representative)	Date <input type="text"/>
Printed Name (if other than number holder)	Relationship (if other than number holder) <input type="checkbox"/> Natural or adoptive parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other (specify) _____
Address	State
City	ZIP Code
	Phone Number

Requesting Organization's Information

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY 1 2 3 4

Telephone Inquiries to SSA

Page 1 of 1

Telephone Inquiries to SSA		
<u>Modules</u>	<u>SSN Last 4 Group</u>	<u>Telephone Number</u>
Module 1	(0000-0999)	(410) 966-1247
Module 2	(1000-1999)	(410) 966-5657
Module 3	(2000-2999)	(410) 597-1045
Module 4	(3000-3999)	(410) 597-1049
Module 5	(4000-4999)	(410) 966-8512
Module 6	(5000-5999)	(410) 597-1053
Module 7	(6000-6999)	(410) 597-1057
Module 8	(7000-7999)	(410) 597-1061
Module 9	(8000-8999)	(410) 966-8844
Module 10	(9000-9999)	(410) 597-1065

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CPWR- Referral (CP-1)

The CPWR Employment Information Request Form is to be completed in its entirety by a representative of the DOL. It is not considered complete until the certifying Point of Contact (POC) has signed and dated the form.

Section 1 - Employee Information

			Employee	Survivor
Last Name	First	MI	Claim Type	
File Number			Social Security Number (if Different from File No.)	

Section 2 - District Office Point of Contact

District Office: **Cleveland** **Jacksonville** **Denver** **Seattle**

Number of attached Employment Response Reports requiring action: _____

Comments or other relevant information for CPWR:

New Referral

Supplemental Referral

Amending Referral

DOL-POC NAME _____ **DATE** _____

SIGNATURE _____

TELEPHONE _____ **EMAIL** _____

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File No.

CPWR-Employment Response Report (CP-2)

New Referral

Supplemental Referral

Amending Referral

Section 1 – Employment to be Researched (To be completed by DOL)

Employer (i.e. Contractor – Subcontractor)	Facility (i.e. Oak Ridge/Y-12)	Position Title

Periods of Employment Requiring Verification

Period 1:	Contractual Relationship	Proof of Employment	Employment on the Premises
Period 2:	Contractual Relationship	Proof of Employment	Employment on the Premises
Period 3:	Contractual Relationship	Proof of Employment	Employment on the Premises
Period 4:	Contractual Relationship	Proof of Employment	Employment on the Premises

Section 2 – CPWR Research Results (To be completed by CPWR)

Type of Record	Eligible Construction Worker		Located	Not Located	N/A	Result/Evidence	
	Y	N				Positive	Negative
A. Union Dispatch/Log -							
B. Pension Fund -							
C. Health & Welfare -							
D. Former Worker Program - Interview Date - _____							
E. Facility/Site -							
F. Other -							

Additional Contacts Identified (if known):

	Name	Address	Telephone	Comment
a				
b				
c				
d				

CPWR Contact Information (Completed by person doing CPWR records search)

NAME _____ DATE _____
 SIGNATURE _____
 TELEPHONE _____ EMAIL _____

Part 2 - Claims

Establishing Covered Employment

Date
COVERED EMPLOYEE:
CLAIMANT:
FILE NUMBER:

Dear:

This letter is in reference to the claim you submitted on (Filing Date) under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) for (insert covered diagnosis). We are in the process of verifying (insert employee name) employment at the (insert the claimed employer, employment periods, facility, and location). To date, we have been (able or unable) to verify his/her (insert summary of the verified employment, if any). However, (the Department of Energy or Corporate Verifier) was unable to verify (employee name) employment at (insert the claimed employer, employment periods, facility, and location).

Because you indicated on the Employment History for Claim under EEOICPA - Form EE-3, an occupation or employer which normally performed work related to a construction or a building trade, we are referring your case to the Center for Construction Research and Training, formerly known as the Center to Protect Workers' Rights (CPWR). The Department of Labor has contracted with CPWR to research and obtain employment records for those employees who may have worked or belonged to a union associated with the construction or building trades (i.e. laborer, teamster, plumber). CPWR performs research and training for the Building and Construction Trades Department under the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), and therefore has direct access to union records across the country. It is possible a representative from CPWR may contact you to clarify questions they may have regarding (employee's name) employment history. Please know that they are not your assigned claims examiner and can not provide you with the status of your claim or collect any documentation related to your case. If you have any questions related to your claim or CPWR's involvement, please contact the (District Office at XXX-XXXX)

Sincerely,

Claims Examine

Subcontractor Worksheet (Example)

Claim Number:
123-45-6789

Employee Name:
A.B. Cees

Occupation:
Carpenter

Claimed Employment Dates	Claimed Covered Facility	Claimed Subcontractor	Verified Contract/Employment	Verified Earning	Verified on Premises
1982	Portsmouth GDP	Terstep Company	Yes-DOE confirmed entire employment		clearance card
1983		"			
1984		"			
1985		"			
1986	Baker Brothers	ACME Builders		SSA records	EE-4 from Former co-worker, D.E. Fees
1987	"	"			EE-4 from widow only

Subcontractor Worksheet

*Claim
Number:* _____

*Employee
Name:* _____

Occupation: _____

Claimed Employment Dates	Claimed Covered Facility	Claimed Subcontractor		Verified Contract/Employment	Verified Earning	Verified on Premises

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<u>Exhibit</u>			
1 SEC Class Screening Worksheet		01/10	10-07

1. Purpose and Scope. The Energy Employees Occupational Illness Compensation Program Act (EEOICPA) established the Special Exposure Cohort (SEC) to compensate eligible members of the Cohort without the need for a radiation dose reconstruction and determination of the probability of causation. 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 the employment caused the specified cancer. This chapter describes the procedures for establishing eligibility under the SEC.

2. Identifying SEC Claims. A person filing a claim can allege inclusion in a SEC by checking the section on Forms EE-1 or EE-2 which asks whether the employee worked at a location that has been designated for membership in the SEC.

In addition, a claimant can identify the particular location that may qualify for consideration for the SEC. The Claims Examiner (CE) must review the initial application forms including Form EE-3, Employment History, carefully to determine whether the potential exists for inclusion in one or more SEC classes.

3. Determining SEC Eligibility. To be eligible for benefits under the SEC provision, an employee must belong to a SEC class. In establishing the SEC, Congress designated four statutory SEC classes. The EEOICPA also allows for addition of new SEC classes based on analysis and determination by the U.S. Department of Health and Human Services (HHS).

A SEC class can be based on a whole facility, limited to specific buildings in a facility or even specific processes within a facility. In some cases, a SEC class may be limited to specific job titles or duties in a particular facility. In addition, each SEC class will have specific workday requirements that must be met; typically an employee must have been employed for a number of workdays aggregating at least 250 workdays at one or more SEC work sites. The workday requirement at Amchitka, Alaska SEC class is met by any employee who spent any part of one workday at that facility, during which he or she was exposed to ionizing radiation in

3. Determining SEC Eligibility. (Continued)

the performance of duty related to the Long Shot, Milrow or Cannikin underground nuclear tests. Finally, to be eligible under the SEC, an employee must also have been diagnosed with at least one of twenty two (22) specified cancers as listed under paragraph 6.

4. Statutory SEC Classes. The EEOICPA designated the following statutory SEC classes according to their respective covered facilities:

a. Gaseous Diffusion Plants (GDP) located in Paducah, Kentucky, Portsmouth, Ohio or Oak Ridge, Tennessee. A DOE employee, DOE contractor employee or an atomic weapons employee qualifies for inclusion in this SEC if he or she was:

(1) Employed for an aggregate of 250 workdays prior to February 1, 1992, at one or more of the above GDPs; and

(2) Monitored during such employment through the use of dosimetry badges for exposure to radiation, or worked in a job that had exposures comparable to a job that is or was monitored through the use of dosimetry badges.

(a) If the employee qualifies for possible inclusion in the SEC on the basis of work at a GDP, but Form EE-3 does not indicate whether a dosimeter was worn, the Claims Examiner (CE) must determine whether the employee had exposure during his or her employment that is comparable to a job that is or was monitored through the use of dosimetry badges.

In making this determination, the CE assumes that the employee had comparable radiation exposure if employment occurred during the following periods at the particular GDPs:

4. Statutory SEC Classes. (Continued)

Paducah GDP: 7/52 - 2/1/92

Portsmouth GDP: 9/54 - 2/1/92

Oak Ridge GDP (K-25): 9/44 - 12/87(not
2/1/92)

b. Amchitka Island, Alaska. The EEOICPA grants SEC membership to DOE employees, DOE contractors or DOE subcontractors, who were employed prior to January 1, 1974 on Amchitka Island, Alaska, and were exposed to ionizing radiation in the performance of duty related to the Long Shot, Milrow, or Cannikin underground nuclear tests. The CE considers the following factors in determining whether the employee was exposed to radiation in the performance of duty:

(1) Exposure to ionizing radiation from the Long Shot, Milrow, and Cannikin underground nuclear testing/explosions which occurred on Amchitka Island. The first detonation, Long Shot, occurred on October 29, 1965. The 80 kiloton underground nuclear explosion leaked radioactivity into the atmosphere. Radioactive contamination on Amchitka Island occurred as a result of activities related to the three underground nuclear tests and releases from Long Shot and Cannikin.

(2) As a result of these airborne radioactive releases, employees who worked on Amchitka Island could have been exposed to ionizing radiation from the Long Shot underground nuclear test. It is believed that such exposure began approximately one month after the detonation occurred. Thus, for purposes of determining SEC employment, the period from approximately December 1, 1965 to January 1, 1974 is to be used, unless the claimant can show that the employee was exposed during the month immediately following the detonation.

4. Statutory SEC Classes. (Continued)

(3) In contrast to other SEC classes with 250 workdays requirement, this SEC class requires that the employee worked at Amchitka Island for any length of time during the period from approximately December 1, 1965 to January 1, 1974 and was exposed to ionizing radiation from underground nuclear tests.

5. Additional SEC Classes. HHS has authority to designate additional classes of employees to be added to the SEC. A class of employees may be included as a member of the SEC if HHS determines that it is not feasible to estimate with sufficient accuracy the radiation dose that the members of the class received and there is a reasonable likelihood that such radiation may have endangered the health of the members of the class.

- a. Overview of the SEC Designation Process. The designation process begins with a petition submitted to the National Institute for Occupational Safety and Health (NIOSH), Office of Compensation Analysis and Support (OCAS). The petitioner may include one or more DOE employees (including DOE contractor or subcontractor employees), or AWE employees, who would be included in the proposed class of employees, or their survivors. Individuals or entities authorized by these employees in writing or labor organizations representing or formerly having represented these employees may also submit a petition.

NIOSH may also initiate a petition if it determines that it cannot complete a dose reconstruction for a class of employees.

(1) NIOSH evaluates the petition for inclusion in the SEC to determine if it contains the minimal qualification to proceed with the SEC designation process in accordance with 42 C.F.R. § 83.13 or § 83.14.

5. Additional SEC Classes. (Continued)

(2) If NIOSH determines that minimum qualification for review and evaluation has been met, it forwards the petition to the Advisory Board on Radiation and Worker Health (Advisory Board) along with its evaluation. During one of its regular Board meetings, the Advisory Board reviews NIOSH's evaluation, hears from the petitioners if they choose and other interested parties. The Advisory Board also reviews any other information it determines to be appropriate for the petition.

(3) The Advisory Board submits a recommendation on a new SEC class to the Secretary of HHS within 30 calendar days of the Board meeting.

(4) The Secretary of HHS makes the final decision to add or deny a new class to the SEC based on the recommendation of the Advisory Board and the NIOSH evaluation. If the Secretary of HHS decides to add a new class to the SEC, he or she issues a designation letter to Congress with the definition of the class.

(5) A new SEC class becomes effective 30 calendar days after Congress receives the Secretary's designation letter, unless Congress objects or provides otherwise.

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

a. A workday is considered equivalent to a work shift. Additional hours worked as overtime will not add up to additional workdays, e.g., two hours overtime for four days is not equivalent to another

6. Workday Requirement: (Continued)

(8-hour) workday. However, two work shifts worked back-to-back would be two work shifts, i.e., two workdays. For an employee whose work shift spans midnight, e.g., 11 PM to 7 AM shift, the work shift is still just one workday.

b. When the employment information shows that the employee worked for a particular period, the CE should not attempt to discern and deduct from the workday any infrequent periods of non-presence or non-work, like sick leave, strikes, layoffs or vacation time that may be specified. However, if the employment evidence clearly establishes that the employee was not present and/or working at the SEC work site for an extended period(s) while on the company payroll, this extended period(s) should not be credited towards meeting the 250 workday requirement.

c. The period of 250 workdays starts with the worker's first day of employment at the SEC work site. There may be breaks in employment, but the workdays may only be accumulated at eligible SEC sites.

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

250 days =	50 five-day weeks, or
	42 six-day weeks, or
	12 months (five-day weeks), or
	10 months (six-day weeks), or
	2,000 hours
One month =	21 days (if evidence indicates six-day weeks, 25 days)

6. Workday Requirement: (Continued)

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

f. There will be some situations where the above approach will not be applicable. These cases will need to be treated on a case-by-case basis, and if necessary, a referral to the Unit of Policy, Regulations and Procedures (UPRP) may be required.

7. Specified Cancers: In addition to satisfying the employment criteria under a SEC class, the employee must also have been diagnosed with a specified cancer to be eligible for compensation under the SEC provision. The following are specified cancers in accordance with 20 C.F.R. § 30.5(ff):

a. Leukemia. [Chronic lymphocytic leukemia (CLL) is excluded]. The onset must have occurred at least two years after initial exposure during qualifying SEC employment.

b. Primary or Secondary Lung Cancer. [In situ lung cancer that is discovered during or after a post-mortem exam is excluded.] The pleura and lung are separate organs, so cancer of the pleura is not to be considered an SEC cancer.

c. Primary or Secondary Bone Cancer. This includes myelodysplastic syndrome, myelofibrosis with myeloid metaplasia, essential thrombocytosis or essential thrombocythemia, primary polycythemia vera [also called polycythemia rubra vera, P. vera, primary

7. Specified Cancers: (Continued)

polycythemia, proliferative polycythemia, spent-phase polycythemia, or primary erythremia] and chondrosarcoma of the cricoid (cartilage of the larynx).

d. Primary or Secondary Renal Cancers.

e. Other Diseases. For the following diseases, onset must have been at least five years after initial exposure during qualifying SEC employment:

- (1) Multiple myeloma (a malignant tumor formed by the cells of the bone marrow);
- (2) Lymphomas (other than Hodgkin's disease);
- (3) Primary cancer of the:
 - (a) Thyroid;
 - (b) Male or female breast;
 - (c) Esophagus;
 - (d) Stomach;
 - (e) Pharynx (including the soft palate, or back of the mouth, the base of the tongue, and the tonsils);
 - (f) Small intestine;
 - (g) Pancreas;
 - (h) Bile ducts;
 - (i) Gall bladder;
 - (j) Salivary gland;
 - (k) Urinary bladder (including ureter and urethra);

7. Specified Cancers: (Continued)

(l) Brain (malignancies only, not including intracranial endocrine glands and other parts of the central nervous system);

(m) Colon (*including rectal/colon*);

(n) Ovary;

(o) Liver (except if cirrhosis or hepatitis B is indicated);

f. Carcinoid Tumors. These tumors, except for those of the appendix, are considered primary cancers of the organs in which they are located. If the organ is one on the specified cancer list, the carcinoid tumor may be considered as a specified cancer.

(1) Carcinoid tumors should be recorded by the organ of the specified cancer. For example, the CE should use the ICD-9 code of 230.7 for a carcinoid tumor in the small intestine.

(2) Carcinoid syndrome and monoclonal gammopathies of undetermined significance are not currently recognized as malignant conditions. Consequently, these conditions should not be considered as cancers.

g. Names or Nomenclature. The specified diseases designated in this section mean the physiological condition or conditions that are recognized by the National Cancer Institute under those names or nomenclature, or under any previously accepted or commonly used names or nomenclature. Cases where there is uncertainty as to whether a diagnosed cancer should be considered a specified cancer must be referred to UPRP.

h. Spread of Cancer. Where cancer has spread to various sites (organs) it may be difficult to identify the site of origin for the cancer. If the pathology report (or medical report) lists several alternatives

7. Specified Cancers: (Continued)

and at least one site is considered a SEC cancer, the claim should be processed first as a SEC cancer claim.

8. Procedures for Processing SEC Claims. Processing SEC claims entails coordination between the UPRP and District Offices/FAB staff.

a. Role of the UPRP:

(1) Issues bulletins with guidance on processing newly designated SEC classes. This will include specific instructions on how to evaluate evidence in the case file to determine SEC eligibility.

(2) Prepares a comprehensive list of all reported cases with claimed employment at a newly designated SEC work site during the period of the SEC class. It will include pending cases, cases previously denied and those at NIOSH. This comprehensive list will be provided to the District Offices and FAB at the time of the issuance of the SEC bulletin.

(3) Unresolved questions on processing SEC claims, including questions on the definition of a SEC class, uncertainty as to whether a diagnosed cancer should be considered a specified cancer or questions regarding calculation of 250 work day requirement may be referred to UPRP for guidance.

b. Role of the Claims Examiner:

(1) Identifies a potential SEC claim by reviewing the information on the claim forms or other pertinent evidence in the case file to determine if there is sufficient evidence to suggest that an employee worked as a member of a named SEC class. For newly designated SEC classes, the CE is to review the comprehensive list provided by UPRP as noted in paragraph 7a(2).

8. Procedures for Processing SEC Claims. (Continued)

(2) Reviews corresponding bulletins for designated SEC classes for procedures on evaluating evidence to determine if the SEC criteria are met.

(3) Completes an initial screening of cases in the comprehensive list provided by UPRP for a newly designated SEC class. A screening worksheet is included as Exhibit 1. The worksheet must be completed for all cases on the comprehensive list. Upon completion, the worksheet is to be included in the case record.

Based upon the initial screening, the cases on the comprehensive list are grouped into three categories: those likely to be included in the SEC class; those not likely to be included in the SEC class; and those for which development may be needed to determine whether the case can be accepted into the new SEC class.

The purpose of this initial screening is to prioritize handling of cases that are likely to be included in the newly designated SEC class. This screening step is only applicable to cases on the comprehensive list. It is not applicable to new claims submitted after the list is generated or when a comprehensive list is not generated. Once screening and prioritization is complete, a more detailed review of all the cases (priority given to cases that are likely to be included in the SEC class) and full development must take place to determine if a case is eligible for benefits under the SEC.

(a) For cases on the comprehensive list at FAB, the designated CE2 Unit is to conduct the initial screening and completion of the worksheet.

(4) Evaluates medical evidence in the case file of a potential SEC case to determine if the

8. Procedures for Processing SEC Claims. (Continued)

employee has been diagnosed with a specified cancer.

(5) If the employee has a specified cancer, the CE must verify that the employee meets all employment criteria in the SEC class designation, including the workday requirement. In determining whether the employment history meets the workday requirement, the CE can consider employment at a single SEC class, or in combination with work days at other SEC classes.

The CE also reviews any documentation that NIOSH may have acquired or generated during the dose reconstruction process to determine if the employee satisfies the employment criteria of a SEC class(es).

(a) NIOSH will identify and return dose reconstruction analysis records for cases with specified cancers that may qualify under a SEC class to the appropriate district office along with a CD for each case. The CD contains all of the information generated to date, e.g., CATI report, correspondence, and dose information. Also included on the CD in the Correspondence Folder, should be a copy of the NIOSH letter sent to each claimant informing the claimant of the new SEC class and that his or her case is being returned to DOL for adjudication. The CE must print out a hard copy of the NIOSH letter for inclusion in the case file.

(b) There may be some cases not identified by NIOSH that the CE determines may be included in the SEC class. If any such case qualifies under the SEC class and the case is with NIOSH for a dose reconstruction, the CE notifies the appropriate point of contact at NIOSH via e-mail to pend the dose

8. Procedures for Processing SEC Claims. (Continued)

reconstruction process and return dose reconstruction analysis records to the appropriate district office. The CE then prints a copy of the "sent" e-mail (making sure the printed copy documents the date it was sent) for inclusion in the case file. In addition, the CE must write a letter to the claimant to advise that the case file has been withdrawn from NIOSH for evaluation under the SEC provision.

(6) Proceeds in the usual manner for a compensable claim and prepares a recommended decision if the employee has a diagnosed specified cancer and meets the employment criteria of the SEC class. The CE notifies the appropriate point of contact at NIOSH via e-mail so that they may close their file. The CE then prints a copy of the "sent" e-mail for inclusion in the case file.

(7) Refers potential SEC cases that were evaluated but which do not qualify under the SEC provision, e.g. cases with non-specified cancers, specified cancers with insufficient latency period, or cases with insufficient SEC employment, to NIOSH for full or partial dose reconstruction.

(a) For those cases which were previously submitted to NIOSH for dose reconstruction but were returned to the district office for consideration in a SEC class, a new NIOSH Referral Summary Document (NRSD) is not required. Instead, the CE notifies the appropriate point of contact at NIOSH via e-mail to proceed with the dose reconstruction. The CE then prints a copy of the "sent" e-mail for inclusion in the case file. The e-mail should include a brief statement of why the case should proceed with dose reconstruction, e.g., non-

8. Procedures for Processing SEC Claims. (Continued)

specified cancer, insufficient latency period or does not meet the 250 work day requirement.

The CE also notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE is to send a copy of this letter to NIOSH.

(b) If the claim meets the SEC employment criteria and includes both a specified cancer and a non-specified cancer, medical benefits are only paid for the specified cancer(s), any non-specified cancer(s) that has a probability of causation of 50 percent or greater, and any secondary cancers that are metastases of a compensable cancer.

For the non-specified cancer, the CE prepares a NRSD for a dose reconstruction to determine eligibility for medical benefits. In these SEC cases, all cancers must be listed on the NRSD, including the specified cancer(s).

- (1) One exception to this rule is an accepted SEC claim where the specified cancer is a secondary cancer. For instance, prostate cancer (non specified cancer) metastasizes to secondary bone cancer. If secondary bone cancer is accepted as a specified cancer under the SEC provision, both primary and secondary cancers (prostate and bone cancer) are accepted for medical benefits under Part B.

However, per regulation 20 C.F.R. § 30.400, "payment for medical

8. Procedures for Processing SEC Claims. (Continued)

treatment of the underlying primary cancer...does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of the EEOICPA." As such, it may be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E. In this case, only prostate cancer is included in the NIOSH NRSD for a dose reconstruction since the secondary bone cancer metastasized from the prostate cancer.

(8) If the CE determines that a case on the comprehensive list, which includes a final decision, does not require any action, the CE writes a brief memo to the file indicating that the file was reviewed and noting the reason why no additional action is necessary. A case classified as not requiring any action is a case that does not meet the SEC criteria and there is no need to return it to NIOSH for dose reconstruction.

c. Role of the District Director:

(1) The District Directors have been delegated authority to sign a Director's Order to reopen a denied final decision if the evidence of record

establishes that the employee is diagnosed with a specified cancer and likely to be included in the SEC class. If the District Director is unsure whether the SEC is applicable to a case, the case must be referred to UPRP.

8. Procedures for Processing SEC Claims. (Continued)

(2) Once a Director's Order is issued, the CE is responsible for issuing a new recommended decision.

(d) Role of the Hearing Representative (HR):

(1) Reviews cases pending a final decision for possible inclusion under the SEC provision. If the employee qualifies under the SEC provision and the district office issued a recommended decision to deny, the HR is to reverse the district office's recommended decision and accept the case.

Every effort should be taken to avoid a remand of a potential SEC claim to the district office. However, if the HR determines that the case cannot be approved based on the SEC designation and that referral to NIOSH is appropriate, the HR must remand the case for district office action.

(2) All cases on the comprehensive list provided by UPRP that are located at a FAB office must be reviewed for possible inclusion under the SEC provision. If no action is required, FAB must write a brief memo to the file as noted under paragraph 7b(8).

SEC Class Screening Worksheet

1) Employee

Name: _____

2) SS# _____

3) Is there proof of a diagnosis of specified cancer? Y/N

If yes, (list cancer type and diagnosis date)

4) Does there appear to be at least 250 days of employment at the SEC site? Y/N

If yes, identify employment period:

5) If either question 3 or 4 is answered "no", is there anything in the file to suggest that additional development might change the answers to "yes?" Y/N

If so, what development is needed?

Coding Action Taken:

Coded ISL "SEC inclusion likely" (#3 and #4 both Yes)

Coded ISD "SEC development needed" (#5 is a Yes)

Coded ISU "SEC inclusion unlikely" (#5 is a No)

_____ Date

_____ Signature

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1. Purpose and Scope. This chapter describes the procedures that the Division of Energy Employees Occupational Illness Compensation (DEEOIC) uses to establish toxic substance exposure under Part E of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

These procedures outline means to develop for exposure to toxic substances at a covered Department of Energy (DOE) and Radiation Exposure Compensation Act (RECA) Section 5 facility. In particular, the chapter addresses the Site Exposure Matrices (SEM) and guidance for its use and explains required actions when SEM data is lacking or incomplete.

2. Rules for Establishing Exposure. To establish that an employee was exposed to a toxic substance, the evidence of file must show evidence of potential or plausible exposure to a toxic substance and evidence of covered DOE contractor/subcontractor or uranium employment at a covered DOE/RECA facility during a covered time period.

a. Documentation. Exposure to a toxic substance can be established by the submission of probative documentation that shows such substance was present at the facility where the employee worked, that there was a reasonable likelihood for employee exposure, and that the employee came into contact with such substance.

b. Presence and Contact. Whenever possible, the claims examiner (CE) considers such issues as whether the substance was present, not only in the facility, but in the specific building(s) and/or areas where the employee worked, and whether the substance was used during the processes involved as part of the employee's job duties and exposure routes (e.g., a welder exposed to fumes). The SEM (discussed below) will be especially helpful in evaluating for the presence of a toxic substance in a certain building/area/work process.

(1) Presence of toxic substance. The CE may look to the SEM, facility exposure records, Data Acquisition Request (DAR) records, the

2. Rules for Establishing Exposure. (Continued)

Occupational History Questionnaire (OHQ), employee records, verified affidavits, DOE Former Worker Program (FWP) screening records, NIOSH site profiles, employee submitted evidence, and other evidence that establishes a toxic substance was present at the facility where the employee worked. The CE may also use Industrial Hygienist (IH) referrals as discussed below.

(2) Employee contact with a toxic substance. The CE's review of the evidence described above may be sufficient to establish that the employee came in contact with the toxic substance. Information such as the claimant's response to the OHQ performed by the Resource Center (RC), reviewed in conjunction with DAR records and the SEM, may help the CE decide what further development may be necessary (e.g., to determine whether contact was likely given the employee's labor category, labor process, or given safety controls or risk factors that may have been present at the worksite).

(3) Plausibility. When evaluating the evidence to determine whether a toxic substance was potentially present at a given facility (by building, area, work process, labor category) and whether it is likely that an employee came into contact with a toxic substance in the course of employment at a covered facility, the CE must determine whether such contact is plausible.

To do so, the CE must review all evidence on file and decide whether it makes sense that the claimed exposure could have potentially occurred. Sometimes this evaluation will require a referral to an IH.

For example, if an employee is claiming lung cancer due to exposure to uranium metal maintained exclusively in a glove box (an enclosure to protect the worker from uranium

2. Rules for Establishing Exposure. (Continued)

exposure), the CE must examine whether or not an exposure route is plausible.

Without evidence that the employee was involved in machining uranium or cleaning out the glove box, or that he or she was exposed in some other way such as a leak in the glove box, no exposure route (inhalation which would potentially be linked to lung cancer) is plausible.

(4) Sample Evaluation of Presence and Contact.

A chemical operator involved in cascade operations at K-25 claims peripheral neuropathy. His responses to the OHQ show he worked with a variety of toxic substances on a routine basis, including mercury. Information obtained through the DAR records confirms his worksite (K-33), which is located within K-25, and job duties.

The CE searches SEM (see paragraph 10 below) and confirms the presence of mercury at the K-33 cascade building. Further, SEM supports a link between mercury and peripheral neuropathy. A physician's report indicates a diagnosis of peripheral neuropathy and mentions that the employee has had tingling in his arms for approximately a year. An accident report notes a major mercury spill during the time in which the claimant worked at K-33.

The evidence is sufficient to establish that the employee had peripheral neuropathy and potential exposure to mercury in the course of his employment at a covered DOE facility. The mercury spill accident report lends support to the finding that it is plausible, given the facts, to assume that the claimant encountered an occupational exposure to a toxic substance in the course of his work.

Any question as to route of exposure (e.g. inhalation, absorption), even if presence is

2. Rules for Establishing Exposure. (Continued)

established, should be referred to an IH, as outlined in paragraph 12 below.

c. Burden of Proof. If no medical evidence is submitted that would lend support to a connection between the claimed condition and potential exposure to a toxic substance (and no such evidence is available from the sources referenced in the previous section), the CE requests such evidence from the claimant before issuing a denial. While the CE must exhaust all reasonable development prior to issuing a denial, the claimant does bear the overall burden of proving his or her claim.

d. Causation Test for Toxic Exposure. The CE must develop the requisite employment and exposure evidence to render a causation determination. Specific causation requirements for cancer and other conditions are outlined in other chapters. In general, the CE develops the evidence on file and a determination is made based upon the "at least as likely as not" causation test.

While resources are provided to assist the CE, there is no simple one-step tool for making this determination. Instead, the CE must base the determination on the totality of evidence in the case file. The CE does not use studies or reports obtained from the Internet or other sources to justify case decisions, unless the National Office (NO) has specifically authorized such usage. In addition, the CE may not base a decision on a vague reference to "medical literature."

(1) Causation Test for Toxic Exposure. Evidence must establish a relationship between exposure to a toxic substance and an employee's illness or death. The evidence must show that it is "at least as likely as not" that such exposure at a covered DOE/RECA facility during a covered time period was a significant factor in aggravating, contributing to, or causing the employee's illness or death, and that it is "at least as

2. Rules for Establishing Exposure. (Continued)

likely as not" that exposure to a toxic substance(s) was related to employment at a covered DOE/RECA facility.

(2) "At Least as Likely as Not." Part E only requires proof that established exposure "at least as likely as not" was a *significant factor* in aggravating, contributing to or causing the employee's illness, disease or death. As with Part B, "at least as likely as not" means 50% or greater likelihood.

When a referral to NIOSH for a cancer claim related to radiation results in a probability of causation of greater than or equal to 50%, the regulations provide that this requirement has been met. In other cases the CE bases a determination on a review of the evidence of file as a whole, to determine if the "at least as likely as not" standard has been met. The CE weighs all of the evidence available and provides a clearly written rationale supporting his or her findings in the recommended decision.

(3) Significant factor. The CE evaluates the evidence as a whole when attempting to determine whether or not exposure to a toxic substance was indeed a significant factor in contributing to, aggravating, or causing the claimed illness or death of the employee. In most instances this evaluation will be done on a case-by-case basis.

In some cases a District Medical Consultant (DMC) evaluation will be necessary. The CE looks at the claimed exposure, the presence of such exposure, the duration of the verified employment, and any other important exposure/employment factors when ascertaining the possible role the toxic substance exposure played in the onset of the covered illness.

e. Using SEM to Evaluate Causation in General. The SEM is not used to establish or deny causation by

2. Rules for Establishing Exposure. (Continued)

itself, but is used as a tool to assist in the evaluation of causation in light of the evidence as a whole. The purpose of this searchable database is twofold. First, the database details many possible toxic substances that may have been present at a given facility. Second, the database describes the relationship between a specific toxic substance and a covered illness.

The CE reviews the database to assist in a determination of whether the claimed toxic substance was present at the facility where employment occurred and whether or not a relationship exists between exposure to a toxic substance and a particular covered illness. However, the database does not serve as a comprehensive list of all potential toxic substances that could be present at a facility, and the CE must confirm additional claimed toxic substances through employment records, DAR records, DOE FWP records, and other means. If the CE cannot confirm the presence of a toxic substance through these sources, the claimant should be notified and given an opportunity to present additional evidence that establishes the presence of such a toxic substance. Finally, once the CE completes all reasonable development and carefully weighs the evidence on the whole, including the SEM findings, the CE must determine whether or not a referral is needed to a DMC or Industrial Hygienist/Toxicologist to further evaluate causation. Procedures for this and other actions are outlined below.

f. DOE Physician Panels. Cases with positive DOE physician panel findings approved by DOE (signed by a DOE official) under the old Part D are accepted for causation on the basis of those findings for all conditions claimed under Part E that were approved by the panel. The CE uses the DOE physician panel finding as the basis for the decision and no further development for causation is required.

If the positive physician panel decision is not approved by DOE (not signed by a DOE official) it is

2. Rules for Establishing Exposure. (Continued)

not an approved finding, however, unsigned reports still may contain useful information for causation development such as medical and exposure evidence that might prove useful in reaching a causation decision based upon all of the other evidence of file. The CE reviews negative panel reports like any other piece of medical evidence in light of the weight of the evidence of file as a whole.

g. Evidentiary Requirements for Survivor Claims. The CE uses any and all of the medical evidence of file in order to develop for causation in a survivor claim. Not only must the evidence of file establish that it is at least as likely as not that toxic exposure caused, contributed to, or aggravated a covered illness, the evidence must also establish that the covered illness caused or contributed to the death of the covered employee.

h. Developing for Toxic Substance Exposure. When developing Part E cases the CE uses established development techniques in addition to certain other steps unique to the Part E adjudication process. The Final Adjudication Branch (FAB) develops medical conditions and employment where possible to avoid issuing a remand order for further development if such development can be conducted at the FAB with little additional effort.

(1) Development Using Existing Case File Materials. In many instances a Part E claim has a corresponding Part B and/or D case file already in existence. When an existing Part B and/or D case file exists, the CE examines the case file materials for medical, employment, and exposure evidence to assist in the causation development process.

Under Part D, DOE collected exposure and employment data through DARs. The CE must examine all existing Part D case file material for DAR records and review all documentation presented with the new Part E claim filing and

2. Rules for Establishing Exposure. (Continued)

any corresponding Part B or D case file to render a causation determination. A filing under Part D is automatically considered a filing under Part E, without a requirement for the filing of another claim form.

(2) A General Rule about Reasonable Development. Given the complex nature of claim file development under Part E, it is necessary for the CE to judiciously determine whether or not the facts warrant issuing a decision or whether additional development is necessary. As a general rule, the CE utilizes the tools outlined in this chapter to the fullest extent possible and issues a decision once all development avenues have been reasonably explored. While the CE issues decisions accepting claims for benefits as soon as the evidence support an acceptance and all statutory criteria are met, denial situations must be heavily weighed and decisions issued only when additional development is unlikely to produce the evidence needed to reach a decision. In essence, the CE evaluates all of the evidence of file to determine whether or not it is plausible that, given the evidence at hand, the claimed illness arose out of the claimed occupational exposure to a toxic substance at a covered facility.

When attempting to determine whether or not sufficient development has been conducted, the CE can look to the claimed condition and the evidence at hand to make an informed determination. If the claimed condition is generally a condition that arises out of occupational exposure, it is incumbent upon the CE to pursue additional development whenever possible. However, if the condition is one that is unlikely to be caused by occupational exposure, the CE can be more certain that additional development might not be necessary and a decision can be issued.

2. Rules for Establishing Exposure. (Continued)

(3) Example. If the claimed illness is chronic silicosis, chronic beryllium disease (CBD), asbestosis, or another condition known to arise almost exclusively out of occupational exposure, but the evidence is not sufficient to accept the claim, the CE refrains from issuing a denial if additional development might establish the employee's claim for benefits.

However, if the claimed illness is heart disease, diabetes, arteriosclerosis, thrombosis, or another disease that often is caused by non-occupational risk factors, the CE can send a development letter and allow the claimant an opportunity to present evidence. If no evidence is received, the CE may issue a decision after weighing the evidence as a whole and determining that no causal link exists between the claimed illness and the covered Part E employment.

3. Sources of Evidence. Establishing exposure to a toxic substance is a key element in developing claims filed under Part E. Developing for such exposure can be complex, and many tools are available to assist the Claims Examiner (CE) in this endeavor.

a. DAR records, which are obtained from DOE, contain a wealth of employment and exposure evidence. They contain a mixture of employment, medical, and exposure evidence. The CE prepares a DAR to DOE pursuant to the guidance in paragraphs 5 and 6 below. If the site information contained in SEM is reasonably complete and sufficient to establish the claimed exposure, no further exposure information should be sought from DOE through a DAR. The DAR can be used to obtain specific information if a claimant is alleging an incident that might not have been captured in SEM.

b. The DOE Former Worker Program (FWP) is an ongoing effort to evaluate the effects of occupational exposures (e.g., to beryllium, asbestos, silica) on the health of DOE workers. These records contain employment, medical, and exposure data.

3. Sources of Evidence. (Continued)

Exposure information obtained from FWP work history interviews taken after the enactment of the EEOICPA, in October 2000, should be used only when corroborated by other evidence that supports the claimed exposure (i.e., DAR information, SEM).

c. Center to Protect Workers' Rights (CPWR) can provide data for use in verifying contractor/subcontractor employment and exposure.

d. Employment and exposure evidence from the claimant or other sources, such as verified affidavits, facility records, is weighed along with the evidence as the whole.

e. The SEM (see paragraph 8 below) provides site-specific exposure information, information about toxic substances and employment processes at a given site, and some limited information concerning potential adverse health effects produced by exposure to certain toxic substances.

f. DOE Physician Panel findings are also a source of employment, medical, and exposure information.

g. Occupational History Questionnaire (OHQ) data obtained by the RC staff document the workplace exposure experienced by an employee. The OHQ is used as a piece of evidence to be evaluated along with the evidence of the file as a whole.

4. Document Acquisition Request. The DAR is the process by which the DO gathers DOE work records on a specified employee. The CE reviews the case file before deciding which documentation to request from the DOE on the DAR Questionnaire. The CE must carefully consider the specific data needs for the individual case. Information received in response to the DAR may vary from site to site, but will contain some or all of the following information:

a. Radiological Dose Records. These documents are radiation exposure records based on readings from dosimetry badges or similar personal recording

4. Document Acquisition Request. (Continued)

devices. They are generally taken at regular intervals over the employee's employment.

b. Incident or Accident Reports. Any abnormal incidents or large plant accidental substance releases affecting the employee are documented in these types of documents.

c. Industrial Hygiene or Safety Records. Documents in these categories could contain periodic inspection reports for health and safety purposes.

d. Pay and Salary Records. These documents include an employee's pay, salary, any workers' compensation claim or other documents affecting wages.

Examples of records from the DOE database could include, but are not limited, to Official Personnel Files of Contractor Employees, Contractor Job Classification, Employee Awards Files, Notification of Personnel Actions, Classification Appraisals, Wage Survey Files, and Unemployment Compensation records.

The CE generally does not need these types of documents unless wage loss is either being claimed by the claimant or a wage-loss claim is obvious to the CE from the case file.

e. Job Descriptions. These are descriptions of the various employment positions at the plant and the duties required to perform the job.

f. Medical Records. These include personal medical histories of the employee if that employee visited the plant infirmary (e.g., Health Unit Control Files, Employee Medical Folder).

g. Other. This category includes any other documentation needed on a case-specific basis which does not fit into any of the other six categories. If this category is checked and a specific request is listed by the CE, DOE personnel may contact the DOL CE for clarification of the request.

5. Requesting the DAR. After reviewing the case file, including the OHQ from the RC, the CE requests the DAR information. This is done concurrently with FWP development. The process for collecting the information differs slightly depending on whether DOE or a corporate verifier (CV) is receiving the DAR. The CE must also review SEM to determine what exposure information already has been assembled from DOE records and other sources. If exposure information necessary to develop the claim already exists in SEM, the CE does not request such information in the DAR.

a. DAR Point of Contact (PoC) List. This list can be found on the NO shared drive and is divided into two sections: DOE DAR PoC and No Known Contact. Each District Director (DD) is responsible for updating and maintaining these records.

The DOE DAR PoC is similar to the current DOE Operations Center PoCs for employment verification. There are some differences, however, so the CE must use this list when requesting DAR documentation directly from the DOE. A DAR Cover Letter and DAR Questionnaire are sent only to a DOE DAR PoC.

b. Sites With No Known DAR PoC. For these sites, the CE undertakes alternate exposure development. Since no known contact exists, a DAR Questionnaire is not used.

6. Completion of DAR. When appropriate, the CE completes a DAR Cover Letter and Questionnaire asking for toxic exposure evidence. If a particular DOE site does not have the ability to scan and submit documentation digitally on a CD, the DOE submits paper documents.

a. Package to DOE. The package includes a cover letter (Exhibit 1) addressed to the DOE PoC, DAR Questionnaire (Exhibit 2) completed by the CE, and copies of Forms EE-1/EE-2 and EE-3.

(1) The CE prints or types the identifying information of the employee in Blocks 1 and 2 of the DAR. The CE annotates any maiden names in Block 1.

6. Completion of DAR. (Continued)

(2) The CE indicates the DOE facility on Form EE-3 in Block 3 of the DAR and any employer name information in Block 4. If the claimant indicates on Form EE-3 that he or she worked for multiple subcontractors at the same DOE facility, the CE completes a separate DAR Questionnaire for each subcontractor. This process helps distinguish between contractors or subcontractors for which DOE has records and those for which it does not.

Similarly, if the claimant claims multiple DOE sites on Form EE-3, the CE completes a separate DAR for each DOE site, as the DAR PoC may be different.

(3) After reviewing the case file, the CE requests the records that are relevant to the case by checking the appropriate box(es) in Block 5, "Types of Records Being Requested."

(4) If the CE has a specific question(s) that needs to be addressed which is not covered in the broader categories listed on the DAR request, the CE completes the "Site Specific Exposure Questions" section of the Questionnaire. The CE considers the condition(s) claimed as well as any specific alleged exposures.

For example, if the claim is for aplastic anemia, the CE may want to ask DOE if and when arsenic or benzene was used in a particular building at the site during a particular timeframe.

b. DAR Response. When DOE's response is received, the CE enters an "ER" code into ECMS (see DEEOIC ECMS procedures for status effective dates and other information).

(1) DOE will have collected the documents requested in Block 5. The DOE checks the corresponding box in Block 6 immediately to the right of the requested category, either "Included

6. Completion of DAR. (Continued)

on CD" or "Unavailable", depending on whether the DOE has any records related to that particular set of records. "Included on CD" also includes hard copy documentation in the event the DOE facility does not have imaging capability.

(2) Also, DOE will respond to any site-specific exposure questions posed by the CE in Block 8, confirming the exposure, denying the possibility of exposure, or indicating there is insufficient evidence to answer the question accurately. The DOE may attach a piece of evidence to the DAR which particularly answers a site-specific question or otherwise clarifies the DOE response to the question. In these instances, the DOE also checks the "SUP" or supplemental box signaling the special response.

(3) Once the DAR response is received, the CE reviews both the questionnaire and the contents of the CD to confirm that all requested documents have been received and that the specific questions about exposure have been adequately answered. Any documents identified on the CD as material to the claim must be printed and placed in the case file.

c. Follow-up with DOE. If DOE does not respond to the RC's initial employment verification request or the DAR questionnaire, the CE contacts the DOE to determine the status of the request.

(1) The DOE is given 30 days to respond to the request (Form EE-5 or DAR). If the DOE does not respond within that time, the CE drafts an inquiry to the DOE, noting the date of the initial request and asking the DOE to respond as soon as possible. The CE provides his or her contact information so that the DOE can quickly respond.

7. DOE Remediation Employment. Since Part E provides coverage for DOE contractor/subcontractor employees and

7. DOE Remediation Employment. (Continued)

their eligible survivors, a claimant alleging DOE contractor/subcontractor employment due to remediation must prove that a contract/subcontract in fact did exist between the claimed employer and DOE/DOE contractor to conduct remediation activities for DOE at the facility in question during the time when DOE was conducting remediation. When developing for exposure in a remediation case, the CE should follow the same steps as is used to develop for DOE contractors and subcontractors.

8. Site Exposure Matrices (SEM). The SEM is a web-based tool designed to assist the CE in developing for exposure to a toxic substance. The SEM identifies the toxic substances that were commonly used in each DOE and RECA Section 5 facility, and contains two general categories of information that may be searched: chemical profiles and site-specific information tailored to the covered facility or site.

Under no circumstances is SEM used as a stand alone tool to deny a claim. Information in SEM can sometimes be used in conjunction with other supporting case file evidence to approve a claim.

a. Site-Specific Data. For a given covered facility or site, SEM provides information about the nature and location of work processes performed (e.g., fuel separation, instrument maintenance, or welding); the work groups involved (e.g., first line supervisor, instrument mechanic, or welder); the toxic substances used (e.g., plutonium nitrate, arsenic, or mercury); and site-specific aliases and potential exposure information about work processes, work groups, toxic substances, buildings, and areas.

b. Potential Nature of Exposure. Data from SEM is interpreted to mean that a worker had a *potential* for exposure to a toxic substance. The CE must review the information yielded from DAR responses, DOE FWP records searches, and the OHQ to hone the SEM search.

c. Employment Data. The CE must obtain as much background as possible to determine the type of work

8. Site Exposure Matrices (SEM). (Continued)

or process the employee performed, the dates of such work or process, the building(s) or area(s) involved, and the toxic substance(s) alleged to have been present to determine through SEM the type of chemicals an employee could potentially have been exposed to while working in a particular building and/or performing a certain job or process. This information can be gathered from the OHQ, DAR, EE-5, or other sources.

d. Validity of SEM. All information in SEM is considered valid and factual. The toxic substance, work process, and facility information in SEM is deemed verified by DOE or other sources, and if a certain toxic substance is listed as present in a given building or facility, the data is accepted as fact and no additional confirmation from DOE or any other source is necessary.

e. Additions to SEM. The database is continually updated and does not contain 100% of the toxic substances potentially present at a given facility. As a result, simply because certain information is absent from SEM does not warrant a claim denial and also does not warrant delaying adjudication until such information might be included in SEM. The CE conducts reasonable development by reviewing the evidence as a whole and issues decisions once such development allows the CE to adjudicate a claim.

9. SEM Policy and Management. The following paragraphs provide a basic outline of SEM and its use as a developmental tool. See the "Site Exposure Matrices Website User Reference Guide" (available on the Shared Drive, Part E folder, SEM subfolder, or accessed through the SEM menu) for complete and detailed instructions as to the use of SEM.

a. Policy. SEM is used as a tool to assist the CE in evaluating the evidence as a whole to determine the existence of a causal link between covered employment, exposure to a toxic substance during such covered

9. SEM Policy and Management. (Continued)

employment, and a resultant illness arising out of such exposure.

As noted above, in certain cases it will be possible to accept a claim based upon the information contained in SEM if such information can be coupled with approved policy guidance as outlined below.

Under no circumstances is a claim for benefits denied solely due to a lack of information contained in SEM, because the data for each facility will never be 100% complete.

b. Management of SEM at NO. A NO SEM Point of Contact (PoC) manages all issues arising out of SEM usage. Implementation questions, requests for access/denial of access to SEM, and any new evidence that might warrant inclusion into SEM are forwarded to the NO SEM PoC.

(1) The NO SEM PoC has a counterpart in the DO SEM PoC, who, the DD appoints to interact with the NO.

When evidence of an exposure not listed in SEM is verified or strongly alleged (supported by documentation) at a facility, the DO SEM PoC prepares a memorandum to the NO SEM PoC (for signature by the DD or designee) requesting IH review for possible inclusion of the toxic substance in SEM. All associated evidence of the presence of the toxic substance is attached to the memorandum.

The NO SEM PoC will review the evidence with the NO IH and other NO staff (i.e., Medical Director, Toxicologist, and Health Physicists) to determine whether the evidence should be included in SEM. If so, the NO PoC advises the Web Site Administrator or appropriate individual to add the information to the database.

9. SEM Policy and Management. (Continued)

In general, the DO SEM PoC interacts with the NO SEM PoC on all issues arising out of SEM operations.

(2) The DO SEM PoC obtains SEM access for DO staff by e-mailing the NO SEM PoC with a request that a staff member be granted access to the system and providing the employee's name, job title, and e-mail address. After review, the NO SEM PoC advises the Web Site Administrator by e-mail to grant access to the individual in question.

The Web Site Administrator contacts all individuals with newly granted access through e-mail, providing access information such as a user name and a temporary password.

(3) Access is disabled when an employee resigns or is terminated. The DO SEM PoC provides an e-mail to the NO SEM PoC with the name of the employee whose access is being disabled and the precise date upon which access must be denied. The NO SEM PoC e-mails the Web Site Administrator requesting that the access be disabled on the requested date, and access is terminated. Due to the sensitive nature of the information housed in SEM, it is important that the DO SEM PoC notify the NO SEM PoC of the need to disable an account within 7 days of an employee's departure.

c. Additions to SEM. DEEOIC encourages claimants and other interested parties to submit new site-related scientific research, studies, or information concerning the presence of toxic substances at covered facilities for evaluation and possible inclusion in SEM. The SEM website at www.sem-dol.gov contains a link for individuals to provide comments or documentation of toxic substance use at a particular facility.

10. SEM Searches. The CE reviews all evidence of file to properly craft his or her SEM query. The CE reviews

10. SEM Searches. (Continued)

employment evidence for job description and facility. Also, employment and exposure evidence in the case file (e.g., facility records, DAR records, OHQ responses, NIOSH/PHS/DOJ data about RECA claims) is reviewed to determine as best as possible exactly where the employee worked and what processes or toxic substances were used in the building or area in which the employee worked. In order to effectuate a thorough and proper search, it is necessary for the CE to develop SEM queries from multiple criteria, including: labor category; process; and health effect. While labor category is the preferred field to begin a search, it is not the only field that should be investigated.

- a. Data Fields. Various fields in SEM hold an array of valuable data viewable by site: the number of toxic substances present (with information about each substance); health effects or diseases known to be associated with a toxic substance; site history; buildings; processes; labor categories; known incidents; and exposure factors.

All fields contain references to the document utilized by SEM to provide the given information. The CE navigates the search fields based upon the known evidence of file, triangulating on the necessary information required to assist in the development and determination of causation.

A search based upon facility-wide information (e.g., all toxic substances known to have been present at the Nevada Test Site) generally will not be specific enough without other qualifiers such as work category and/or work process, and may not produce usable information for a causation determination.

At a minimum, especially when searching DOE sites, the CE establishes the employee's job category, work process, and/or building/area or employment before performing a SEM search. The more information a CE has about an employee's occupational history when searching SEM, the more likely it is that the SEM

10. SEM Searches. (Continued)

search will prove useful in helping the CE determine causation.

b. Searches of Universal Information. This set of fields contains the most recent scientifically based evidence about toxic substances and their relation to illnesses. The occupational disease links in SEM are imported from the widely accepted and well rationalized medical science database called Haz-Map, a database of the National Library of Medicine (NLM). While the NLM database, Haz-Map, is often utilized in other circumstances as a resource, the CE must never use Haz-Map as a development or adjudicatory tool. Only SEM is acceptable for use in case file development and adjudication. It is unacceptable to base a decision, particularly a remand order, on any information contained in Haz-Map beyond the established links populated directly into SEM. Haz-Map serves many purposes for the public and medical professional fields and will often cite suggestive research that it has not accepted as a basis for finding a demonstrable link between a given substance and an occupational illness.

(1) The "Toxic Substance Information" field is useful when the evidence indicates the toxic substance(s) to which the claimant was potentially exposed. When a toxic substance is selected, SEM provides a "chemical profile" of the substance, including its Chemical Abstracts Service (CAS) number, which identifies the chemical, aliases for the substance name, chemical and physical properties (e.g., liquid or gas, odor, and color), and health hazard ratings assigned by sources routinely used by industrial hygienists to evaluate workplace substances.

(2) The "Toxic Substance by Alias or Property" field is used to find a toxic substance using an unofficial name, or by a physical or chemical property. Using this link allows the CE to find the identity of toxic substances by keying in part or all of the name, unofficial name (alias),

10. SEM Searches. (Continued)

or description of a toxic substance using a physical or chemical property.

The result may be no match, one match, or multiple matches. For example, searching for "yellow" will return a list which includes uranium dioxide, and searching for "yellowcake" will return a shorter list which still includes uranium dioxide.

(3) The "Toxic Substance by Chemical Category" field is used to find a toxic substance by category, such as gases or metals. If the claimant is not specific about the substance to which he or she was exposed, but describes it in general terms, this link will allow the CE to review a list of substances to which the employee may have potentially been exposed. After selecting a chemical category from the drop down menu (gases, metals, acids, etc.), a listing of all toxic substances within that category at the site is shown.

Example: The CE knows that the employee worked as a laborer in the pilot plant at the Feed Materials Production Center (Fernald) and is claiming chronic bronchitis. The OHQ indicates that the claimant does not recall exact exposures, but does recall a sharp, pungent odor and states that he "breathed in this gas all the time." The CE selects "Gasses" from the chemical category drop down menu and all gasses known to have been present at Fernald are listed. The CE searches each gas and finds that sulfur dioxide was present in the pilot plant and that laborers are a labor category of possible exposure and that the gas has a pungent odor and that chronic bronchitis is a health effect of exposure.

(4) SEM provides a list of known health effects produced by a given toxic substance. SEM can also be searched to determine whether or not a given facility contained a toxic substance that

10. SEM Searches. (Continued)

could produce the health effect claimed. When searching this way, the CE searches by the claimed illness (e.g., asthma, skin cancer) to determine what toxic substances at a given site could have potentially caused, contributed to, or aggravated the claimed condition.

(a) The "Toxic substance by health effect" section displays the toxic substances that could cause the health effect or disease.

For example, the above-described laborer from the Fernald Pilot Plant claims chronic sinusitis as a result of his or her employment at Fernald. A search of the condition "chronic sinusitis" shows that no toxic substances contained within the Fernald database match the search criteria, meaning that no known substances involved in a work process at Fernald could have induced chronic sinusitis.

While this is not sufficient evidence to deny causation, the CE must evaluate other evidence to determine whether or not the employee's condition was caused, contributed to, or aggravated by his or her employment.

(b) The CE also can search SEM for toxic substances that cause a health effect by searching with a disease or health effect alias. That is, if the CE does not know the official name of the disease (e.g., pulmonary disease, chronic obstructive, a general term for lung ailments that can include emphysema, chronic bronchitis, and in some cases asthma) the CE can search by the word "lung." This generates a search of all toxic substances present at a given facility that could affect lung function.

The CE can review the list of substances to determine if they were present in the

10. SEM Searches. (Continued)

employee's work process or building and whether these substances could potentially cause one of the lung diseases commonly referred to as COPD.

(c) The CE uses the "Disease or Health Effect by Alias" search if the organ affected by the disease is known. Using this link opens a page which allows the CE to find health effects or diseases by keying in all or a portion of the formal name of a health effect or disease. The SEM provides a list of health effects or diseases, which contain the search text in their formal names. For example, searching for "liver" returns *Hemangiosarcoma* of the liver.

c. Searches Specific to Selected Site. This section contains the most recent information about covered DOE facilities, uranium mines, uranium mills, and uranium transport operations. The CE searches these site fields for specific information about a facility, the work processes performed there (e.g., PUREX fuel separation, instrument maintenance, welding), and the toxic substances involved in those work processes, broken down by labor category (e.g., welder, yellow cake operator, electrician).

This group of searchable fields assists the CE in evaluating whether or not the employee's work history meets the presence and contact standard in the causation test for toxic substance exposure set out above. The CE searches site-specific fields when the CE knows the site of employment and also when the CE knows the building/area of employment, the work process performed and/or the labor category claimed.

(1) Site History. This section contains unclassified references from official DOE or DOE contractor web sites providing a description of the DOE facility or uranium mine or uranium mill. It provides dates of operation, known owners/operators, and historical reference data

10. SEM Searches. (Continued)

about the site. This description is available in SEM for both DOE facilities and uranium mines and mills.

(2) Areas. This section is only displayed if the selected site has defined areas. All defined areas are viewable by selecting a drop down menu identifying each known area by number and/or title. This section is used when the CE knows the area in which the employee worked. Work processes, labor categories, toxic substances and incidents will be listed for each specified area at the site.

For example, the employee claims to have worked on the bull gang in Area 16 at the Nevada Test Site from 1966 to 1970 and is claiming occupational asthma. The CE searches the Nevada Test Site facility by Area and queries Area 16, which shows all known potential toxic substances in that area, all labor categories, and work processes.

A search of the toxic substances present at the time of the claimed employment shows that of all substances present, cobalt can cause occupational asthma. A further search indicates that the bull gang labor category, involved in the labor process of reentry and mineback operations, is shown as a risk factor for cobalt exposure during the time in which employment is claimed. Verification of the claimed employment by DOE is sufficient to establish potential exposure.

(3) Buildings. This section is searchable when the CE knows the official or unofficial name of the building in which the employee worked. This section lists all historical references to the building, hazardous chemicals present, the area where the building was located, work processes, labor categories, and known incidents involving the building. This search category is available only for DOE sites. Data for uranium mines and

10. SEM Searches. (Continued)

mills will simply state the site history, processes, and searchable labor categories.

(a) The building information subsection lists all the major buildings (by number and title) at the site (e.g. the K-33 Process Building within the K-25 East Tennessee Technology Park).

(b) The CE enters a building by alias, or common name, for a worksite that does not appear in the searchable buildings list (e.g., the K-33 Process Building above is also known as the "Cascade Building"). SEM lists the proper names and numbers of buildings to which the slang or common name could refer. This search capacity assists in locating a building when no formal building name is identified in the employment history.

(4) Processes. This section lists all known processes at the site (e.g., carpentry, ash crushing, crane operations) and contains the related labor categories, timeframes, and toxic substances. This category is searchable for DOE facilities and uranium mines and mills. When searching for a labor process, the CE may know the type of process in which the employee was involved (e.g., welding, drillback core sampling, solvent recovery), but not the specific labor category involved.

Knowing the work process can assist the CE in conducting a search for potential exposure to toxic substances, because sometimes several different job categories can be involved in one work process and a process might be spread out among several different buildings within a facility (e.g., a process operator at Portsmouth GDP involved in cascade operations could have worked in X-326, X-330 and X-333, all buildings

10. SEM Searches. (Continued)

in which the work process "cascade operations" took place).

(a) DOE facilities list all processes known to have occurred at the site. For instance, if the CE knows an employee worked in Building 202-A at the Hanford Site, SEM indicates that the process in that building was PUREX fuel separation, lists all labor categories involved in this operation, and the toxic substance present when this operation took place.

This assists the CE in determining the toxic substances to which an employee could potentially have been exposed, based upon the process listed and the timeframes in which the employee may have been involved in such processes.

(b) For RECA mills, the following categories are examples of processes: laboratory, maintenance, and all other than laboratory and/or maintenance. Some mills did not have a laboratory component and therefore list fewer than three processes (e.g., Slick Rock in Colorado lists only maintenance and all processes other than maintenance). The CE must identify the labor sub category (actual work performed) whenever possible.

For example, if the CE knows that an employee worked as a bulldozer operator at Grand Junction in Colorado, the CE searches the labor subcategory field to identify that job title. Once it is identified, the CE clicks on the bulldozer labor subcategory and finds that a bulldozer operator is classified in the labor process "all other than laboratory and maintenance." All potential toxic substance exposure for that subcategory and labor process group is

10. SEM Searches. (Continued)

listed, and the CE can match the findings against the claimed/verified illness and exposure.

(c) Much of the work performed at RECA mines was fairly uniform and easily categorized with regard to process. While SEM does not list work processes for a RECA mine, labor categories exist as outlined below. Only exposure arising from processes and work that actually took place at a uranium mine or mill is considered when evaluating a claim for causation.

(d) Individuals employed in the transport of uranium ore or vanadium-uranium ore to and/or from covered RECA mines or mills are covered under the EEOICPA. However, when developing exposure for an ore transporter, the CE only counts exposure that could potentially have taken place on the premises of a covered RECA mine or mill.

Exposure that could have potentially occurred when the ore transporter was *in transit* is not covered under the EEOICPA and is not considered by the CE when developing for causation. See EEOICPA PM 2-1100 for a more complete discussion of covered exposure under RECA.

(5) Labor Categories. The CE can search by labor category if the employee's job title or job title alias specific to a certain facility is known. It is important to narrow down employment verification requests and information obtained on Form EE-3 to determine the exact labor function performed by an employee if possible.

The RC staff must make certain to obtain the most specific employment information that is available from the employee/survivor and the employment

10. SEM Searches. (Continued)

verifier entity when conducting initial employment verification.

The CE must conduct additional development where necessary to further identify the exact definition of the employee's functions and the timeframe(s) of those functions at a given site, seeking the greatest specificity possible.

(a) Labor category information lists all the labor classifications or work group titles at the site (e.g., electrician, crane operator, barrier operator).

(b) If the employee's job title does not appear on the drop down list of labor categories above, the entry on the claims form may be a slang or unofficial title. The CE may be able to find the official labor category, (e.g., maintenance mechanic) by keying in the slang or commonly used title (e.g., pipe fitter).

(c) Construction worker exposures are separated into two categories: those due to toxic substances inherent to the construction craft, and those caused by performing the construction work on a DOE site. The CE must consider both exposure categories when assessing exposure for construction workers.

Construction exposure is searched as its own category outside of the facility lists. As such, it does not matter where the construction took place. If the CE is searching SEM for a construction worker's claim, the CE searches by toxic substance and by work process (e.g., adhesive work, brazing, carpentry) and labor category (e.g., electrician, millwright, iron worker). Searches for construction trade exposures contain the same toxic substances,

10. SEM Searches. (Continued)

work processes, and labor categories for all covered facilities.

(d) For RECA mines, three labor categories are listed: prospecting, mining, and support/maintenance. The CE determines the duty performed (e.g., mining or maintenance) when searching SEM for information about a site listing more than one process. Some sites list only one possible work process and the CE need only confirm that employment is claimed or verified at the given site.

Once the work process is identified at the mine where employment took place, the CE can search a list of toxic substances to determine the one(s) to which an employee could have potentially been exposed while working at the mine.

For instance, the Arrowhead #1 mine in Eagle County, Colorado, lists "prospecting, no mining" as the only work process performed at that site. This means that the only work process performed at the Arrowhead #1 site was prospecting for uranium and that no actual uranium mining operations took place at that site.

The Bay Mule mine in San Miguel County, Colorado, lists "mining" as its only work process. A mixture of possible work processes will be listed for the RECA facilities depending upon what type of work activities actually occurred at the site.

(6) Incidents. The incident information field lists known major incidents and accidents experienced at the site. The entries provide a brief descriptive title of the incident, the year the incident occurred, and the location of the incident (building or area). An example would

10. SEM Searches. (Continued)

be: Uranium cylinder rupture and release, 1976, Building X-344.

(a) This information may assist in corroborating a claim if the claimant has referred to a particular accident or incident as having caused acute or extreme exposure to a toxic substance. Facility incident and accident information may be found in DAR responses, employment records, DOE FWP records, and OHQ summaries.

(b) The CE must evaluate incidents and accidents with regard to the evidence of file as a whole. Simply corroborating a claimed exposure is not sufficient to establish causation. The CE must review the medical evidence and, if necessary, seek the opinion of an IH or DMC about the possibility as to whether or not the type of incident or high exposure event (as viewed in association with the evidence as a whole) could prove a significant factor in causing, contributing to, or aggravating the claimed illness. Further, certain incidences of high or extreme exposure should be considered when evaluating whether or not a required disease latency period can be eased or waived entirely.

(7) Exposure Factors. This section lists the safety programs, risk factors and timeframes used to gauge an employee's potential exposure as it relates to work process, labor category, building, and area.

(a) Safety programs serve as controls that may have reduced the likelihood of employee exposure to toxic substances (e.g., through use of respirators, protective clothing).

(b) Risk factors are conditions or practices that may have increased the

10. SEM Searches. (Continued)

likelihood of employee exposures to toxic substances, such as periods of time when employees were not properly protected.

(c) Timeframes reflect known periods within which a known correlation exists. For example, certain timeframes outline the period in which it is known that a certain toxic substance was present in a certain building (e.g., from 1956 to 1988 ammonium fluoride was present in Area 200 East and involved in the work process of PUREX fuel separation activities).

Also, timeframes outline periods in which certain safety programs or measures were in place at a given building or area. This information may assist the CE when evaluating the likelihood that a claimant was exposed to a toxic substance.

Safety Control Example: In 1999, DOE enforced beryllium controls such that work could only be performed in certain buildings. The employee claims beryllium illness from beryllium exposure in 2000, yet the employment evidence shows that he or she worked in a building where beryllium was never present due to DOE controls. When dealing with beryllium, the CE must be aware of the potential for residual contamination, and in this instance it must be unequivocally verified that beryllium was never present at the facility in question.

d. Links Within Searchable Fields. Within SEM the various areas, facilities, buildings, processes, activities, labor categories, incidents and toxic substances which are known to have existed or occurred onsite are linked to one another. For example, such relationships expressed in the matrices might be:

10. SEM Searches. (Continued)

(1) "Toxic xxx was in building aaa at some time;"

(2) "Activity bbb was performed by Labor Category ddd and involved work with Toxic yyy in Building 111;"

(3) "Activity bbb was performed during Labor Process ddd and involved work with Toxic zzz in Building 111;" and

(4) "Labor category ppp involved work at all parts of the site".

e. Sample SEM Search # 1. DOE verifies employment at the Portsmouth GDP from 1955 to 1960. Form EE-3 indicates that the employee worked as an instrument mechanic in Building X-333 from 1955 to 1960. The verified diagnosed medical condition is aplastic anemia.

A search of the SEM by Health Effect shows that aplastic anemia can be caused by arsenic, benzene, and plutonium exposure. The CE further consults the Haz-Map database link which provides a description of aplastic anemia and indicates that arsenic, benzene, and plutonium are among the hazardous agents that can cause the disease. A latency period of weeks to years is indicated.

The Building information for Building X-333 lists all known chemicals used at that site, and arsenic, benzene, and plutonium are among them. The SEM further shows that the Labor Process of Instrument Maintenance took place in Building X-333 from 1953 to 1957 and lists the Labor Category Instrument Mechanic as involved in this process during this timeframe.

The CE reviews the SEM findings as well as other relevant evidence (medical opinions provided by qualified physicians that opine a link between the occupational exposure and the aplastic anemia, DAR records showing definite arsenic and benzene exposure,

10. SEM Searches. (Continued)

DOE FWP records, and OHQ results supporting a finding of potential occupational exposure to benzene, arsenic and plutonium) to determine whether sufficient evidence exists to accept the claim. In this instance, the evidence as a whole supports acceptance.

f. Sample SEM Search # 2. An employee claims employment as a chemical operator in Building X-705 at the Portsmouth GDP from 1966 to 1982. DOE confirms the employment. The employee is claiming asthma and chronic bronchitis, and medical evidence diagnosing COPD has been received. The CE reviews the OHQ and finds that the claimant indicated in his interview that he does not know specifically what chemicals he was exposed to, but does recall working with an acidic substance with a sour, vinegar-like odor.

The CE reviews SEM, searching by labor category and building, and finds that acetic acid was used in the employee's work process in Building X-705 and that it has a sour, vinegar-like odor. A SEM search for health effects for acetic acid shows that it is known to be associated with occupational asthma. The DAR record response does not show that the claimant worked with acetic acid in the course of his employment, but that he did come into contact with various solvents.

The CE should follow up with the treating physician to clarify the diagnosis. The CE may consider referral to a DMC to review the evidence and determine whether or not the potential for acetic acid exposure caused the claimant's lung condition. The CE will also want the DMC to try and specify the lung condition.

g. RECA SEM Searches. When searching for a specific RECA location (mine or mill), the CE locates the facility by the state in which it operated, by its name, or by its alias. For instance, the uranium mill "Durango" can be found by searching mills in Colorado, by the name "Durango," or by searching the site alias: Vanadium Corp of America, or VCA.

10. SEM Searches. (Continued)

RECA mines are also located in SEM by the county in which they operated. RECA mine and mill work process categories are more general than the DOE work process categories. The CE attempts to determine the exact labor category (specific job title or activity) whenever possible when conducting a SEM search about a RECA facility.

Uranium mines are categorized as being either underground or surface mines, and typical mining operations include the following: drilling; blasting; shovel/machine digging; and hauling materials.

11. SEM Inquiries. Whenever a SEM query is conducted, the CE must document the case file record to show that a SEM search took place and enter the corresponding ECMS coding.

a. Recommended Decision. Prior to issuing a recommended decision (RD) denying benefits, the CE must ensure that the most updated version of the SEM data is contained in the case file and referenced properly in the decision.

(1) This is done by double checking the search initially conducted to make certain that an element not found in the initial search (i.e., a toxic substance) has not been added to the SEM since the date of the initial search. The CE prints out the results of the new search immediately prior to issuing the RD.

(2) The CE must make certain that the SEM record is properly preserved in the case file for FAB review. SEM will show the latest date on which an update was made to the system that changes the data available about a given facility.

(3) If the date listed in SEM remains the same as it was when the original search was conducted, the CE will know that no new information has been added to SEM and no new search is required. However, if the date has been changed since the date of the last search, the CE must search SEM

11. SEM Inquiries. (Continued)

again to determine whether additions or changes will change the outcome of the SEM search and potentially affect the outcome of the adjudication.

b. Decisions Issued As Needed. Because SEM is a living document that is updated as data becomes available, the CE does not wait for information in SEM to be updated before issuing a decision. If a SEM search is conducted and no information is available, or the site is not yet complete or searchable in the database, the CE issues a decision after developing the case as completely as possible, pursuant to normal procedures.

c. FAB Review. FAB ensures that the SEM search was conducted, where applicable, during the FAB review of the recommended decision.

(1) FAB may remand the case to the DO if a SEM search was needed but not conducted, or if the search was conducted improperly in a way that materially affects the outcome of the RD, or if the SEM data relied upon by the DO was changed or updated significantly enough to warrant additional development or a potentially different adjudicatory outcome.

(2) Before issuing the FAB decision, the FAB must ensure that the SEM record is the most complete and updated data available in SEM and that no significant changes (additions of toxic substances or changes in work process definitions or timeframes) have been made since the issuance of the recommended decision.

(3) This checking of the SEM search data to determine whether or not a new data element was added that will alter the outcome of the decision is conducted in the same manner as set out above for denied recommended decisions.

11. SEM Inquiries. (Continued)

(4) The FAB CE/Hearing Representative (HR) does not print out a copy of a new search, but places an entry into ECMS Notes indicating that no new evidence exists in SEM to alter the findings in the recommended decision.

(5) If new evidence is uncovered that does alter the findings of the RD, a remand order may be necessary. However, if the SEM data is updated after the issuance of the recommended decision or the DO SEM search, and such update does not affect the outcome of the decision, a remand is not warranted.

d. Use of SEM Findings. When using SEM as a finding in an RD or a decision of the FAB, the CE/HR cites the technical document upon which the SEM data search result is founded, as well as SEM, in the decision. As always, the DO CE or FAB CE/HR clearly outlines the rationale for accepting or denying causation based upon all of the evidence weighed as a whole. Below is an example of the language approved for use when referencing SEM.

Decision Language Example: Source documents used to compile the U.S. Department of Labor Site Exposure Matrices (SEM) establish that a person in the labor category of "Operator" at the Savannah River Site could potentially be exposed to the toxic substance asbestos. The SEM lists asbestosis as a possible specific health effect of exposure to asbestos and contains a list of the buildings at the Savannah River Site where that particular toxic substance is or was present during the years that the claimant worked there. The employment record provided by the Department of Energy (DOE) contains several numbers that appear to reference the employee's work location including a number G160-235. The most comparable building listed in the SEM was 235F. Data contained in SEM for 235F establishes that asbestos was used in this building and that the labor category of "Operator" is associated with this building.

12. National Office Specialist Review. If the CE identifies an exposure issue that requires review by an IH, the CE alerts his or her supervisor. *Prior to seeking NO assistance, the CE must exhaust all reasonable exposure development pursuant to the guidance set out in this Chapter.*

If the supervisor grants approval for the referral, the CE prepares an e-mail to the Health Services Program Analyst (HSPA) requesting review. The HSPA forwards the e-mail to a Medical Health Science Unit (MHSU) specialist who reviews the contents and assigns the question to the appropriate specialist based upon their scientific discipline.

However, if the MHSU specialist determines that the issue does not warrant a referral, the e-mail is returned instructing the CE to pursue further development. Once the issue is assigned to an IH for review, the IH conducts such review and responds to the CE in a timely manner.

a. Questions for IH. The CE outlines succinctly what information is known about the issue (e.g., the employee was a stainless steel welder at Savannah River from 1982 to 1985 who is diagnosed with asthma) and what is needed from the expert (could the employee have been exposed to nickel)? The CE uses the information in SEM and the case file as a whole to frame the question as carefully as possible based upon the claimed employment, process and illness. A Statement of Accepted Facts (SOAF) must accompany the referral to the IH.

(1) The facility in question (narrowed down to building and area where possible) and the work performed is always a critical factor when querying the IH about exposure. The CE uses SEM whenever possible to assist in this narrowing process, but if no information exists in SEM, the CE crafts the question as best as possible based upon whatever evidence is available in the case file.

(2) The CE may also forward a general question about a facility when information cannot be found

12. National Office Specialist Review. (Continued)

in SEM and the facility in question is either not yet uploaded to SEM or the data is incomplete.

For instance, a CE may need to know whether asbestos was present as a general rule in the Clarksville facility. The CE may ask a general question such as this of the IH, but should include as much specificity in the query as possible, especially labor category, processes, and time periods.

b. IH Review. The IH reviews the issue framed by the CE and determines whether more information from the case file is required to answer the question, or if the entire case file is needed. The IH role is to anticipate, recognize, and evaluate hazardous conditions in occupational environments, and to opine based upon his or her specialized knowledge. The IH strives to answer the question based upon the information outlined by the CE.

However, if additional information is required, the IH may request whatever documentation from the case file is necessary. If required, the IH requests the entire case file if individual pieces of information from the file will not suffice to answer the question posed by the CE.

(1) The IH mainly addresses issues about routes of exposure (e.g., whether or not a welder at a given facility could have been exposed to nickel). An IH also may verify whether or not a toxic substance was/could have been present during a certain work process (e.g., welding, or instrument maintenance) at a given site, or if a certain labor category (e.g., welder, or instrument mechanic) could have come into contact with a given toxic substance in the performance of his or her duty at the site.

The IH may also be asked to determine the *plausibility* that a certain toxic substance was present or that a claimed exposure could have

12. National Office Specialist Review. (Continued)

occurred based upon the work history and/or accident/incident report.

(2) The IH also reviews SEM searches performed by the DO to determine whether or not they were performed correctly and accurately.

c. Request for Case File. If the IH requests the entire case file, the CE prepares the WS/WR memorandum for the DD's signature. The WS/WR memorandum is addressed to the Policy Branch Chief at NO. Upon receipt of the case file, the Policy Branch Chief forwards the case file to the IH for review.

d. IH Memorandum. The IH renders an expert opinion in the form of a memorandum that addresses the issue as specifically as possible. The IH's reply addresses the specific question posed by the CE in the e-mail/SOAF/WS/WR memorandum, and employs his or her specialized training to make findings based upon the evidence of file and clearly rationalized science.

e. DMC Referrals to IH. In certain instances, a case forwarded to a DMC may not contain enough information regarding occupational toxic exposure for the DMC to render an expert opinion. In these situations, the DMC should refer the case to an IH through the DO.

(1) DMC referrals for causation which do not adequately identify a route and extent of exposure require the DMC to contact the Medical Scheduler (MS) via e-mail within 3 days of receipt of the referral package, and request an IH referral. If exposure data are inadequate due to an incomplete SEM profile, incomplete DOE records, or other missing information that makes a causation determination impossible without a clearer exposure evaluation, then an IH referral is warranted. If the Medical Scheduler is unavailable the DMC should then contact the assigned CE.

12. National Office Specialist Review. (Continued)

(2) The MS forwards the DMC's IH referral request via email to the assigned CE for review. A copy of this email is placed in the case file. Telephone requests for an IH referral must be documented in the Telephone Management System (TMS).

(3) Upon receipt of the email from the MS, the CE forwards the case file and Statement of Accepted Facts (SOAF) to the Supervisor/Senior CE for review. If the Supervisor/Senior CE concurs with the need for an IH referral, he or she sends an email with the SOAF attached to the Health Services Program Analyst (HSPA) located at the NO, requesting an IH review and places a copy of the SOAF and the sent email in the claimant's file. The CE enters the "WS" code into ECMS (Washington, DC: Sent To), with a reason code of "IH" (Industrial Hygienist Review) (see DEEOIC ECMS procedures for status effective dates and other information). The "WS" code ensures that the time taken for review by an IH will not be counted as time necessary for DMC review.

(a) Upon receipt of the email from the Supervisor/Senior CE, the HSPA assigns the referral to an IH.

(b) The IH reviews the SOAF and any other relevant information that may be requested, and renders an expert opinion in the form of a memorandum based upon the facts of the claim, the information available through SEM, and professional judgment regarding the likelihood and extent of any exposure(s). The IH then emails a copy of the memorandum to the CE, Senior CE, and Supervisor.

(c) The IH has 15 days from receipt of the referral to complete the memorandum. If 15 or more days pass without receipt of the memo, the CE notifies the Senior

12. National Office Specialist Review. (Continued)

CE/Supervisor, who then follows up with an email to the HSPA.

(d) When the IH memo is received the CE reviews the opinion to ensure that the question asked has been sufficiently answered, gives a copy of the memorandum to the MS, and places a copy in the claimant's file. The CE then enters the "WR" code into ECMS (Washington, DC: Received Back From).

(e) The MS will FedEx a copy of the IH memorandum to the DMC for review and notify the CE, Senior CE, and the Supervisor via e-mail of when this action was taken.

(4) The CE continues to monitor and track the file after the IH memorandum has been furnished to the DMC.

(a) The DMC has 21 days from the date of receipt of the IH memorandum to return a completed report accompanied by a bill to the MS. If the DMC report is not received within 21 days from the date of the IH memorandum, the CE notifies the MS, who follows up with a phone call to the DMC. The call is documented in TMS.

(b) If, upon review of the IH memorandum, the DMC has questions, the DMC contacts the IH via email.

(5) If the Supervisor/Senior CE determines that the case does not warrant an IH referral after receiving the SOAF and file from the CE, the Supervisor/Senior CE returns the SOAF and case file to the CE with instructions to pursue further exposure development.

(a) The CE notifies the MS via email that further exposure development is needed, places a copy of the sent email in the case

12. National Office Specialist Review. (Continued)

file, and mails an exposure development letter to the claimant. In the letter to the claimant, the CE advises that exposure development is needed for adjudication. The CE enters code DO (TD) - Development of Toxic Exposure into ECMS with a status effective date the date of the letter. Upon mailing the request to the claimant the CE enters an ECMS note describing the action and inserts a 30-day call-up.

(b) The MS notifies the DMC via phone that further exposure development is needed for the case. The call is documented in TMS.

(c) After 30 days has passed with no response from the claimant, the CE prepares a second letter to the claimant (accompanied by a copy of the initial letter), advising that following the initial letter, no additional information has been received. The CE advises that an additional period of 30 days will be granted for the submission of requested information, and if the information is not received a decision will be issued. The CE enters code DO (TD) - Development of Toxic Exposure into ECMS with a status effective date the date of the second letter.

(d) The CE notifies the MS via email that the requested information has not been received, places a copy of the sent email in the case file.

(e) Upon receipt of the email from the CE the MS prepares a letter to the DMC notifying that the requested information has not been received. In the letter, the MS requests the DMC to return or destroy the case material. A copy of this letter is placed in the case file.

12. National Office Specialist Review. (Continued)

(f) If the claimant submits relevant exposure data in response to the CE's request, it must be reviewed to determine if it is of sufficient probative value to request an IH referral or return to the DMC. If the CE determines that there is insufficient evidence to warrant an IH referral, a decision can be issued. If the CE determines that the new information is sufficiently comprehensive to obviate the need for IH review, referral to the DMC can be completed.

f. Complex Referrals. Some referrals to NO will be so complex as to require IH and medical or possibly toxicology review. In these instances, the NO Medical Director and/or the NO Toxicologist may also review the case materials/case file to assist in addressing the CE's inquiry. The proper specialist will be determined by an MHSU specialist at NO upon review of the query and/or case file materials. The NO Medical Director and/or Toxicologist will provide expert opinions in such cases where a review is necessary by more than one specialist at the same time.

If an issue referred to the NO contains elements that might require expertise in the field of occupational exposure, medicine, and/or toxicology, it is forwarded to NO as outlined above with an initial e-mail query. The appropriate specialist(s) will review the query and determine what additional information (including the case file) is necessary to resolve the issue at hand.

g. Synergistic or Additive Effect. In certain instances a physician might opine that a claimant's radiation and toxic substance exposure together worked in tandem to produce a synergistic or additive effect that brought about a cancer. DOL has not found scientific evidence to date establishing a synergistic or additive effect between radiation and exposure to a toxic substance, and if the physician presents this finding he or she must provide actual scientific or

12. National Office Specialist Review. (Continued)

medical research evidence to support the finding before the CE may consider the assertion.

If a physician makes this assertion the CE requests that the physician provide medical evidence of a synergistic or additive effect and a clearly rationalized medical opinion as to whether or not the effect is of a significant nature to establish that the combination of the radiation and the exposure to a toxic substance was "at least as likely as not" a significant factor in aggravating, contributing to, or causing the cancer.

- (1) If the physician provides rationalized scientific evidence revealing a synergistic or additive effect, the DO sends the case file to NO for review by a NO Health Physicist (HP) and/or the DEEOIC Medical Director. The HP reviews the physician report and all evidence of file and drafts a memorandum containing his or her professional opinion as to causation which is sent to the CE for use in issuing a determination in the case. See the ECMS section to this Chapter for referral coding.

U.S. DEPARTMENT OF LABOR

EMPLOYMENT STANDARDS ADMINISTRATION
OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES' OCCUPATIONAL
ILLNESS COMPENSATION
(District Office Address)



(Date)

EMPLOYEE NAME:
CLAIM FILE NUMBER:

(DAR POC Address)

To Whom It May Concern:

A claim for benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) has been submitted with respect to the employee named above, claiming employment at a Department of Energy facility. He or she is claiming that employment for the Department of Energy or one of its contractors or subcontractors has contributed to a covered illness. Your facility has been identified as having possession of or access to records which may identify employment and toxic substance exposure regarding this individual.

Included as an attachment to this cover letter is a copy of the claimant's EE-1 or EE-2 Claim for Benefits, the EE-3 Employment History and a Document Acquisition Request (DAR) Questionnaire. Marked on the attached DAR Questionnaire is the name of the employee, employee SSN, employer name and the facility where employment is alleged to have occurred as well as selected categories of documentation we hope you have at your facility.

Please conduct a reasonable search for the requested documentation and provide a copy of those records in digital PDF format on a compact disc (CD) if available. You may make as many copies of the DAR Questionnaire as necessary.

Please return the completed DAR Questionnaire, the CD and any hard copy documents to the address provided above. If you have received this request in error or if you have any other concerns, please feel free to contact me directly at ***-***-**** or fax ***-***-****.

Sincerely,

Claims Examiner

Attachments:

EE-1/2 Claim for Benefits
EE-3 Employment History

**Document Acquisition Request Form
(DAR)**

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation
Programs



This form is used to request specific documentation regarding DOE employees and DOE contractor employees at DOE covered facilities under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). The DOE Operations Center will request the records specified by DOL from each facility. The facility will transfer the documentation onto a compact disc (CD) in electronic PDF format and forward the completed DAR form and CD directly to the requesting District Office.

Employee Information (Completed by DOL)			
1. Name (Last, First, Middle Initial)	2. Social Security Number		
3. Department of Energy Facility	4. Employer Name (If a subcontractor employee)		
5. Types of Records Being Requested (Completed by DOL)		6. Record Availability	
		Included on CD	Unavailable
<input type="checkbox"/> Radiological Dose Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Incident Or Accident Reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Industrial Hygiene and Safety Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pay and Salary Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Job Descriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Site Specific Exposure Questions (Completed by DOL)		8. DOE Response	
<i>Example: Was asbestos used in building X-333?</i>			
1. Do you have any classified documents regarding this employee we should be aware of?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Certification (Completed by DOE)			
By signing this form, the DOE is acknowledging that it has conducted a reasonable search of available records and that the information provided on this sheet and the electronic documentation provided on a compact disc (CD) or hard copy accurately reflects the results of that search.			
Print Name:		Telephone No: ()	
Signature:		Address:	
		Date:	

Instruction Sheet for the Document Acquisition Request (DAR)

Block 1: The Department of Labor (DOL) Claims Examiner (CE) completes this block by either typing or legibly writing the name of the employee using Last Name, First Name, and Middle Initial. The CE also lists a maiden name if known.

Note: Attach a copy of the EE-1/2 and EE-3

Block 2: The DOL CE types or legibly writes the Social Security Number (SSN) of the employee in this block.

Block 3: The DOL CE types or legibly writes the claimed Department of Energy (DOE) facility identified by the claimant on the submitted Employment History Form (EE-3) (i.e. Portsmouth Gaseous Diffusion Plant).

NOTE: If the claimant indicates employment at multiple DOE sites, a separate DAR Form is completed for each DOE site claimed.

Block 4: The DOL CE places the contractor or subcontractor name in this block if a subcontractor or contractor is identified on the EE-3 (i.e. Grinnell Corporation).

NOTE: If the claimant indicates employment at a DOE site with multiple subcontractors, a separate DAR Form is completed for each subcontractor.

Block 5: Types of Records Being Requested. The DOL CE determines from the case file documents (i.e. Occupational Health Questionnaire, EE-3, EE-4, medical evidence) which types of records are pertinent to the individual case and checks the appropriate block corresponding to the type of record needed.

Radiological Records: These documents are radiation exposure records based on readings from dosimetry badges or similar personal recording devices. They are generally taken at regular intervals over the employee's employment period.

Incident or Accident Reports specific to the employee: Any abnormal incidents or large plant accidental substance releases which effect the employee are documented in these types of documents (Safety and Security Records, unusual occurrence reports, off normal reports, effluent release information, Type A and Type B accident/investigation reports, etc).

Industrial Hygiene or Safety Records: Documents in these categories could contain periodical inspection reports for health and safety purposes pertaining to the employee (i.e. Occupational Injury Files, Investigation Records, Security Records, Individual Industrial Hygiene assessments, Health Hazard Inventories, etc).

Pay and Salary Records: These documents include an employee's pay, salary, any workers' compensation claim or other documents affecting wage. Examples of records that may contain this information include **but are not limited to** Official Personnel Files of Contractor Employees, Contractor Job Classification Manuals, Employee Awards Files, Notification of Personnel Actions, Classification Appraisals Files, Wage Survey Files and Unemployment Compensation Records.

Job Descriptions: These are descriptions of the various employment positions at the plant or site and the duties required to perform the job; they are employee specific.

Medical Records: Personal medical histories of the employee if that employee visited the plant infirmary (i.e. Health Unit Control Files, Employee Medical Folder, etc.).

Other. This category is reserved for any other documentation the CE may feel necessary to request on a claim specific basis which do not fit into any of the other six categories. If this category is checked and a specific request listed by the CE, DOE personnel may contact the DOL CE for clarification of the request if necessary.

Block 6: Record Availability. This block is completed by the DOE. The DOE DAR POC completing the form either checks the block "Included on CD" or check the block "Unavailable" depending on whether the DOE has any records related to that particular set of records. "Included on CD" also includes hard copy documentation in the event the DOE facility does not have imaging capability.

Block 7: Site Specific Exposure Questions. This block is completed by the DOL CE by posing specific toxic substance exposure questions to the DOE. These questions could be gleaned from the claimant's EE-3, other documents in the case file and/or the Occupational Health Questionnaire completed by the Resource Center and should be phrased in such a manner that DOE may provide a "yes or no" answer.

Block 8: DOE may check "yes" or "no" to each site specific question posed by the CE. If DOE cannot confirm the question either way, the DOE indicates that they have insufficient documentation to make a decision on the question by selecting the "unknown" block. There may be times the DOE may want to attach relevant documentation which may clarify an answer in this section. In this case, the DOE DAR POC checks "sup" (supplemental). This will signify additional documentation is attached to the DAR Questionnaire regarding that particular question.

Block 9: This block is completed by the DOE DAR POC certifying the results of the records search. The DOE DAR POC prints his or her name, address and telephone number on the form and signs and dates it in the appropriate spaces. Prior to certifying the results of the records search, the DOE ensures that any clarification regarding the types of records DOL is requesting should be made with the requesting DOL CE.

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Superseded

1. Purpose and Scope. Proper development and weighing of medical evidence is essential to the sound adjudication of claims for benefits and to the comprehensive management of Energy Employees Occupational Illness Compensation Program Act (EEOICPA) claims. This chapter discusses the Claims Examiner's (CE) function in developing and evaluating medical evidence and weighing conflicting medical opinions.

2. Sources of Medical Evidence. Most medical reports come from one of these sources:

a. Claimant's health care provider, including the attending physician, consulting experts and medical facilities. Treatment records from a clinic operated at an employing facility would also be considered records of a health care provider.

b. Department of Energy's Medical Monitoring Programs, administered by certain Department of Energy (DOE) facilities that maintain medical examination records and exposure data on their employees. For example, the DOE Former Worker Programs began in 1996 and are designed to evaluate the effects of the DOE's past operations on the health of former workers at DOE facilities, and offer medical screening to former workers.

c. ORISE (Oak Ridge Institute for Science and Education), which administers the beryllium screening program by providing initial beryllium-related testing at various locations across the country. Individuals who test positive for beryllium sensitivity are offered more extensive testing for chronic beryllium disease (CBD) and medical monitoring.

d. District Medical Consultants (DMC), who furnish medical opinions, guidance and advice based upon review of the case file and familiarity with EEOICPA requirements.

e. Second Opinion Physicians, who may provide examination, diagnostic testing, and rationalized medical opinion when a detailed, comprehensive report and opinion are needed from a specialist in the appropriate field.

2. Sources of Medical Evidence. (Continued)

f. Referee Specialists, who may examine the employee, arrange diagnostic tests and furnish rationalized medical opinion to resolve conflicts between the claimant's physician and the DMC/Second Opinion Physician where the weight of medical evidence is equally balanced.

3. Types of Medical Evidence. Medical evidence in EEOICPA cases consists of the following major categories:

a. Treatment records are the most prevalent form of medical evidence. They consist of any record made during the evaluation, diagnosis and treatment of a patient by his or her health care providers. They include:

(1) Attending physician records (e.g., chart notes, reports, etc.) They include records of medical consultants assisting the attending physician.

(2) Records of doctors consulted by the patient for an independent medical opinion.

(3) Evidence of diagnostic testing (e.g., x-ray films, EKG tracing, etc.) and the reports of medical providers interpreting the tests.

(4) Treatment records from hospitals, hospices, or other health care facilities.

b. Medical evaluations may occur for a variety of reasons other than to further the diagnosis and treatment of the patient. What distinguishes medical evaluations from treatment records is the purpose of the examination. Medical evaluations include:

(1) Evidence from the Department of Energy's Medical Monitoring Programs (e.g., former worker screening records, pre-employment physicals, termination physicals, etc.)

3. Types of Medical Evidence. (Continued)

(2) Examinations required under state or federal compensation programs (e.g., evaluations for state workers' compensation claims, Social Security disability examination, etc.)

(3) Medical reports or opinions obtained for litigation under state or federal rules of evidence.

c. EEOICPA reports produced following a referral to a DMC, second opinion physician or referee specialist.

d. Other types of medical evidence include:

(1) Death certificates which contain information about the cause of death or date of diagnosis.

(2) Secondary evidence relied upon by a doctor in forming an opinion. For example, a doctor may rely upon information provided by an Industrial Hygienist (IH) in determining the cause of an illness.

(3) Affidavits containing facts based on the knowledge of the affiant regarding the date of diagnosis.

(4) Cancer Registry records may be used in some cases to establish a diagnosis of cancer and date of diagnosis.

4. Contents of a Medical Report. The value of findings and conclusions contained in medical records varies.

a. Treatment Records.

(1) A doctor's report of examination usually contains a description of subjective complaints, objective findings, assessment and plan for follow up or treatment. The Subjective, Objective, Assessment and Plan format is often shown in the medical records by the letters S, O, A and P. Even where the SOAP abbreviation is not used, the records tend to follow this pattern.

4. Contents of a Medical Report. (Continued)

(a) The subjective section records information obtained from the patient. It generally contains information about why he or she is seeking treatment, complaints, medical history and current treatment. A subjective section might state, for example, "Patient comes in today to have us look at a lump on his neck that has gotten larger over the last month."

(b) The objective section records the doctor's findings based on his observation, examination and testing. An objective section might state, for example, "The patient looks older than his stated age, his breathing is labored and his x-ray shows a spot on his left lung." The three general classes of objective findings are:

(i) Laboratory findings such as complete blood count (CBC), tissue biopsy, bone marrow smear or biopsy, beryllium lymphocyte proliferation test (LPT), etc.

(ii) Diagnostic procedures such as x-rays, ultrasound, computerized axial tomography (CAT), magnetic resonance imaging (MRI), electromyogram (EMG) and similar techniques of visualizing or recording physiological conditions. Some objective tests are subject to greater interpretation by the health care provider.

For example, an x-ray used to diagnose a broken leg is more objective, while a Minnesota Multiphasic Personality Inventory (MMPI) used to diagnose schizophrenia is more subjective.

4. Contents of a Medical Report. (Continued)

(iii) Physical findings which are noted by the doctor's visual inspection, palpation and manipulation of the body. They include description of demeanor, readings of temperature or pulse, description of respiration, observation of affect, etc.

(c) The assessment section contains the doctor's opinions, suspicions and diagnoses. In most cases, the value of a medical report is found in the assessment. The scope of the assessment will vary with the type of medical condition and its complexity.

The assessment section may contain statements such as, "The pathology report was reviewed and showed the presence of small cell carcinoma of the lung" or "Based on the patient's rest tremor, balance problems and rigidity of muscles, I believe he has Parkinson's disease."

(d) The plan section describes the treatment plan and prognosis. The doctor may, for example, prescribe medication, refer the patient to an expert, or suggest additional testing.

(2) Reports of tests and procedures should contain the employee's name, date of the test, the objective data obtained, and the signature of the person responsible for conducting the test or procedure. Where appropriate, reports should include a physician's interpretation of laboratory tests or diagnostic procedures.

Tests for which interpretation is necessary include, but are not limited to, pathology reports, lymphocyte proliferation tests, X-rays, MRIs, CAT scans, pulmonary function tests, MMPIs, and the Beck Depression Inventory. In cases where no interpretation is provided, the CE must seek a medical interpretation. The CE is not to interpret test results, as that is a medical judgment.

4. Contents of a Medical Report. (Continued)

(3) Hospital, hospice and clinic records will contain the same type of doctor's records and diagnostic testing as outlined above. Also, the CE should review the admission summary, surgery reports, nursing notes, the discharge summary, autopsy reports, etc.

b. Medical Evaluations. Generally, medical evaluations contain the following types of information:

(1) A description of why the examination is being conducted. The report may state, for example, "Mr. Smith is referred by the Department of Labor and Industries for an independent medical evaluation regarding his claim for asbestosis."

(2) A description of the information the physician has reviewed and relied upon in reaching his or her conclusions. This often includes a discussion of the course of treatment, which describes past treatment undergone by the patient and the physician's recommendation for present and future care.

(3) A description of any examination and tests performed during the evaluation.

(4) Opinions of the evaluating physician with an explanation of evidence used and a discussion of how the conclusions were reached.

c. EEOICP Referrals. DMC, Second Opinion Physician or Referee Specialist reports should contain the same general information as any other medical assessment. In addition, the report should contain a well-reasoned response to any questions presented by the CE in the referral, including a summary of the evidence and medical references used.5. Developing Medical Evidence. Although it is ultimately the responsibility of the claimant to submit medical evidence in support of his or her claim, the CE must assist the claimant to meet the statutory requirement for medical evidence for any illness claimed. This may include seeking clarification from a

5. Developing Medical Evidence. (Continued)

DMC, a second opinion physician or a referee specialist. The CE develops medical evidence to adjudicate a claim, determine percentage of impairment, establish a causal relationship between a covered illness and wage-loss, and resolve inconsistencies and conflicts in medical opinions.

a. Deficient Evidence. When a deficiency in the medical evidence is identified, the CE contacts the claimant or the treating physician to request additional medical evidence.

For example, an initial claim is submitted to the District Office (DO) for skin cancer but does not include a pathology report or any other positive diagnostic evidence. The CE writes to the claimant, identifies the deficiency and requests the specific evidence needed to establish skin cancer under Part B and Part E.

b. Telephone Requests. In many situations, a minor deficiency in the medical evidence can be easily overcome with a telephone call to the physician's office to request specific documents. If, however, a phone call does not produce a favorable result, the CE should send a written request.

(1) Statements made by the physician over the telephone do not constitute valid medical evidence.

(2) If the doctor relays information essential to the outcome of a claim, the CE must document the call in ECMS and request that the physician submit a written statement.

c. Written Requests. The CE may decide that the best method of collecting the evidence is to submit a written inquiry directly to the physician (with a copy to the claimant).

(1) If records are requested from a treating physician, the Form EE-1/EE-2 submitted by the claimant serves as a medical release to obtain the requested medical information.

5. Developing Medical Evidence. (Continued)

(2) If a reply is not received within 30-45 days or the response does not resolve the deficiency, the CE considers other options for obtaining the required medical evidence (e.g., a DMC referral, cancer registry or death certificate).

d. Unavailable Medical Records. If a treating physician's records have been destroyed or are otherwise unavailable, the CE attempts to obtain a statement from that physician.

(1) The Physician's Statement should contain the following information:

(a) An affirmation that the physician treated the employee for the claimed condition(s).

(b) A statement that the requested medical records are no longer available.

(c) A discussion that includes the diagnosis and date of diagnosis.

(d) The physician's signature and the date signed.

(2) A Physician's Statement is considered a medical document and not an affidavit.

6. Weighing Medical Evidence. When medical evidence is submitted from more than one source, the CE must evaluate the relative value, or merit, of each piece of medical evidence. This is particularly important in cases where there is a conflict between the medical evidence received from the DMC and the treating physician. A thorough understanding of how to weigh medical evidence will assist the CE in determining when and how further medical development should be undertaken and assigning weight to the medical evidence received.

a. How to Evaluate Evidence. In evaluating the merits of medical reports, the CE assigns greater value to:

6. Weighing Medical Evidence. (Continued)

- (1) An opinion based on complete factual and medical information over an opinion based on incomplete, subjective or inaccurate information.
- (2) A well-reasoned or well-rationalized opinion over one that is speculative.
- (3) The opinion of an expert in the relevant medical field over the opinion of a general practitioner or an expert in an unrelated field.
 - (a) Medical evidence used to establish a compensable medical condition must be from a physician. The definition of physician includes surgeons, podiatrists, dentists, clinical psychologists, psychiatrists, occupational medicine practitioners, optometrists, and osteopathic practitioners within the scope of their practice as defined by state law.
 - (b) Chiropractors may only be considered physicians in EEOICPA cases for treatment of manual manipulation of the spine to correct a subluxation as demonstrated by x-ray to exist (usually relevant only in consequential injuries).
 - (c) However, chiropractic care may be authorized as treatment for an accepted condition. Any such treatment must be prescribed by a physician, and the physician must provide rationale as to how the type of treatment in question relates to the covered condition.

b. In weighing medical evidence, the CE evaluates the probative value of each piece of the evidence of file and considers the following questions with respect to each report.

- (1) Is there a definitive test? Some conditions can be established by objective testing. A positive pathology report from a physician is sufficient

6. Weighing Medical Evidence. (Continued)

evidence of the diagnosis of cancer. A physician's report of a positive beryllium lymphocyte proliferation test of lung lavage cells showing abnormal findings is sufficient evidence of the diagnosis of beryllium sensitivity.

(2) Is the physician's opinion rationalized? The term "rationalized" means that the statements of the physician are supported by an explanation of how his or her conclusions are reached. This explanation and discussion are what constitutes medical rationale. This is of particular importance when there is a complex medical issue or when there are conflicting medical opinions in the case file.

(3) Is the physician's opinion based upon a complete and accurate medical and factual history? For example, a physician opined that his patient's lung cancer is related to exposure to diesel engine exhaust. This doctor's opinion has less probative value if the doctor erroneously cites an incorrect date of diagnosis or exposure date.

(4) Is the physician a specialist in the appropriate field? The physician's qualifications will have a bearing on the probative value of his or her opinion. For example, if a general practitioner has a patient with rest tremors, balance problems and muscle rigidity, a diagnosis of alcohol abuse with dehydration may seem reasonable. However, if a conflicting report is received from a board-certified neurologist diagnosing Parkinson's disease based on the same symptoms, it would carry greater weight because a neurologist is an expert on neurological disorders. This is particularly true for an illness like Parkinson's disease that cannot be confirmed by an objective laboratory test.

(5) Is the physician's opinion consistent with the findings? A physician's preoperative opinion that a patient has cancer is of little probative value if the pathology report of a tumor biopsy shows no malignancy.

7. Using Death Certificate to Establish Diagnosis. A death certificate signed by a physician may be used to establish a diagnosis of cancer if the following actions have failed to produce viable medical evidence:

a. Claimant Advised. The CE must advise the claimant in writing of the medical evidence necessary to establish a diagnosis of cancer and grant him or her the opportunity to submit all available medical records. This letter must address the specific documents that are missing and explain the specific types of records needed.

b. Additional Medical Development. If the claimant cannot secure medical records, the CE must contact potential sources of medical information, such as doctors' offices, hospitals, clinics, nursing facilities, or laboratories, to determine whether any records exist which could establish a diagnosis. The CE requests, either in writing or by telephone, any medical records and reports that may include a diagnosis (i.e., pathology report, autopsy report, physicians' reports, lab results, medical payments, hospitalization, surgeries, initial examinations, referrals, etc). Any contact with a medical facility must be documented in the case file or ECMS even if the outcome is not positive.

In most cases, a death certificate must be signed by a physician to be accepted as medical evidence. However, if the death certificate lists the name of the physician as the certifier, but is not signed, this is still acceptable if the death certificate is signed by another official attesting to its truthfulness.

Some states have implemented electronic upload of death certificates. A death certificate may be used to establish a diagnosis of cancer if it listed the physician as the certifier along with a license number and an electronic signature.

Nothing in this section should be interpreted as limiting the use of a death certificate for other purposes, such as evidence of the cause of death under Part E.

8. Using Affidavits to Establish Date of Diagnosis. While an affidavit cannot be used to establish a medical diagnosis, it can be used to establish a date of diagnosis after the CE has made a reasonable effort to establish the date of diagnosis from the medical records. CE actions should include the following:

- a. Advice to Claimant. The claimant must be advised in writing that medical evidence (i.e., pathology report, autopsy report, physician's reports) should be submitted to establish a date of diagnosis.
- b. Additional Medical Development. If the claimant and the CE cannot obtain medical evidence to establish the date of diagnosis, the CE must request copies of affidavits from those in a position to know the former worker's condition during the illness. For example, a home health nurse or relative who provided care to the employee may provide an affidavit.
- c. Death Certificate. If reliable affidavits are not received, then the CE may use the date of diagnosis or date of death from the death certificate.
- d. Medical Review. If an affidavit reveals evidence of a medical condition, but no physician's diagnosis is contained in the file, the case may be forwarded to either the DMC or to an outside physician for review and possible confirmation of a diagnosis.

9. Reviews by District Medical Consultant (DMC). A DMC plays a vital role in resolving medical issues by evaluating medical evidence and rendering independent medical opinions. The DMC is crucial in cases where the employee is deceased and the medical records are minimal or inconclusive. Some other examples of DMC services include the following:

- a. Clarification and confirmation of diagnosis if the evidence is inconclusive.
- b. Opinion about consequential injuries or surgical procedures to determine coverage under the Act.
- c. Opinion on the appropriateness of medical treatment.

9. Reviews by District Medical Consultant (DMC). (Continued)

- d. Opinion on causation under Part E from a medical standpoint.
- e. Opinion regarding the onset and period of illness-related disability for a wage-loss claim.
- f. Opinion on impairment if the employee elects to have a DMC perform the rating.
- g. DMC may interpret and clarify other physicians' reports, test results or technical language in complex cases or cases where the attending physician is deceased.

10. Role of CE in DMC Referrals. The CE maintains responsibility for the case and uses the services of the DMC only for direction and clarification. Under Part E, the CE must have fully evaluated toxic exposure including the use of Site Exposure Matrix (SEM) or referral to Industrial Hygienist (IH) prior to DMC referral.

- a. CE determines when a DMC referral is required.

(1) The following are some examples of when a DMC referral may be required:

(a) The CE is unable to conclude whether pre-1993 medical evidence is sufficient to diagnose chronic beryllium disease.

(b) Medical tests are submitted which do not provide clear diagnosis or interpretation (e.g., an LPT that does not clearly state that the test is positive or negative).

(c) It is unclear if a medical condition not shown on the death certificate was a significant factor in causing, contributing to or aggravating an employee's death. For example, an employee dies of a heart condition, but the covered condition claimed by a survivor was asbestosis.

10. Role of CE in DMC Referrals. (Continued)

(d) To determine if the confirmed exposure to a toxic substance is linked to the illness claimed by the employee.

(2) The followings are examples of when a DMC referral may not be necessary:

(a) The CE determines other action, such as requesting additional records from the claimant or treating physician, may be more appropriate. In most cases, a DMC referral is not necessary if the treating physician with the proper expertise provides plausible medical evidence that is well rationalized.

(b) The CE determines that additional evidence relevant to the DMC referral might be available through an Occupational History Interview or Document Acquisition Request. Once the relevant evidence is reviewed, a DMC referral may not be necessary, e.g., when there is no evidence of exposure to a toxic substance.

b. Referral to DMC. When referring a case to a DMC, the CE must provide the following to the Medical Scheduler as a complete package:

(1) A Medical Consultant Referral Form (Exhibit 1). The CE completes the entire form (except the name and address of the DMC, which the Medical Scheduler enters), signs it and places it on the front of the referral package. It is crucial that the CE selects the most appropriate preferred medical specialty to perform the review. The CE considers the following in determining the preferred medical specialty:

(a) Causation questions are usually best handled by occupational medicine specialists. Occupational medical specialists can also evaluate the diagnosis and treatment of occupational lung conditions, i.e. asbestosis, silicosis, CBD, pneumoconiosis, and COPD.

10. Role of CE in DMC Referrals. (Continued)

(b) Diagnosis or treatment questions are usually best handled by medical specialists for the condition or procedure being considered. Selecting generalist/internal medicine/family practice is appropriate if the condition involves a medical specialty not listed on the referral form. For example, heart problem, kidney problem or bone and joint problem should be directed to a generalist.

(c) Impairment questions are best performed by specialists with specific impairment experience for the particular organ system.

(2) A Statement of Accepted Facts (SOAF) (Exhibit 2), which is a narrative summary of the factual findings in a case. It must include:

(a) Identifying information, including the claimant's name, case file number and relevant personal information (e.g., date of birth, date of death, etc).

(b) A description of the medical evidence, including any accepted conditions or other diagnosed medical conditions. Medical information in the case file that is not relevant to the referral need not be reiterated in the SOAF.

(c) A detailed description of the claimant's employment history and exposure data including any relevant information from Site Exposure Matrices (SEM) and opinion from the industrial hygienist (IH) referral.

(i) Where the employee worked, dates of employment, and his or her job title and duties if relevant to the referral.

10. Role of CE in DMC Referrals. (Continued)

(ii) Any exposure of the employee to toxic substances that are linked to the claimed medical condition.

(iii) Information about the nature, extent and duration of exposure.

(iv) Job descriptions or industrial hygiene records, if available. If not, data from the United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, found on the internet at: <http://www.bls.gov/search/ooH.asp?ct=OOH>

For example, using this site the CE might state, "The DOL Bureau of Labor Statistics has found that the job of *Boilermakers and boilermaker mechanics* is to make, install, and repair boilers, vats, and other large vessels that hold liquids and gases. Boilers supply steam to drive huge turbines in electric power plants and to provide heat and power in buildings, factories, and ships."

(d) General Requirements for SOAF:

(i) All evidence on which the SOAF is based must be part of the case record. The CE may not make findings based on undocumented evidence.

(ii) Facts must be complete and correctly stated. Omission of a critical fact or incorrect statement diminishes the validity of a medical opinion.

(iii) Facts must be specific as to time of occurrence. Whenever possible, workplace factors should be quantified so the physician can correlate the exposure with medical or scientific data on causality.

10. Role of CE in DMC Referrals. (Continued)

Quantification might include levels of exposure, concentrations of asbestos fibers in the air, levels of noxious substances, the (approximate) number of times exposed, etc. Terms such as light, heavy, undue, severe, and abnormal should be avoided, since they are subject to great differences of interpretation.

(iv) Facts must be clearly stated. Simple words and direct statements reduce the potential for ambiguity or misinterpretation. Use of legal terms and program jargon should be avoided.

(v) Facts must be presented in an orderly manner, and grouped chronologically within sections relating to employment, exposures, and medical conditions.

(3) List of Questions for the DMC to address. (See Exhibit #3 for example)

(a) For referrals under Part B, questions should be specific to each statutory requirement for any of the compensable occupational illnesses.

(b) The CE must limit the questions to those that address the particular issue or problem for which clarification is required. Questions must be specific.

For example, in a pre-1993 CBD claim, a general question is, "Based upon your review of the enclosed medical evidence, do you feel that the claimant had CBD?" A specific question is, "Does the x-ray show characteristic abnormalities consistent with CBD?"

(c) For referrals under Part E, questions should identify the standard of proof required.

10. Role of CE in DMC Referrals. (Continued)

For example, rather than ask "Was asbestosis a cause of death?" the CE asks, "Is it at least as likely as not that asbestosis was a significant factor in causing, contributing to or aggravating the employee's death?"

(d) The CE is not to rely upon the DMC for any non-medical issues, for example requesting legal conclusions (e.g., whether the employee has cancer as defined by the EEOICPA).

(4) A Form OWCP-1500 (Health Insurance Claim Form), completed as outlined:

The CE or Medical Scheduler initially completes the following portions of Form OWCP-1500: Employee's name, address, date of birth, sex and SSN. (If the employee is deceased, the address section does not need to be completed). Section 24C (type of service) and 24E (diagnosis code) must both be completed with a "1." The CE or Medical Scheduler must also enter an ICD-9 code in section 21 and a procedure code in section 24D. Exhibit 4 provides a list of ICD-9 codes and procedure codes that correspond to the type of medical service requested. For example, if the OWCP-1500 is for payment of a DMC file review for impairment, the CE enters ICD-9 code V49.8 in section 21 and procedure code FR004 in section 24D.

The DMC completes sections 24 A, F, G; 25; 28; 30; 31 and 33 and signs the bill. The completed form is given to the Medical Scheduler.

c. Post Referral to DMC. The Medical Scheduler advises the CE via email that the case has been sent to the DMC. The CE continues to monitor and track the file after the request has been sent to the DMC.

10. Role of CE in DMC Referrals. (Continued)

(1) If the DMC identifies exposure issues that require further development before he or she can render a medical opinion, the DMC must contact the Medical Scheduler within 7 days of receipt of the referral package. The Medical Scheduler advises the CE and the CE supervisor.

The CE and the supervisor evaluates the exposure issue as noted by the DMC to determine if the CE can pursue further exposure development or if an IH referral is warranted.

After development, the Medical Scheduler submits the IH report or additional exposure information to the same DMC to proceed with the medical evaluation. Once the issue has been resolved, the DMC has 21 days to return a completed report accompanied by a bill to the Medical Scheduler. If the DMC has further questions or is unable to proceed with rendering a medical opinion, the DMC must contact the Medical Scheduler.

(2) If the CE does not receive the medical report from the DMC within 30 days from the date of the completed referral, the CE notifies the Medical Scheduler, who follows up with a phone call to the DMC.

(3) Once the medical report and completed OWCP-1500 is received from the DMC, the CE reviews it for accuracy and completeness. The review should include the DMC's interpretation of test results, evaluation of medical reports submitted for review, answers to each question posed, and the DMC's rationale showing how his or her opinion is supported by the evidence in the file. The CE also reviews the OWCP-1500 to ensure that fees charged are appropriate to the services performed. The basic fee for file review and narrative medical report is \$300 per hour. DEEOIC has established \$2,400 as limits for a file review. If a bill for medical file review is over \$2,400, the CE must advise the District Director.

10. Role of CE in DMC Referrals. (Continued)

(a) If the medical report and OWCP-1500 are accurate, appropriate and complete, the CE contacts the Medical Scheduler to authorize payment of the medical bill no later than the next business day.

(b) If the report and OWCP-1500 are not accurate, appropriate or complete, the CE determines whether a telephone call to the DMC can resolve the deficiency. If not, the CE notifies the Medical Scheduler by memo or email, indicating the discrepancies or deficiencies. If necessary, the Medical Scheduler notifies the DMC and requests an addendum report and/or clarification of the fees charged.

d. ECMS. To ensure prompt payment of all physician referral bills (i.e. DMC, second opinion, referee or expert medical bills), ECMS must also be updated to set up the "prior approval" process through the medical bill processing agent (BPA). The CE enters the prior approval as if entering a new medical condition. The following fields in ECMS are required:

(1) Condition Type - Select 'PA', for prior approval

(2) ICD-9 Code - Enter the ICD-9 code that corresponds to the type of medical bill to be paid. The ICD-9 code entered in ECMS must match the ICD-9 code in the OWCP-1500 as specified in paragraph 10b(4). See Exhibit 4 for a list of ICD-9 codes.

(3) Status Effective Date - Enter the date of the physical examination or the date of referral for file review.

(4) Eligibility End Date - Enter the date of the physical examination for second/referee/expert opinions, or the date the DMC's response.

(5) Medical Condition Status - Change the medical condition status to 'A'.

10. Role of CE in DMC Referrals. (Continued)

e. Request for Report. If the claimant requests a copy of the DMC's report, the CE provides a copy of the report with a cover letter, which includes a disclaimer paragraph. For example, "Attached is a copy of the medical report that you requested. Please be advised that {Enter the DMC's name} is a medical consultant for the Department of Labor. The Department of Labor will make the final decision in this claim. Please do not contact {Enter the DMC's name} regarding this report. If you have additional evidence to submit in support of your claim or if you have any questions or concerns regarding this report, please contact me at {Enter the DO's toll free number}.

f. Advises the District Director or designee, through a CE or supervisor, of any problems with regards to the timeliness or quality of the DMC reports or complaints from the claimant.

11. Role of Medical Scheduler in DMC Referrals. Each District Director designates a Medical Scheduler, who processes and tracks DMC referrals and ensures prompt payment of the bills. The following are the Medical Scheduler actions:

a. Returns any incomplete DMC package to the CE with a memo in the front of the file listing the information needed.

b. If the DMC package is complete, emails designated National Office staff person on all referrals to an outside DMC. This email includes the employee's name, file number and the preferred DMC medical specialty requested. To ensure equitable distribution of work among the DMCs, the designated National Office staff person chooses a DMC from a master list and emails the Medical Scheduler the name of the assigned DMC, mailing address, phone number and email address.

c. Compares the list of treating physicians shown on the Consultant Referral Form to the assigned DMC from the National Office. If a DMC has been involved in the treatment of the claimant or if the DMC is not available

11. Role of Medical Scheduler in DMC Referrals. (Continued)

to perform the review, the Medical Scheduler requests another DMC from the National Office.

d. Prepares a cover letter to the DMC after ensuring availability. The cover letter includes a description of the billing specifications (Exhibit 5). If the package does not contain a Form OWCP-1500, the Medical Scheduler completes one as outlined above.

e. Sends a copy of the cover letter, Medical Consultant Referral form, SOAF, List of Questions, medical records and OWCP-1500 to the DMC, and retains a copy of the cover letter and Medical Consultant Referral form outside the case file for tracking purposes.

If referral is to an internal DMC, the cover letter, Medical Consultant Referral form and copies of medical records need not be provided to the DMC. Rather, the entire file can be routed to the internal DMC, who can respond to the list of questions submitted based on review of the original SOAF and records contained in the case file.

(1) Includes an express mail envelope and air bill so that the external DMC can return the completed report and bill to the proper DO.

f. Notifies the CE via email once the package is mailed to the external DMC or the file is forwarded to an internal DMC.

g. Maintains a copy of the Form OWCP-1500 along with a copy of the medical report in a separate folder when the DMC responds within 30 days. The original medical report and OWCP-1500 are forwarded to the CE for review and inclusion in the case file.

h. Requests an addendum report if the CE cannot resolve deficiencies in the DMC report directly with the DMC. The second request to the DMC for an addendum report must include:

11. Role of Medical Scheduler in DMC Referrals. (Continued)

- (1) A cover letter to the DMC indicating the discrepancies as written by the CE.
- (2) Copies of all medical evidence (or the case file for internal DMC referrals).
- (3) The SOAF.
 - i. Submits approved OWCP-1500 and a copy of the DMC report to the BPA for processing upon confirmation by the CE that the DMC report and OWCP-1500 are complete and accurate. To ensure prompt payment of the medical bill, the Medical Scheduler or Fiscal Officer writes "Approved" in the top right hand corner of the OWCP-1500 with a signature and date in black ink. The OWCP-1500 must also be stamped PROMPT PAY in black ink, and the Prompt Pay date (date received in the DO plus 7 days) must be entered in block 11. The Medical Scheduler destroys the DMC report and OWCP-1500 once BPA has paid the bill.
 - j. Serves as the liaison between the DMC and DEEOIC claim staff. For example, if the DMC is unable to proceed with the medical review for any reason, (e.g., need for an IH referral, SOAF is incomplete, etc.), the DMC discusses the issue with the Medical Scheduler. The Medical Scheduler notifies the CE or the supervisor.
 - k. Notifies the District Director or assigned National Office staff person of any problems dealing with the DMC or a staff member of the DMC.

12. Second Opinion Examinations. Section 30.410 of the EEOICPA regulations states that:

OWCP sometimes needs a second opinion from a medical specialist. The employee must submit to examination by a qualified physician who conforms to the standards regarding conflicts of interest adopted by OWCP as often and at such times and places as OWCP considers reasonably necessary.

12. Second Opinion Examinations. (Continued)

To prevent conflicts of interest, a DMC cannot serve as a second opinion physician. The databases for DMCs and second opinion physicians are separate and distinct.

a. Role of the CE.

(1) Determines when a second opinion is necessary and indicates the specialty of the second opinion physician required and, if necessary, the time period within which the examination is to take place.

(2) Ensures that all necessary medical information is sent to the Medical Scheduler. The same procedure for a referral to a DMC (see paragraph 10 above) including providing paperwork (Medical Consultant Referral Form, SOAF, OWCP-1500, etc.) and prompt payment of second opinion medical bills will be followed. The exception is that the Medical Scheduler must call the second opinion physician to schedule a timely appointment. In addition, section 21 of the OWCP-1500 must be entered with ICD-9 code V68.2 and section 24D must be entered with the procedure code SEP01 for second opinion file review only or SEP02 for second opinion file review requiring physical examination (See Exhibit 4).

(3) Prepares a letter to the physician that lists the questions that he or she must specifically address. The CE must limit the questions to only those that address the particular issue or problem for which clarification is required.

(4) Calls the physician's office to ensure that the claimant has attended the appointment.

(5) Makes all required entries in ECMS for activities related to second opinion referrals (See paragraph 10d).

(6) Advises the District Director or designee, through a CE or supervisor, of any problems with regards to the timeliness or quality of the medical reports or complaints from the claimant.

12. Second Opinion Examinations. (Continued)b. Role of the Medical Scheduler.

(1) Follows the same procedure for a referral to a DMC (see paragraph 11 above) for completing and providing paperwork including prompt payment of second opinion medical bills.

(2) Schedules the second opinion medical appointment in accordance with the CE's request.

(a) The Medical Scheduler must make the appointment within a reasonable amount of time after initially requested by the CE.

(b) If the CE indicates a certain period within which the examination is required, the Medical Scheduler contacts the physician to see if the deadline can be accommodated. If not, another physician is selected, if possible.

(3) Selects the physician through the ACS web portal <http://owcpstaff.dol.acs-inc.com> under Provider Search link.

(a) To allow for the rotation of physicians used for second opinions, the DO must develop and maintain an internal tracking system (e.g., a spreadsheet) that the Medical Scheduler can use to identify when a particular physician last provided a second opinion. It should be possible to add contact information as well.

If a physician subsequently states that he or she no longer wishes to be involved in the program, this information must be added to the system so the Medical Scheduler knows not to contact that physician.

(b) For jurisdictions that have small numbers of available physicians, it may be necessary to use the same second opinion physician on a more regular basis. This is acceptable as long as the

12. Second Opinion Examinations. (Continued)

physician has not been involved with any medical examinations of the claimant.

(4) Arranges for the examination within a reasonable distance from the residence of the employee, if possible. Unless unusual circumstances exist, the examination must be scheduled within 100 miles of the employee's residence. A distance of 25 miles or less is preferable. If extended travel is required, the arrangements and reimbursement are handled on a case by case basis.

(5) Ensures that the physician is enrolled in the EEOICPA program. A DEEOIC provider number is required before the physician can be paid. If the physician does not have a DEEOIC provider number, the Medical Scheduler must include a copy of the Provider Enrollment Form OWCP-1168 and the complete provider package with the letter sent to the physician. After the completed form is returned, the Medical Scheduler forwards it to the BPA, which provides the Medical Scheduler with a DEEOIC provider number for the physician.

(6) Contacts the physician to make sure he or she is willing to accept the employee for evaluation and schedules an appointment.

(7) Notifies the claimant, in writing, of the second opinion examination. The claimant must be notified at least 30 days prior to the scheduled appointment.

(8) Forwards the Form OWCP-1500, cover letter describing the billing specifications (Exhibit 6), list of questions for the second opinion physician to address, SOAF and any medical documentation.

(9) Enters a call-up for the CE in ECMS for the date of the appointment so the CE can call the physician to determine if the employee attended the appointment.

c. Role of the District Director/Designee.

12. Second Opinion Examinations. (Continued)

- (1) Evaluates complaints about specific physicians.
- (2) Evaluates and reviews medical evaluations \$2,400 or higher.
- (3) Evaluates problems with the quality and timeliness of the physician's reports.
- (4) Determines whether a physician should be removed or added to the pool of physicians to be considered for future examinations.

13. Referee Specialist Examinations. The same referral procedures are followed as a second opinion examination. However, section 21 of the OWCP-1500 must be entered with ICD-9 code V65.8 and section 24D must be entered with procedure code REF01 for referee referrals requiring only a file review or REFER for referee referrals requiring also a physical examination.

a. Regulatory Authority. Section 30.411(b) of EEOICPA states that:

If a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser or consultant, or a qualified physician submitting an impairment evaluation; the OWCP shall appoint a third physician qualified in the appropriate specialty who conforms to the standards regarding conflicts of interest adopted by OWCP to make an examination. This is called a referee examination.

In most instances, careful weighing of the medical evidence should allow for resolution of the issues without having to resort to a referee or "impartial" specialist. However, where the weight of medical evidence is divided equally between the opinion of the treating doctor and that of the second opinion physician, a referee opinion must be obtained.

13. Referee Specialist Examinations. (Continued)

b. Value of Report. The probative value of the referee specialist's report, if sufficiently rationalized, is granted special weight. Usually, the opinion of a referee specialist constitutes the greater weight of the medical evidence of record.

c. Factors to Consider. The CE/Medical Scheduler should consider the following points with respect to referee medical examinations:

(1) A conflict of medical opinion must actually exist as determined by weighing the medical evidence. The CE must decide the relative value of opposing opinions in the medical record by considering all factors, to include each physician's specialty and qualifications, completeness and comprehensiveness of evaluations and rationale, and consistency of opinions.

(2) The questions to the referee medical examiner must be case-specific. Since this examination is made to resolve a particular conflict, the CE must ensure that the questions to the physician are sufficiently detailed and narrow to resolve the conflict.

(3) The referee specialist's report, once received, must fulfill its intended purpose, i.e., it must resolve the conflict in medical opinion. Therefore, the CE must ensure that the referee specialist's report is comprehensive, clear and definite; that it is based on accurate information; and that it is supported by sound and substantial medical reasoning.

If the report is vague, speculative, or incomplete, or it does not contain sufficient rationale to justify the conclusion reached, it is the responsibility of the CE to secure a supplemental report from the referee specialist to correct the defect.

(4) If the referee specialist is unable or unwilling to provide a supplemental report, or if the supplemental report is still incomplete, vague, speculative or unjustified, the Medical Scheduler

13. Referee Specialist Examinations. (Continued)

arranges for a second referee evaluation. This measure is undertaken with care, since a premature or inappropriate second referee examination would defeat the intent of Section 30.411 and could lead to a suspicion that OWCP is "shopping" for a physician whose opinions it prefers.

14. Failure to Undergo Medical Examination. Under the following circumstances, the adjudication process may be suspended for failure to undergo a medical examination.

a. Follow-up Action. If the employee is to be examined as part of a second opinion or referee examination, the CE contacts the physician's office on the date of the examination to confirm the employee kept his or her appointment. If the employee was examined, the CE should expect a report within 30 days. This guideline also applies if a case is referred for a file review.

b. Failure to Appear. If the physician's office reports that the employee did not appear for his or her scheduled appointment, the employee and any representative should be contacted by a documented phone call or in writing to request an explanation. If a reasonable explanation is provided, the CE re-schedules the examination, through the Medical Scheduler and sends written confirmation of the date, time and location of the rescheduled examination to the employee and representative, if any.

If the employee does not respond to the CE's request for an explanation or if an explanation is provided and the CE determines good cause is not established, or if the employee fails to appear for the re-scheduled examination without good cause, the CE issues a letter advising the employee and representative that the issue to be resolved (i.e., adjudication of a consequential injury, request for surgery, medical supply, etc.) cannot be further adjudicated until the medical examination is completed.

14. Failure to Undergo Medical Examination. (Continued)

The CE suspends any further action to adjudicate the outstanding issue until the employee agrees to undergo a medical examination. This suspension does not affect the employee's entitlement to ongoing benefits for other medical conditions and/or treatments which have been accepted in the case.

Superseded

Part 2 - Claims

Medical Consultant Referral Form

Employee: Employee's name File Number: File number

I. Purpose of Referral (check one or more):

- | | |
|--|--|
| <input type="checkbox"/> Impairment Rating | <input type="checkbox"/> Diagnostic Clarification |
| <input type="checkbox"/> Part B CBD/Silicosis Review | <input type="checkbox"/> Incapable of Self Support |
| <input type="checkbox"/> Part E CBD | <input type="checkbox"/> Wage Loss |
| <input type="checkbox"/> Causation | <input type="checkbox"/> Other: _____ |

II. Preferred Medical Specialty (check one or more):

- | | | |
|--|--|--|
| <input type="checkbox"/> Aerospace Medicine | <input type="checkbox"/> Hematology | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Anesthesiology | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pulmonary |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Neurology | <input type="checkbox"/> Rehabilitation Medicine |
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> Obstetrics-Gynecology | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Forensic Medicine | <input type="checkbox"/> Occupational Medicine | <input type="checkbox"/> Toxicology |
| <input type="checkbox"/> General Preventive Medicine | <input type="checkbox"/> Oncology | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Pain Medicine | |

III. Requested Impairment Evaluation (check one, if more than one organ system evaluation needed check Whole Body)

- | | | |
|--|--|---|
| <input type="checkbox"/> Cardiovascular (Heart/Blood Vessel) | <input type="checkbox"/> Hematopoietic (Blood) | <input type="checkbox"/> Pulmonary (Lung) |
| <input type="checkbox"/> Digestive Tract | <input type="checkbox"/> Mental/Behavioral | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Ear, Nose, Throat (ENT) | <input type="checkbox"/> Musculoskeletal | <input type="checkbox"/> Urinary/Reproductive |
| <input type="checkbox"/> Endocrine | <input type="checkbox"/> Neurology (Nervous) | <input type="checkbox"/> Whole Body |
| <input type="checkbox"/> Eye | <input type="checkbox"/> Pain | <input type="checkbox"/> Other: _____ |

IV. The following physicians have been involved with this case:

- | | |
|----------------------------|----------------------------|
| 1. <u>Physician's name</u> | 5. <u>Physician's name</u> |
| 2. <u>Physician's name</u> | 6. <u>Physician's name</u> |
| 3. <u>Physician's name</u> | 7. <u>Physician's name</u> |
| 4. <u>Physician's name</u> | |

V. Medical Condition/s Claimed: Medical condition claimed, Medical condition claimed, Medical condition claimed, Medical condition claimed.

Attachments:

- Statement of Accepted Facts (SOAF) with questions for resolution
- Copies of medical reports
- X-rays
- Other (specify): _____

_____	_____
(Printed Name)	(Title)
_____	_____
(Signature)	(Date)

Statement of Accepted Facts (SOAF)

Employee: Employee's name

File Number: File number

Date of Birth: Employee Date of Birth

Date of Death: Employee's Date of Death

Medical Information:

Employment Information:

Other:

Claims Examiner

Claims Examiner

(Printed Name)

Date

(Signature)

(Date)

Questions:

CE: Choose from options below or add your own:

1. **Impairment** Please provide a whole body impairment rating for the accepted conditions listed above in accordance with the 5th edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides)* with specific page and table references included in your report. Please provide the rationale and objective findings to support your conclusions.
2. **Impairment** If it is not possible to complete an impairment rating based on the medical evidence we provided, please advise us what medical records and/or testing is required to complete the rating.
3. **Diagnosis** In your opinion, do the medical records support a diagnosis of **medical condition**? If so, please provide the first date of diagnosis, diagnosis, and the ICD-9 code.
4. **Causation** If **medical condition** was diagnosed, in your opinion is it at least as likely as not that exposure to toxic substances during the course of employment at **covered facility** was a significant factor in aggravating, contributing to, or causing the employee's **medical condition**?
5. **Causation** Does the employee's work history and exposure potential make it at least as likely as not that the exposure to the toxic substances was a significant factor in causing, contributing to or aggravating the employee's **medical condition**?
6. **Causation** If so, please provide the earliest date of diagnosis(es) and ICD-9 code of the condition you believe is related. Please provide the rationale and objective findings to support your conclusion that the condition(s) are related to the work exposure.

Claims Examiner

Claims Examiner

(Printed Name)

Date

(Signature)

(Date)

ICD-9 CODES AND CORRESPONDING PROCEDURE CODES

ICD-9 Code	V49.8	DMC File Review
Procedure Codes	FR001	Causation file review completed by DMC
	FR002	Supplement file review completed by DMC (i.e. Causation, Impairment, Diagnosis Clarification, Wage Loss)
	FR003	Diagnosis clarification file review completed by DMC
	FR004	Impairment rating file review completed by DMC
ICD-9 Code	V70.9	Impairment Rating by Non DMC (Includes physical exam)
Procedure Code	PE001	File review including physical exam (Non DMC)
ICD-9 Code	V68.89	Wage Loss
Procedure Code	WL001	File review completed by DMC
ICD-9 Code	V68.2	Second Opinion
Procedure Codes	SEP01	File review only
	SEP02	File review including physical exam
ICD-9 Code	V68.2	Expert Referral
Procedure Codes	CNSLT	File review only
	CNSL1	File review including physical exam
ICD-9 Code	V65.8	Referee Referral
Procedure Codes	REF01	File review only
	REFER	File review including physical exam
ICD-9 Code	V68.81	Medical Records Fees
Procedure Code	MR001	Payment for medical records

Sample Letter to District Medical Consultant

Dear Dr. :

I want to thank you for agreeing to provide your medical opinion on this case in your capacity as a district medical consultant (DMC) for the Energy Employees Occupational Illness Compensation Program (EEOICP).

Please refer to the DMC Handbook and related EEOICP policies and procedures that govern all aspects of DMC's standard operation procedures.

Please review the medical reports and test results of record, the Statement of Accepted Facts prepared by this office and any other pertinent information and answer fully each question posed by the submitting Claims Examiner. All medical opinions must contain detailed supporting rationale based on actual findings and accepted medical literature. Unsupported conjecture and speculative judgments cannot be accepted. [If the issue is degree of permanent impairment of the whole body, please fully show how the percentage of impairment is derived in accordance with the AMA Guides to the Evaluation of Permanent Impairment (Guides). This should include references to specific pages and tables in the Guides and you should indicate whether the employee has reached maximum medical improvement.]

If the referral is inappropriate, please contact me and return all the case material. Some examples of inappropriate referral would include a referral in which you have a conflict of interest, or questions posed that are not within your area of qualified clinical expertise, [or you are not a qualified expert in the area of impairment ratings in an impairment referral,] or you cannot perform the evaluation within the time limitations, or you do not understand or agree with the basis or implications of "accepted conditions" or the Statement of Accepted Facts.

Billing: After completing your review, submit your report along with the attached OWCP-1500 to our office for review. The OWCP-1500 must be signed and dated with DOL Provider Number and Federal Tax ID Number annotated in block # 25 and # 33. A FEDEX envelope and pre-paid air bill are enclosed for your convenience. If this form is not used, we may have difficulty

identifying your bill and reimbursement may be delayed.

Note: The bills for your services cannot be approved until you fully answer the questions and you provide detailed supporting rationale for your opinion.

Fees: The basic fee for review of the file and narrative medical report is \$300 per hour. Please note that the program has established 8 hours and \$2,400 as limits for a DMC case review with the understanding that most reviews are completed in 1-3 hours. However, the program also recognizes that the review of a particularly complex case may require additional time and effort. In such a case, please annotate your report with justification as to why additional time and/or research were required to answer the questions. Charges exceeding these amounts are closely reviewed by the District Director who may approve or deny any additional amount based on the degree of complexity of the case, the comprehensiveness of the report, or the extent of appropriate and necessary research performed.

Security of Files: Confidentiality concerns are addressed in the DMC Handbook and related program policies and procedures. DEEOIC files and related materials are to be treated in a confidential manner. Files and related material must not be reproduced for any reason. When not in actual use, files and related material must be kept in secure storage under lock and key accessible only to those individuals providing services under this agreement. These files and related material remain the property of the U.S. Department of Labor. Please destroy the case materials once your report is accepted. As per the privacy policy, no information containing personally identifiable information (PII) may be sent by email from non-Federal government email servers. Information containing PII should be faxed using a "Medical Confidential" cover page. For more information on privacy and email transactions, please review <http://esa/owcp/Bulletin/OWCPBULLETIN08-2.pdf>.

Please make every effort to submit your report within 15 calendar days of receipt of this package. If you feel that your report will be late, please contact me immediately. Your report and the OWCP-1500 are to be sent to the following address:

Division of Energy Employees Occupational Illness Compensation
Attn: XXX; Medical Scheduler
(Address of DO)

Before mailing, please use the DMC checklist, found in the DMC Handbook, to make sure that you have complied with the requirements of the program.

Again, we appreciate your cooperation and wish to thank you for your assistance in this matter. If you have any questions or concerns regarding this referral, please contact me at: XXX-XXX-XXXX.

Sincerely,

Medical Scheduler

Enc: Medical File
Statement of Accepted Facts (SOAF)
Questions
OWCP - 1500
FEDEX Envelope

Sample Letter to Second Opinion/Referee Physician

Dear Dr. Name:

Arrangements have been made with your office for the above named claimant to undergo an independent medical assessment on {Date} at {Time}.

The purpose of the examination is to assess this employee's medical condition with respect to the stated condition(s) in the claim. Enclosed is a copy of the pertinent medical evidence from the case file; a Statement of Accepted Facts, which presents a broad history of the case; and a list of questions to be addressed. You are advised to review this information prior to the examination to garner an understanding of the case context.

[NOTE: This sentence can be used if required - The patient has been instructed to bring with them **{Identify specific medical information}**. However, you are authorized to refer the employee for any non-invasive diagnostic testing which you feel is required to address the questions raised by the District Office. The provider of such services must submit billing directly to the address listed above for payment. The above listed case file number must appear on any billing submitted.

As long as your report contains the necessary information, you are ensured payment by the Office of Workers' Compensation Program (OWCP) for services rendered. Enclosed in this package is a Form OWCP-1500 with appropriate authorization codes. This form must be used to bill for your service. If you have any difficulties completing the form, please contact me. Please be aware that payment cannot be processed until a report is received which addresses the particular questions being raised.

Please note that you must not release your report to the claimant or representative, but should instead refer any request for it to the Department of Labor Claims Examiner.

Also, please note that the rescheduling of an examination cannot be done without the authorization of the DOL's District Office.

If there are any questions or concerns, please contact me directly at the District Office at XXX-XXX-XXXX. You may fax the report with the completed billing form attached to XXX-XXX-XXXX.

Sincerely,

Medical Scheduler

Superseded

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Chapter 2-900 Eligibility Criteria for Cancer and Radiation

Exhibits

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1. Purpose and Scope. This chapter discusses the procedures for determining whether an employee has been diagnosed with a covered cancer and the procedures for establishing causation as a result of exposure to radiation.

2. Identifying a Claim for Cancer. The Claims Examiner (CE) must first identify whether the claim is being made for cancer. If Form EE-1 or Form EE-2 is marked for a cancer, then a cancer claim is established. The claimant is expected to identify the specific type of diagnosed cancer on the claim form.

3. Covered Cancers. Energy Employees Occupational Illness Compensation Program Act (EEOICPA) regulations states that to establish a diagnosis of cancer, medical evidence must be presented which sets forth the diagnosis and the date of the diagnosis. The CE must verify that sufficient medical evidence is submitted to substantiate a diagnosis of cancer.

a. Diagnosis of Cancer. The case record must include medical report from a qualified physician that lists a cancer diagnosis. The cancer diagnosis must be based on the following evidence:

(1) Tissue examination is the most conclusive method for making a cancer diagnosis as it provides the physician with the following vital information regarding the tumor or lesion:

(a) The tissue of origin (where the tumor or lesion originated); and

(b) The benign, uncertain, or malignant status. Only malignant (cancerous) tumors/lesions are addressed in this chapter.

(2) Tissue examinations are described by the following methods:

(a) Pathology report (tissue has been removed from site);

(b) Surgical pathology report (organ, tumor, or lesion has been surgically removed);

(c) Autopsy report; or

3. Covered Cancers. (Continued)

(d) Post-mortem examination report.

(3) A diagnosis can sometimes be made based on one or more of the following methods which are listed in order of preference. If the CE is unable to determine an affirmative diagnosis based on the medical evidence submitted, the case may be referred to a District Medical Consultant (DMC).

(a) Cytology report describes cells obtained by scraping (e.g., from bone marrow), or by washing (e.g., fluid from lungs). An examination conducted by one of these cytology methods is generally less conclusive than tissue examination because the organization and extent of the tumor may not be as apparent. A positive cytology report would be a basis for further tests.

(b) Imaging (e.g., X-ray, CAT Scan, MRI) are the least specific type of tests in the diagnosis of cancer. Generally, X-rays are used as a basis for further tests. Radiology tests are extremely beneficial in determining the spread of cancer and/or determining the effects of cancer treatments.

(4) If the employee is deceased and none of the tests listed above were done, a survivor's claim will likely be based on official documents. In this situation the CE must attempt to obtain the documents listed below. Referral to a DMC should be made only if the CE is unable to determine an affirmative diagnosis.

(a) Hospital admission/discharge reports or physician's reports describing the tumor;

(b) Hospice records;

(c) If all efforts to obtain additional documents fail, a death certificate signed by a physician may be used to establish a cancer diagnosis. However, a death certificate alone should be used only as a last resort.

3. Covered Cancers. (Continued)b. Diagnosis of Multiple Primary Cancers.

(1) If more than one primary cancer is identified in the medical evidence in the same organ with the same diagnosis date and the cancers are classified as the same type of cancer, all of the identified cancers are to be considered as only one primary cancer.

For example, if three biopsies are taken from the left breast on the same date and all are listed as infiltrating ductal carcinomas, the biopsies are to be considered as indicating only one primary cancer of the left breast.

However, if biopsies taken from the left breast on the same date indicate a lobular carcinoma and an infiltrating ductal carcinoma, these cancers are considered as two primary cancers, since the cancer types are different.

If a physician clearly notes that there are two (or more) separate primary cancers, the physician's interpretation prevails whether or not a pathology report confirms multiple primary cancers.

(2) The above guidance applies only to multiple primary cancers of the same type in an organ. Situations involving bilateral organs are more complicated. Bilateral organs include the lungs, kidneys, adrenals, ovaries, and testes.

Biopsies taken from the left and right lungs might indicate the same type of cancer, e.g., non-small cell adenocarcinoma, in the right and left lungs. While one cancer may actually be metastatic from the other lung, without any indication in the pathology report or other medical evidence, it would be impossible to determine whether these two adenocarcinomas are two primary cancers or just one cancer.

3. Covered Cancers. (Continued)

Cases involving primary cancers identified in bilateral organs and classified as the same type of cancer should be referred to an oncologist DMC for review.

If biopsies identify two different cancers, e.g., a non-small cell adenocarcinoma in the right lung and an oat cell carcinoma in the left lung, these two carcinomas should be considered as separate primary cancers.

c. Date of Diagnosis. The date of initial diagnosis is required in any claim for cancer. The date of diagnosis is also a critical element used in the Interactive Radio-Epidemiological Program (IREP) for calculating the probability of causation (PoC). The employee's occupational exposure to radiation must be before the initial date of diagnosis for cancer in order for it to be compensable under Part B. While the date of diagnosis may be noted on Form EE-1 or Form EE-2, the CE must independently review all of the medical evidence submitted in a claim package to determine the earliest date of cancer diagnosis.

(1) When using a pathology report to determine the date of diagnosis, the date that the tissue is obtained should be used as the date of diagnosis. The pathology report must be signed by a physician.

(2) In certain claim situations, the CE will have to use reasonable discretion in the type of evidence that will be used to accept the date of diagnosis. For example, if the employee is deceased, and the only documentation available to support the diagnosis of cancer is the employee's death certificate signed by a physician, the CE may accept affidavits from survivor(s) and/or other individuals to establish that the cancer was diagnosed subsequent to the employee's initial exposure to radiation.

3. Covered Cancers. (Continued)

For example, a home health nurse might indicate in an affidavit his or her knowledge that on a specified date, a physician made a diagnosis of the employee's condition, as well as the circumstances under which he or she acquired such knowledge. However, affidavits may *not* be used to establish the medical diagnosis itself, only the date of diagnosis.

d. Deficiency in Medical Evidence. The CE must advise the claimant of any deficiency in medical evidence and allow the claimant a period of up to 60 days to submit additional medical evidence.

4. Pre-Cancerous and Non-Malignant Conditions. With the types of diagnostic methods described above, some conditions, which could develop into cancer if left untreated, are being diagnosed and treated in the very early stages of development. If the medical evidence provided by the claimant establishes a diagnosis which demonstrates the condition is in a pre-cancerous stage of development or is non-malignant, the condition is not covered under this chapter and would not be covered under Part B. However, the CE may still need to develop for benefits under Part E for causal relationship between the pre-cancerous conditions or non-malignant conditions and toxic exposure.

5. Specified Cancers. Members of the Special Exposure Cohort (SEC) who are diagnosed with any of the 22 specified cancers are eligible for benefits without the need for a dose reconstruction. Eligible members of a SEC class have a presumption that the diagnosed specified cancer was caused by eligible SEC employment.

Meeting the criteria of the SEC does not guarantee survivor compensation under Part E. Under Part E, the evidence must also establish that the covered cancer caused, contributed to, or aggravated the death of the employee.

6. Non-SEC Cancers. Any primary cancer that cannot be considered as a specified cancer for a SEC claim is considered a non-SEC cancer. A primary cancer incurred by an employee at a non-SEC site is also considered a non-SEC cancer. In some cases, a cancer is identified by its secondary site because the primary site is unknown. In these cases, the primary site must be established by inference (see paragraph 17e). If the primary site that was established by inference is not considered a specified cancer, it is also considered a non-SEC cancer.

7. Non-SEC Cancer and Dose Reconstruction. Once the CE has determined that the employee has a diagnosed non-SEC cancer (other than chronic lymphocytic leukemia (CLL)) and covered employment, the claim must be referred to the National Institute for Occupational Safety and Health (NIOSH) for a dose reconstruction to determine the PoC between the diagnosed non-SEC cancer and the dose potentially received during the covered employment. If CLL is the only diagnosed cancer, the CE does not send the case to NIOSH because NIOSH has identified CLL as a non-radiogenic cancer. However, the CE must still develop CLL for toxic substance exposure if there is a claim under Part E. Refer to paragraph 17i for further handling.

a. Claimant Not SEC Member. When a claim is filed based on SEC membership but the employee is not a SEC member (i.e. the employment was outside the designated SEC time period or the employee did not work the necessary workdays at the SEC site), the CE must forward the claim to NIOSH for dose reconstruction, as long as the employee was diagnosed with a cancer and has confirmed covered employment.

b. SEC Case with Award. For any SEC cases where an award has been made for a specified cancer, any non-SEC cancers for the case must be forwarded to NIOSH for dose reconstruction to determine eligibility for medical benefits. In these SEC cases, all cancers must be listed on the NIOSH Referral Summary Document (NRSD), including the specified cancer(s).

(1) An exception to this rule includes those SEC claims where a primary cancer which is not a specified cancer metastasizes to a secondary cancer site that is considered a specified cancer. For instance, prostate cancer (non-specified cancer) metastasizes to

7. Non-SEC Cancer and Dose Reconstruction. (Continued)

secondary bone cancer (specified cancer). If the bone cancer is accepted as a specified cancer under the SEC provision, both primary and secondary cancers (prostate and bone cancer) are accepted for medical benefits under Part B. However, per regulation 20 C.F.R. § 30.400, "payment for medical treatment of the underlying primary cancer...does not constitute a determination by OWCP that the primary cancer is a covered illness under Part E of the EEOICPA." As such, it may be necessary for the CE to refer the prostate cancer to NIOSH for dose reconstruction to determine eligibility for benefits under Part E for prostate cancer. In this situation, since the bone cancer is a secondary cancer with known primary site (prostate), it is not included in the NIOSH NRSD for dose reconstruction.

c. Multiple Skin Cancers. When a claimant provides evidence that the covered employee had a relatively large number of skin cancers, the CE will proceed as follows.

(1) Each malignant skin neoplasm (e.g., basal or squamous cell cancer) will be considered as a separate primary cancer, unless it is noted in the medical record that the neoplasm is a metastatic lesion.

(2) For NIOSH dose calculations, the date of diagnosis and the location (e.g. arm, neck, back) of the skin cancer are important and should be indicated in the medical section of the NRSD.

d. Multiple Primary Cancers for Other Organs/Locations. If more than one primary cancer location is identified for an organ in the medical records (e.g., multiple sites of primary cancer in the lung), the CE should note that fact in the medical section of the NRSD, including the cancer locations within the organ and the diagnosis date. NIOSH will perform dose calculations for each primary cancer site in a specific organ. When NIOSH reports the dose reconstruction results, the CE will calculate PoC values for each of the primary cancers in that organ.

8. Preparing Non-SEC Cancer Claim Files for Referral to NIOSH. This preparation includes completion of a NIOSH Referral Summary Document (NRSD). The NRSD (Exhibit 1) is a tabular form containing the medical and employment information accepted by the CE as factual. This form provides NIOSH with the necessary information to proceed with the dose reconstruction process.

a. Instructions. Step-by-step instructions for completing the NRSD are included in Exhibit 2. Only the NRSD is approved for use in submitting a case to NIOSH.

b. Smoking History. The employee's smoking history is required for cases that include primary lung cancer (including primary trachea, bronchus, and lung) or for secondary cancer with an unknown primary cancer that includes lung cancer as a possible primary cancer.

(1) The method used to gather smoking history is Form EE/EN-8 (Exhibit 3).

(2) Upon receipt of the information from the claimant, indicate the smoking level (at the time of cancer diagnosis) using the designations shown in the NRSD. If the case evidence contradicts information obtained on the questionnaire, the CE should clarify the discrepancy with the claimant prior to referral to NIOSH.

(3) If the claimant does not return the initial questionnaire within 30 days, the CE must send a follow-up letter advising that the questionnaire must be returned within the next 30 days or the case will be administratively closed. After a total of 60 days has elapsed, the CE informs the claimant by letter that the case will be administratively closed under Part B. The case may still be developed for causation based on toxic substance exposure under Part E.

(a) If the CE can obtain the relevant information from the employee's medical records or Document Acquisition Request (DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired.

8. Preparing Non-SEC Cancer Claim Files for Referral to NIOSH.
(Continue)

c. Ethnicity. Employee's ethnicity is required for skin cancer cases.

(1) The method used to gather this information is Form EE/EN-9 (Exhibit 4).

(2) Upon receipt of the information from the claimant, indicate the ethnicity using the designations shown in the NRSB.

(3) If the initial questionnaire is not returned by the claimant within 30 days, the CE must send a follow-up letter advising that the questionnaire must be returned within the next 30 days or the case will be administratively closed. After a total of 60 days has elapsed, the CE informs the claimant by letter that the case will be administratively closed.

If the CE can obtain the relevant information from the employee's medical records or DAR, the NRSB may be completed using that information, and forwarded to NIOSH with an explanation of where the information was acquired.

d. Case Referred to NIOSH.

(1) The evidence in file must support any finding made by the CE and documented in the NRSB. The CE must make a copy of the NRSB and place it in the case file.

(2) A copy of the entire case file is forwarded with the NRSB to NIOSH.

(3) The CE advises the claimant in writing that the case has been sent to NIOSH for dose reconstruction (Exhibit 5).

9. Preparing Amendments to NRSD for Non-SEC Cancer Claims. Sometimes CEs obtain additional information on a case after it has been referred to NIOSH but before the completion of the dose reconstruction. This includes new information related to the employee's employment, new medical condition(s), or other survivor-related information.

When new information become available, this information must be forwarded to NIOSH so it is available for dose reconstruction. The CE must include the portion of the NRSD that has changed based on new evidence reviewed by the District Office (DO). Mark "Amendment" on the top of the NRSD and include the employee's name, DOL case number, NIOSH tracking number, and DOL Information (including the Senior CE or journey level CE's signature). The CE clearly identifies and separates any "Amendment" NRSDs from NRSDs that are submitted with the DO's weekly package to NIOSH.

a. NIOSH Reports. NIOSH provides weekly reports to the DOs listing the cases for which the NIOSH contractor started performing dose calculations in the past week. The CE responsible for the case(s) listed on the report must review the information in the case file against the information sent to NIOSH in the NRSD. Any revisions to information contained in the original NRSD must be forwarded to NIOSH using an amended NRSD. This will allow NIOSH to use the correct information in its dose reconstruction.

b. "Supplement" NRSD. If the CE needs to submit additional evidence to NIOSH, such as additional medical information for the same reported cancer, this must be submitted using a NRSD with "Supplement" marked, and only the DOL case number, NIOSH tracking number, and employee's name need be included. A supplemental NRSD should be used only for a submission that does not change the original information in the NRSD. Clearly mark any supplemental packages and separate them from NRSDs that are submitted with the DO's weekly package to NIOSH.

10. Cases Pended While at NIOSH. During the dose reconstruction process, NIOSH may place a case in a "pend status" for technical reasons. Examples may include: the addition of time to a facility's covered period; a technical dose reconstruction issue for a facility; or a change to a site profile, based on the identification of additional dose data.

Placement in pend status does not stop the dose reconstruction process, but may delay completion of the dose reconstruction. Placing a case in a pend status alerts the NIOSH staff that clarification is needed on a specific issue that may affect the dose reconstruction. DOL is not necessarily notified of a case placed in pend status for technical reasons or when these issues are resolved.

11. Cases Pulled While at NIOSH. During the dose reconstruction process, it may be necessary for NIOSH to contact the CE to resolve a discrepancy, or request clarification. Normally this contact is via e-mail or telephone. All contact from NIOSH is to be handled as quickly as possible, and a response provided within three working days. If the question cannot be answered without further development, the CE advises NIOSH of the steps being taken and an approximate time frame for completion.

In cases where further development is needed as determined by NIOSH or DOL, NIOSH pulls the case from the dose reconstruction process and advises the CE by email. NIOSH may also pull a case to allow DOL to determine if a case can be accepted under a SEC class. Since a pulled case stops the dose reconstruction process, the CE must proactively develop the case so the dose reconstruction process can proceed or a decision can be rendered on a SEC case.

a. Cases Pulled by DOL. When DOL determines that further development is needed before a dose reconstruction can proceed, the supervisor, Senior CE (or journey level CE), or DO NIOSH liaison sends an e-mail (with copies to the other two DO staff) to the NIOSH Public Health Advisor (PHA) with a request that NIOSH pull the case status while DOL develops the case for additional information. The CE must advise the claimant in writing when a case is pulled by DOL from the dose reconstruction process.

11. Cases Pulled While at NIOSH. (Continued)

(1) The e-mail briefly explains the specific information the DO is attempting to clarify or obtain, e.g., employment, medical, smoking or race/ethnicity questionnaire, etc.

(2) On receipt of the development information, DOL staff notifies the appropriate NIOSH PHA (with copies to the other two DO staff) by e-mail of the resolution of the issue and requests that the case be removed from pulled status. The DO must also prepare and forward, as necessary, an amended NRSD containing the new information. The CE must also advise the claimant in writing that the case is removed from pulled status and dose reconstruction may proceed.

b. Cases Pulled Due to SEC. NIOSH may identify cases submitted for dose reconstruction that should be considered for inclusion in a SEC class, typically when a new SEC class is designated. NIOSH pulls these cases from the dose reconstruction process and returns these cases with the dose reconstruction analysis records in the form of a CD to the appropriate district office for further development. NIOSH also sends a letter advising the claimant that his or her claim is being returned to DOL for adjudication.

If DOL identifies a case that qualifies under the SEC provision but was not pulled by NIOSH from the dose reconstruction process, the CE, through the Senior CE (SrCE) or journey level CE, notifies the appropriate NIOSH PHA via e-mail to return the dose reconstruction analysis records for further development. In these cases, the CE will send a letter to the claimant advising that the case is pulled from the dose reconstruction process for evaluation under the SEC provision.

If it is determined that the case does not qualify for the SEC class, the CE, through the SrCE or journey level CE, notifies the appropriate NIOSH PHA via e-mail to proceed with the dose reconstruction. The CE prints a copy of the "sent" e-mail for inclusion in the case file. The e-mail includes a brief statement explaining why the case should proceed with dose reconstruction, e.g., non-specified cancer, insufficient latency period or does not meet the

11. Cases Pulled While at NIOSH. (Continued)

250-work-day requirement. In addition, the CE notifies the claimant by letter that the case is returned to NIOSH for dose reconstruction and the reason(s) it does not qualify for the SEC class. The CE also sends a copy of this letter to NIOSH.

12. NIOSH Actions. Upon receipt of a claims package from DOL, NIOSH takes several actions to determine the employee's radiation dose.

a. Request DOE Records. These records will include radiation dose monitoring and radiation exposures associated with the employment history.

b. Interview the Claimant(s). The purpose of the interview(s), also known as the Computer Assisted Telephone Interview (CATI), is to identify any additional relevant information on employment history and develop detailed information on work tasks and radiological exposures.

c. Apply Dose Reconstruction Methods. This allows NIOSH to estimate radiation doses for workers seeking compensation for cancer who were not monitored or inadequately monitored, or whose records are missing or incomplete for exposure to radiation at a Department of Energy (DOE) or Atomic Weapons Employer (AWE) facility.

d. Conduct Closing Interview. After providing the claimant with a copy of a draft dose reconstruction report, NIOSH conducts a closing interview with the claimant to review the dose reconstruction results and the basis upon which the results were calculated. This is the claimant's final opportunity during the dose reconstruction process to correct or provide additional information that may affect the dose reconstruction.

e. Obtain Signature on Form OCAS-1. Subject to any additional information provided by the claimant, the claimant is required to sign and return Form OCAS-1 to NIOSH within 60 days, certifying that he or she has no additional information and that the record for dose reconstruction should be closed.

12. NIOSH Actions. (Continued)

Upon receipt of the signed Form OCAS-1 and completion of any changes in the dose reconstruction resulting from new information provided, NIOSH forwards a final dose reconstruction report, "NIOSH Report of Dose Reconstruction under EEOICPA", to DOL and to the claimant.

(1) NIOSH does not forward the dose reconstruction report to DOL for adjudication without receipt of Form OCAS-1 signed by the claimant or an authorized representative of the claimant.

(a) The claimant's signature on Form OCAS-1 does not mean that the claimant agrees with the dose reconstruction. Rather, the claimant is agreeing to the process and that he or she provided NIOSH with all relevant evidence.

(b) If the claimant or the authorized representative fails to sign and return Form OCAS-1 within 60 days, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimant or the authorized representative.

(c) Upon receiving this notification by NIOSH, the CE must also administratively close DOL's claim by entering a "NO" in the case status screen, since DOL cannot determine the PoC, a necessary step in adjudication of the claim, without a dose reconstruction estimate produced by NIOSH. The CE enters the date of receipt of the NIOSH letter (date stamp) as the status effective date.

(d) If the employee meets the employment requirements, prior to entering the administratively closed code ("NO") in Part E ECMS, the CE must determine if a causal link exists between the claimed illness and exposure to toxic substances (other than radiation) at a DOE facility or certain RECA facility. If no causal link is established, the CE places a "Memo to the File" explaining the sequence of events

12. NIOSH Actions. (Continued)

and then administratively closes the case in ECMS Part E.

(e) The CE must advise the claimant by letter that the case is closed. If the claimant later decides to sign the Form OCAS-1, he or she will be required to notify DOL, after which the claim will be referred back to NIOSH for reopening. The claimant should be advised that DOL cannot complete adjudication without NIOSH's findings.

(f) If additional information is submitted, NIOSH will review the evidence, prepare a new dose reconstruction report, and send a new Form OCAS-1 to the claimant and allow for an additional 60-day comment period.

(2) If the case has multiple claimants, NIOSH will wait 60 days for receipt of all signed Forms OCAS-1. If, after 60 days, NIOSH does not receive Form OCAS-1 from any of the claimants, NIOSH will administratively close the dose reconstruction and notify DOL of this action after notifying the claimants or the authorized representatives. The CE must also administratively close DOL's claim in accordance with paragraph 12e(1). If, after 60 days, NIOSH receives only one signed Form OCAS-1, NIOSH will forward the dose reconstruction package to DOL.

(a) The CE writes to the claimant(s) who did not sign Form OCAS-1 and ask why he or she did not sign Form OCAS-1. The claimant(s) should be asked to provide this information within 30 days. The CE should consider any arguments given by the claimant(s), and if substantive, refer the case back to NIOSH. Substantive arguments may include discovery of additional relevant information related to dose reconstruction, e.g., information or documents concerning radiological exposures, other co-workers, or operations and radiological controls at the specific facility.

12. NIOSH Actions. (Continued)

(b) If arguments for refusals to sign are not provided or not substantive, or if no response is received within 30 days, the CE should issue a Recommended Decision (RD) awarding (or denying) benefits to all eligible claimants (even those claimants who did not sign the form). One signed Form OCAS-1 is sufficient to proceed with issuing a decision.

13. Receipt of Dose Reconstruction Results from NIOSH.

a. Content of NIOSH Report. The "NIOSH Report of Dose Reconstruction under EEOICPA" provides the information that the CE needs to perform a PoC calculation, which is necessary to render a decision on the claim. The NIOSH report includes the following information:

- (1) Annual dose estimates related to covered employment for each year from the date of initial radiation exposure at a covered facility to the date of cancer diagnosis;
- (2) Separate dose estimates for acute and chronic exposures, different types of ionizing radiation, and internal and external doses, providing dose information for the organ or tissue relevant to the primary cancer site(s) established in the claim;
- (3) Uncertainty distributions associated with each dose estimated, as necessary;
- (4) Explanation of each type of dose estimate included in terms of its relevance for estimating PoC;
- (5) Identification of any information provided by the claimant relevant to dose estimation that NIOSH decided to omit from the basis for dose reconstruction, justification for the decision, and if possible, a quantitative estimate of the effect of the omission on the dose reconstruction results; and

13. Receipt of Dose Reconstruction Results from NIOSH.
(Continued)

(6) A summary and explanation of information and methods applied to produce the dose reconstruction estimates, including any factual findings and the evidence upon which those findings are based.

b. NIOSH CD. When the case is returned to DOL, NIOSH will forward all case file documents via compact disc (CD), since all documents referred to NIOSH and used in the dose reconstruction are optically scanned into the NIOSH computers. NIOSH will uniquely identify (on the label on the CD case) the employee's Social Security number. The CD will include the dose reconstruction input file (Excel spreadsheet) to be used for calculating the IREP probability of causation. The NIOSH CD should be kept with the case file.

(1) Information contained on the NIOSH CD will include:

(a) Dose reconstruction files, CATI; dosimetry data; the NIOSH Report of Dose Reconstruction under EEOICPA; NIOSH's PoC calculation; Form OCAS-1; the NIOSH-IREP input file; and pertinent Atomic Energy Commission (AEC)/DOE reports, journal articles or other documents.

(b) Correspondence, including NIOSH letters to claimants, phone conversation notes, and e-mails.

(c) DOE files (data files listed in order of importance on the CD), including DOE dose and work history information and other DOE documents that NIOSH requested, such as incident reports and special studies.

(d) DOL files, including a copy of the case file optically imaged by NIOSH and the OCAS tracking sheets (signatures and dates).

(2) NIOSH will incorporate all important information from the above sources into the dose reconstruction report. Publicly available documents will be

13. Receipt of Dose Reconstruction Results from NIOSH.
(Continued)

referenced by citation. Documents not publicly available will be placed in the record and, as noted above, will be included on the CD.

(3) The CE need not review all of the documents on the CD. Those documents that normally will not require review include the DOE documents, the claimant interview, the NIOSH-run PoC calculation, and the NIOSH-conducted closing interview.

NIOSH runs the PoC calculation to reduce the time needed to complete the dose reconstruction, and the PoC results are incorporated into the dose reconstruction findings. NIOSH's IREP run is used for its internal purposes only, and the CE should not use NIOSH's IREP calculations as a basis for a determination in the claim. The CE must always run the IREP separately.

(4) NIOSH will have the pertinent documents (dose reconstruction report, other records of import to the CE) in a directory titled "A_DR Files" so that the CE can include those documents in the hard copy for review. The CE prints the dose reconstruction report and the signed Form OCAS-1 and includes them in the case file.

After running the PoC calculation, the CE prints and retains a hard copy of the DOL IREP run in the case file.

c. NIOSH Unable to Perform Dose Reconstruction. In some cases, it may not be possible for NIOSH to complete a dose reconstruction because of insufficient information to reasonably estimate the dose potentially received by the employee. In these situations, NIOSH notifies any claimant for whom a dose reconstruction cannot be completed and describes the basis for this finding. NIOSH forwards its determination to DOL and the CE issues a Recommended Decision (RD) to deny the claim based on NIOSH's inability to complete the dose reconstruction.

13. Receipt of Dose Reconstruction Results from NIOSH.
(Continued)

The CE notes in the decision the claimant may pursue the SEC petition process per 42 C.F.R. Part 83.13 or 83.14. The claimant has the opportunity to seek administrative review of this result after a Final Decision to deny the claim.

14. Review of Claim for Rework of Dose Reconstruction. The CE must compare the dose reconstruction (DR) report to the evidence in the case file. If there are any significant discrepancies or changes between the information in the case file and the DR report, including erroneous or incomplete information, or for which new information was recently received, the CE must determine if rework may be necessary.

Significant discrepancies or changes would include, for example, additional cancer identified or changed cancer site, changed employment facilities or dates, different ICD-9 code, or change in date of cancer diagnosis.

a. Cancer Changes Rework.

(1) If additional cancer(s) is identified after the DR is performed and:

(a) PoC is less than 50%, the CE submits a rework request to the DEEOIC Health Physicist.

(b) PoC is 50% or greater, a rework is not required. All additional primary cancers would be eligible for medical benefits. The CE documents the newly identified cancer(s) in the case file and notifies the NIOSH PHA of the additional cancer(s) so NIOSH can update their records.

(2) If two or more primary cancers are addressed in the DR, and it is later determined that one or more of the cancers should not have been included in the DR (e.g., the cancer was found to be a recurrent cancer or an erroneously reported cancer) and:

14. Review of Claim for Rework of Dose Reconstruction.
(Continued)

(a) PoC is less than 50%, a rework is not required. The PoC for the remaining cancers will still be below 50%. The CE should: use the PoC as calculated as the PoC of record and note appropriately; document the discrepancy between the cancer(s) identified in the DR and those determined by DOL to be cancers in the case file and in the RD; and notify the NIOSH PHA of the change to the cancer(s) status so NIOSH can update its records.

(b) If PoC is 50% or greater, submit a rework request to the DEEOIC Health Physicist. Also, if a primary cancer addressed in the DR is subsequently found to be a secondary cancer with an unknown primary, or an in-situ cancer, submit a rework request to the DEEOIC Health Physicist.

DOs cannot substitute newly identified cancers or additional cancers not used in the DR, or their diagnosis dates, for incorrectly reported cancers found in the DR.

b. Smoking and Race/Ethnicity Changes Rework. If information related to race/ethnicity or smoking history changes after the DR is performed, the CE should re-run IREP using the revised information. A rework is not required except for the following:

(1) If the PoC is initially below 45% and then increases above 50% or greater after re-running IREP using the revised information, the CE submits a rework request to the DEEOIC Health Physicist.

(2) If the PoC was above 50% and the change reduces the PoC below that threshold, the CE submits a rework request to the DEEOIC Health Physicist.

c. ICD-9 Code Changes Rework. Changes can affect the internal and/or external dose models used in the DR and/or the IREP model. Accordingly, the CE submits a rework request for changes in ICD-9 codes, other than those

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14. Review of Claim for Rework of Dose Reconstruction.
(Continued)

exceptions listed below, to the DEEOIC Health Physicist.
If the ICD-9 code changes *within* the following series, no
rework is required (e.g., 188.8 to 188.5):

Series	Cancer	Internal (IMBA) Organ	External Organ	IREP Model
151	Malignant Neoplasm Stomach	Stomach	Stomach	Stomach
152	Malignant Neoplasm Small Bowel	Small Intestine	Stomach	All digestive
154	Malignant Neoplasm Rectum/Anus	LLI	Colon	Rectum
156	Malignant Gallbladder /Extra hepatic	Gallbladder	Bladder	Gallbladder
157	Malignant Neoplasm Pancreas	Pancreas	Stomach	Pancreas
161	Malignant Neoplasm Larynx	Extra-thoracic (ET2)	Esophagus	Other Respiratory
162	Malignant Neoplasm Trachea/Lung	Lung	Lung	Lung
174	Malignant Neoplasm Female Breast	Breast	Breast	Breast
175	Malignant Neoplasm Male Breast	Breast	Breast	Breast
180	Malignant Neoplasm Cervix Uteri	Uterus	Uterus	Female genitalia less ovary
182	Malignant Neoplasm Uterus Body	Uterus	Uterus	Female genitalia less ovary
186	Malignant Neoplasm Testis	Testes	Testes	All male genitalia
188	Malignant Neoplasm Bladder	Bladder	Bladder	Bladder
232	Carcinoma in situ skin	Skin	Skin	Malignant Melanoma AND Non-melanoma skin-Squamous cell

(1) For ICD-9 code 232.0, if the type of cancer is specified by DOL (Malignant melanoma or Non-melanoma skin-Squamous cell), NIOSH will use only the specified IREP model. If the cancer is not specified, NIOSH will run both IREP models and the model which results in the highest PoC will be used.

14. Review of Claim for Rework of Dose Reconstruction.
(Continued)

(2) This table is excerpted from NIOSH document ORAUT-OTIB-0005, "Internal Dosimetry Organ, External Dosimetry Organ, and IREP Model Selection by ICD-9 Code".

d. NIOSH-IREP Changes Rework. If the ICD-9 code changes, but the organs used by NIOSH for calculating internal and external dose remain the same (only the IREP model organ changes), the DO should request direction by the DEEOIC Health Physicist for instructions to rerun IREP for the proper IREP cancer model (organ).

e. Diagnosis Date Changes Rework. The net effect of a change in the diagnosis date depends mostly on the type of cancer, the worker's age at the time of diagnosis, and whether or not the year of diagnosis falls within the latency period for development of cancer (which, in turn, varies by IREP cancer model). Depending on the factors listed above, it is possible for an earlier diagnosis date to result in an increase in the PoC. For changes to the diagnosis date:

(1) When the PoC is less than 40% and,

(a) The diagnosis date is in the same calendar year, a rework is not required.

(b) If the diagnosis date is found to be outside the calendar year (either earlier or later), the CE submits a rework request to the DEEOIC Health Physicist.

(2) When the PoC is between 40% and 49.99%, and there is any change to the diagnosis date, the CE submits a rework request to the DEEOIC Health Physicist.

(3) When the PoC is 50% or greater,

(a) If the diagnosis date is found to be later, but still within the same calendar year, a rework is not required.

14. Review of Claim for Rework of Dose Reconstruction.

(Continued)

(b) If the diagnosis date is found to be outside the calendar year (either earlier or later), the CE submits a rework request to the DEEOIC Health Physicist.

(c) The CE documents the difference in the diagnosis date in the case file and ensures that the difference in the diagnosis date used in the DR is noted in the RD.

(d) The CE notifies the NIOSH PHA of the change in the diagnosis date so NIOSH can update its records.

f. Employment Changes Rework.

(1) If the PoC is 50% or greater and additional DOL-verified employment is identified, a rework is not required.

(2) If the PoC is 50% or greater and the DOL-verified employment is found to be less than that used in the DR, the CE submits a request for rework to the DEEOIC Health Physicist for review, and includes an electronic copy of the DR report.

(3) If the PoC is between 40% and 49.99%, and additional DOL-verified employment is identified, the CE submits a request for rework to the DEEOIC Health Physicist for review, and includes an electronic copy of the DR report.

(4) If the PoC is less than 40%, and additional DOL-verified employment is identified:

(a) If all the additional employment falls within the same calendar year and the year is addressed in the DR, a rework is not required.

(b) If the additional employment extends into, or is wholly within another calendar year not addressed in the DR, the CE submits a rework request to the DEEOIC Health Physicist.

14. Review of Claim for Rework of Dose Reconstruction.

(Continued)

(5) Some DRs contain more employment than originally verified by DOL in the NRSD. NIOSH may have DOE dosimetry or employment records for periods not identified by DOL, or the DR may use a continuous period rather than considering numerous breaks in employment.

(a) If the case is likely non-compensable, NIOSH may add the additional time period to the DOL-verified employment for the purpose of completing a dose reconstruction (unless it is military, navy nuclear or non-DOE federal service) in a timely manner.

(b) If the PoC is less than 50% and the DR contains employment added by NIOSH, a rework is not required. However, the CE must write a memo to file that DOL did not verify part of the employment period assumed by NIOSH, but that the employment period was assumed correct for the purpose of completing the DR in a timely manner.

Should new information arise to warrant performing the dose reconstruction again (e.g., additional cancer diagnosis, additional employment at another site), only employment verified by DOL will be used, which may be more restrictive than that allowed in the current DR. This must also be explained in the RD.

If NIOSH has added employment to a claim that is likely compensable, NIOSH must contact the CE with the additional employment information for DOL review and verification. After verification the CE must submit an amended NRSD to NIOSH.

(c) If the PoC is 50% or greater and the DR contains employment added by NIOSH but not approved by the DO, the CE submits a rework request to the DEEOIC Health Physicist.

14. Review of Claim for Rework of Dose Reconstruction.

(Continued)

(6) If military, navy nuclear, or non-DOE federal service is identified in the DR, the CE submits a rework request to the DEEOIC Health Physicist.

(7) For any PoC, if changes to the employment site(s) are identified, the CE submits a rework request to the DEEOIC Health Physicist.

(8) When a rework is not required, the CE must still document the changes to the employment in a memo to file and ensure that the difference(s) between the employment used in the DR compared to the DOL-verified employment is noted in the RD. Finally, the CE notifies the NIOSH PHA of the change(s) in employment so NIOSH can update its records.

g. Additional Survivors (Claimants) Identified Rework.

(1) If the PoC is 50% or greater, NIOSH does not need to interview any newly identified claimants. A rework is not required.

(2) If the PoC is less than 50%, NIOSH will interview the new claimant(s), at the claimant(s)' request, to determine if there is some information that could significantly affect the DR and therefore prompt the submission of a rework request to the DEEOIC Health Physicist.

15. Procedures for Requesting Rework. For cases in which the CE determines that a rework is necessary, the CE must e-mail the Supervisory CE (SCE), SrCE or journey level CE with the Amended NRSD (ANRSD) attached, noting the issues with the DR.

a. A copy of the e-mail message (printed from the sent file to document the date of issue) must be placed in the case file.

(1) Use an e-mail subject that is specific to the individual rework request. For example: last four

15. Procedures for Requesting Rework. (Continued)

digits of DOL ID, NIOSH ID Number, DO, and "Rework", i.e., 1234-NIOSH ID #123456-Denver-Rework.

(2) Briefly summarize how the current NIOSH DR was performed. Include the employment history used by NIOSH in the DR; the cancer(s), ICD-9 code(s) and diagnosis date(s) used in the DR, and the PoC resulting from this information used in the DR.

(3) Describe the reason(s) for the rework request. For example, an additional cancer has been verified, the wrong cancer was reported in the NRSR, the primary cancer was determined for a secondary cancer reported as an "unknown primary," more or less employment was determined, or the diagnosis date for one of the cancers in the DR was found to be incorrect.

(4) Determine whether the employment history and cancer information listed on the DR Coversheet is the exact information used by NIOSH in the DR. If the information reported in the NRSR does not match the information stated on the DR Coversheet, review the DR report, particularly in the sections "Dose Reconstruction Overview," and "Information Used", where NIOSH describes in more detail the information used to complete the DR. This text may resolve an apparent discrepancy.

(5) Refer to Exhibit 6 for examples of rework requests and types of information needed.

b. An amended NRSR is prepared as necessary.

c. The PoC value is not entered in ECMS when a case is referred back to NIOSH. If a PoC value is already entered, the CE deletes the previous PoC value.

d. The DEEOIC Health Physicist serves as the central liaison between NIOSH and DOL on all issues related to dose reconstruction. If the SCE, SrCE or journey level CE agrees with the CE's e-mail findings regarding rework, he or she must forward the CE's e-mail along with the amended NRSR to the DO NIOSH liaison. In turn, the DO NIOSH

15. Procedures for Requesting Rework. (Continued)

liaison sends the request along with the amended NRSD to the DEEOIC Health Physicist and copies the CE, SCE, SrCE or journey level CE, and District Director.

(1) The DEEOIC Health Physicist reviews the request for rework and determines whether a rework is required.

(2) If additional information is needed to make a determination, which may include requesting the case file, the DEEOIC Health Physicist contacts the CE.

e. Rework Not Needed. If the DEEOIC Health Physicist determines that information would not change the outcome of the DR, he or she will send an e-mail to the DO NIOSH liaison, with a copy to the CE, or SCE, and District Director, explaining the rationale for not continuing the review of the DR. When the CE receives this response, he or she must print the e-mail for the case file and proceed with the IREP calculation and enter the PoC value(s) into ECMS.

(1) Updating Records. Any changes made to a case with a DR, regardless of whether the case is submitted for a formal rework review by a DEEOIC Health Physicist, should be documented in the case file and should reference the guidelines used to make that determination.

When the DO makes changes to information used in the NIOSH DR, and no rework is required, the DO NIOSH liaison or other designated person sends an e-mail to the appropriate NIOSH PHA. This e-mail must indicate what information was changed, such as the ICD-9 code, cancer name, employment dates, etc.

This allows NIOSH to update its records for the case, which is most critical with respect to changes involving ICD-9 codes and PoC values different from those initially generated by the dose reconstruction. Forwarding these changes also allows NIOSH to more accurately compile statistics on the types of cancers

15. Procedures for Requesting Rework. (Continued)

addressed in EEOICPA decisions that required a NIOSH DR.

If a new PoC calculation was performed using new information without the need for rework, the DO NIOSH liaison must advise the NIOSH PHA via e-mail and attach the new IREP summary file. For example, in a case with an initial PoC less than 45%, the DEEOIC Health Physicist determined that a change in the ICD-9 code did not require a rework of the dose reconstruction, but just a different NIOSH-IREP model run. If the new IREP run resulted in a PoC less than 45%, the CE may use the new IREP run and PoC as the value for the dose reconstruction but must advise NIOSH as noted above.

(2) If the DEEOIC Health Physicist has determined that a rework is not necessary, but discrepancies appear to exist between the NIOSH dose reconstruction and DOL's analysis of the DR and subsequent calculation of the PoC (e.g., one or more cancers were subsequently deemed not covered, changes in the diagnosis date, differences in NIOSH employment dates and DOL-verified employment dates) the CE addresses the discrepancies in the RD.

(3) Any future DR rework based on additional verified cancer(s) or employment will be performed using only DOL-verified information, which may be more restrictive than information used in the previous DR (i.e., in some likely non-compensable cases, NIOSH may assume a continuous employment period rather than considering numerous breaks in employment for purpose of completing a DR in a timely manner). Therefore, it is possible in some cases for the subsequent PoC to remain the same, increase only slightly, or even decrease to some degree if the DR is reworked in the future.

f. Rework Needed. If the DEEOIC Health Physicist determines that a rework is necessary, he or she will e-mail the CE, SrCE or journey level CE, SCE, District Director and the DO NIOSH liaison to proceed. In certain

15. Procedures for Requesting Rework. (Continued)

non-standard rework requests, the DEEOIC Health Physicist will also copy the designated NIOSH Office of Compensation Analysis and Support (OCAS) contact person(s) on the e-mail. The CE must place a copy of the e-mail in the case file.

(1) The CE must take the following actions:

(a) Forward the amended NRSD as an electronic attachment via e-mail to the NIOSH PHA assigned to the DO.

(b) Send a letter to the claimant (Exhibit 7) explaining that the case has been returned to NIOSH for a review of the dose reconstruction.

(c) Send a copy of this letter to the appropriate NIOSH PHA along with the weekly DO submissions to NIOSH. The dates on the amended NRSD and the letter to the claimant must be the same, since this will be the date used for the new status code entry into ECMS.

g. After a new draft dose reconstruction (DR) report is completed, NIOSH will send it to the claimant along with another Form OCAS-1. The claimant has 60 days to sign and return the form.

16. Reviews of Dose Reconstruction. If the claimant objects to NIOSH's decision on the results of the dose reconstruction, the objection must be filed with the FAB. FAB evaluates the factual findings upon which NIOSH based the dose reconstruction. All objections related to dose reconstruction must be sent to a DEEOIC Health Physicist for review, unless the objections are solely related to factual findings, i.e., whether the facts upon which the dose reconstruction report was based were correct.

a. Factual Objection: If the HR or CE determines that the factual evidence reviewed by NIOSH was properly addressed, the HR or CE accepts NIOSH's findings, in which case no referral to a DEEOIC Health Physicist is necessary. However, if the HR or CE determines that NIOSH did not review substantial factual evidence, he or she contacts a

16. Reviews of Dose Reconstruction. (Continued)

DEEOIC Health Physicist to determine if a rework of the dose reconstruction is necessary.

If the DEEOIC Health Physicist determines that a rework of the dose reconstruction is necessary, the HR or CE then remands the case to the DO for referral to NIOSH for a rework.

b. Technical Objection: A technical objection may involve either methodology or application of methodology. Examples of methodology of dose reconstruction may include but is not limited to analyzing specific characteristics of the monitoring procedures in a given work setting; identifying events or processes that were unmonitored; identifying the types and quantities of radioactive materials involved and using current models for calculating internal dose. The NIOSH "efficiency" process of using overestimates and underestimates in dose reconstruction is another example of a methodology. Upon receipt of the technical objection(s), the HR or CE discusses it with his or her supervisor to obtain approval to submit the objection(s) for DEEOIC Health Physicist review. Following are steps taken to track technical objections submitted for DEEOIC Health Physicist review:

(1) The HR or CE prepares a memo to the DEEOIC Health Physicist that identifies only the dose reconstruction-related technical objections (not including any factual objections).

(2) The HR or CE attaches electronic version of the memo (in addition to the NIOSH dose reconstruction report, IREP summary for each cancer and CATI summary for each claimant from the NIOSH disc) to an e-mail message addressed to the DEEOIC Health Physicist with copies to the FAB supervisor and FAB support team. The e-mail message should contain the following information in the subject line: the HR or CE's FAB office location; "Tech Obj"; the last 4 digits of the claim #; and the name of the covered facility, e.g., (FAB NO) Tech Obj-4112(Hanford).

16. Reviews of Dose Reconstruction. (Continued)

(3) The HR or CE spindles the memo in the file and documents ECMS Notes to explain that supervisory approval has been granted and that the aforementioned actions have been completed.

(4) Upon receipt of the technical objection(s), the DEEOIC Health Physicist determines whether the technical objection is one of application or methodology. Methodology used by HHS in arriving at reasonable estimates of the radiation doses received by an employee, established by regulations issued by HHS at 42 CFR Part 82, is binding on FAB. Objections concerning the application of that methodology (20 CFR § 30.318) is referred by the DEEOIC Health Physicist to NIOSH for their opinion. NIOSH is asked to respond within 30 days. The DEEOIC Health Physicist then sends his or her written opinion (and NIOSH's opinion, if any) to FAB. Upon receipt of the DEEOIC Health Physicist's review of technical objections, the HR or CE spindles the responses in the file. If the case needs to be reviewed by NIOSH, the FAB will be instructed to remand the case back to the DO for referral to NIOSH.

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. Under Part B, a covered employee seeking compensation for cancer, other than as a member of the SEC seeking compensation for a specified cancer, is eligible for compensation only if DOL determines that the cancer was "at least as likely as not" (that is, a 50% or greater probability) caused by radiation doses incurred in the performance of duty while working at a DOE facility and/or an Atomic Weapons Employer (AWE) facility.

This includes radiation doses from medical X-rays for the pre-employment physical examination, annual physical examinations, and a termination (exit) physical examination, but does not include radiation to which the employee may have been exposed during airline flights, as such exposures are not incurred from activities at the sites.

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. (Continued)

EEOICPA does not include a requirement limiting the types of cancers to be considered radiogenic; CLL is considered non radiogenic pursuant to HHS regulation.

a. NIOSH-IREP. The CE must use the updated version of radioepidemiological tables developed by the National Institutes of Health as a basis for determining PoC. This software program, named the NIOSH-Interactive RadioEpidemiological Program (NIOSH-IREP), is based on NIOSH regulations found at 42 C.F.R. Part 81. NIOSH-IREP allows the CE to apply the National Cancer Institute risk models directly to data on individual claimants.

b. Uncertainty. NIOSH-IREP allows the CE to take into account uncertainty concerning the information being used to estimate PoC. There typically is uncertainty about the radiation dose levels to which a person has been exposed, as well as uncertainty relating to levels of dose received to levels of cancer risk observed in study populations.

Accounting for uncertainty is important because it can have a large effect on the PoC estimates.

c. Credibility Limit. As required by the Act at Section 7384n(c)(3)(A), the NIOSH-IREP uses the upper 99 percent credibility limit to determine whether the cancers of employees are at least as likely as not caused by their occupational radiation doses. This helps minimize the possibility of denying compensation for those employees with cancers likely to have been caused by occupational radiation exposures.

d. Guidelines. Specific guidelines concerning the calculation of the PoC for certain cancers are noted below.

(1) Carcinoma in situ (CIS), or cancers in their early stages, are not specifically included in NIOSH-IREP models. These lesions are becoming more frequently diagnosed, as the use of cancer screening tools, such as mammography, has increased in the general population. The risk factors and treatment for CIS are frequently similar to those for malignant

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. (Continued)

neoplasms, and, while controversial, there is growing evidence that CIS represents the earliest detectable phase of malignancy. Therefore, for purposes of estimating PoC, carcinoma in situ (ICD-9 codes 230-234) should be treated as a malignant neoplasm of the specified site.

Current NIOSH guidance on which IREP models to run for in situ squamous cell carcinoma (SCC) skin cancer is contained in Table 4, "Cancer Models to be Used in the Calculation of Probability of Causation," in the NIOSH-IREP Technical Documentation. The guidance in the table directs the use of two models for in situ skin cancer cases. For the ICD-9 code 232 series the CE must use the IREP models for both malignant melanoma and non-melanoma skin-squamous cell.

When a physician specifically identifies the in situ skin cancer as squamous cell carcinoma (SCC), the IREP guidance in the above-mentioned tables is not applicable and the CE must run the SCC model only. If not so identified, then the CE continues to run both models for in situ skin cancers.

(2) For other cancers requiring the use of NIOSH-IREP, the CE must assume that neoplasms of uncertain behavior (ICD-9 codes 235-238) and neoplasms of unspecified nature (ICD-9 code 239) are malignant, for purposes of estimating PoC.

e. Cancers for Which the Primary Site is Unknown. Some claims involve cancers identified by their secondary sites (sites to which a malignant cancer has spread), where the primary site is unknown.

(1) This situation most commonly arises when death certificate information is the primary source of a cancer diagnosis. It is accepted that cancer-causing agents, such as ionizing radiation, produce primary cancers. In a case in which the primary site of cancer is unknown, this means that the primary site must be established by inference to estimate PoC.

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. (Continued)

(2) For background purposes, Exhibit 8, which is reproduced from Table 1 in 42 C.F.R. Part 81, indicates, for each secondary cancer, the set of primary cancers producing approximately 75% of that secondary cancer among the U.S. population (males and females were considered separately). NIOSH performs the dose reconstruction for the cancer site that yields the highest PoC.

If the PoC yields a PoC greater than 50%, all of the secondary cancers are covered for medical benefits even if no dose reconstruction was performed for that secondary cancer.

f. Cancers of the Lymph Node. The CE must consider all secondary and unspecified cancers of the lymph node (ICD-9 code 196.0) as secondary cancers (those resulting from metastasis of cancer from a primary site). For claims identifying cancers of the lymph node, Exhibit 8 provides guidance for assigning a primary site and calculating the PoC using NIOSH-IREP.

g. Claims With Two or More Primary Cancers. For these claims, DOL uses NIOSH-IREP to calculate the estimated PoC for each cancer individually. The CE then performs an additional statistical procedure following the use of NIOSH-IREP to determine the probability that at least one of the cancers was caused by radiation (discussed further in the NIOSH-IREP procedures). This approach is important to the claimant because it determines a higher PoC than is determined for either cancer individually.

For cases involving multiple primary cancers where the PoC is greater than 50%, all of the primary cancers will be covered for medical benefits.

h. Claims for Leukemia. Sometimes NIOSH guidance requires that two or three NIOSH-IREP models be run for a particular cancer. This most often occurs with different types of leukemia. NIOSH only includes the NIOSH-IREP input and associated summary sheet providing the highest PoC in the "DR Files" on the disk sent to the DO.

17. Proving Causation Between Diagnosed Non-SEC Cancer and Covered Employment. (Continued)

i. Claims for Chronic Lymphocytic Leukemia (CLL) Only.

CLL is a form of leukemia not found to be radiogenic in studies conducted worldwide of a wide variety of radiation-exposed populations. Therefore, pursuant to HHS regulations, the PoC for CLL is assigned a value of zero. The CE will insert Exhibit 9 into the file for the record. Exhibit 9 is a letter from NIOSH that states the Department of Health and Human Services (HHS) guidelines for determining the PoC for CLL. Since CLL has a PoC of zero, the CE adjudicates the claim without sending the case to NIOSH. The RD must contain a reference to the DHHS regulations and cite 42 C.F.R. § 81.30 denying compensation benefits under Part B of the Act.

(1) In cases where there are multiple primary cancers including CLL, and the PoC is greater than 50%; medical benefits will be covered for CLL. When CLL is diagnosed after an award has been made for a greater than 50% PoC, medical benefits are paid for CLL.

(2) CLL may be compensable under Part E of the Act. The CE must determine if causation can be established for CLL and exposure to toxic substances other than radiation under Part E.

18. Calculation of PoC Using NIOSH-IREP Computer Program. DOL must calculate the PoC for all cancers, except CLL, using NIOSH-IREP. The risk models developed by the National Cancer Institute and the Center for Disease Control for NIOSH-IREP provide the primary basis for developing guidelines for estimating PoC under EEOICPA. They directly address 33 cancers and most types of radiation exposure relevant to claimants covered by EEOICPA.

a. NIOSH Cancer Models. The NIOSH Cancer Models take into account the employee's cancer type, year of birth, year of cancer diagnosis, and exposure information such as years of exposure, as well as the dose received from gamma radiation, X-rays, alpha radiation, beta radiation, and neutrons during each year. A glossary of cancer descriptions for each ICD-9 code is provided in 42 C.F.R. Part 81 and is reproduced as Exhibit 10.

18. Calculation of PoC Using NIOSH-IREP Computer Program.
(Continued)

b. Smoking History and Racial/Ethnic Identification. The risk model for lung cancer takes into account smoking history. The risk model for skin cancer takes into account the race or ethnic identification of the claimant. (However, it does not consider exposure to sunlight, since sunlight is not a toxic substance.)

None of the risk models explicitly account for exposure to other occupational, environmental, or dietary carcinogens. For cases with lung (primary or secondary, with unknown primary) or skin cancer, the CE must determine the smoking history or race or ethnic identification of the claimant.

c. Risk Models. NIOSH-IREP is specifically designed for adjudication of claims under EEOICPA and incorporates cancer risk models that have been modified to reflect the radiation exposure and disease experiences of employees covered under EEOICPA.

d. NIOSH-IREP Operating Guide. The CE must use procedures specified in the NIOSH-IREP Operating Guide to calculate PoC estimates under EEOICPA.

The guide provides step-by-step instructions for the operation of NIOSH-IREP. The procedures include entering personal, diagnostic, and exposure data; setting/confirming appropriate values for variables used in calculations; conducting the calculation; and obtaining, evaluating, and reporting results. There are two user guides, one for cases with a PoC less than 45% or greater than 52%; and another, termed the Enterprise Edition, for cases with PoCs of 45% to 52%. Enterprise Edition cases can be identified by looking at the Excel input file name which would include the notation "EE."

(1) For cases with a PoC less than 45% or greater than 52%, the CE accesses NIOSH-IREP on the NIOSH website at http://198.144.166.6/irep_niosh/ to perform the PoC calculation. The CE must use data from the CD for the NIOSH-provided input file for each cancer.

18. Calculation of PoC Using NIOSH-IREP Computer Program.
(Continued)

After the IREP calculation is completed for each cancer, the CE prints out the NIOSH-IREP PoC results directly from the web page and retains it in the case file. The copy shows the web page address and date at the bottom, which documents that the CE independently ran the IREP.

When two or more cancers are present, the CE uses the multiple primary cancer equation to calculate the total PoC, and saves this report as a hard copy.

(2) For cases with POCs between 45% and 52%, another software program, called the NIOSH-IREP Enterprise Edition (NIOSH-IREP-EE), is used to perform the PoC calculation. The website address for the program, the User's Manual, and the password (which NIOSH will change every few months), is available by contacting the DOL Health Physicist.

The Enterprise Edition is used for this PoC range to achieve better statistical precision and further reduces the chance of denying a claim because of sampling error.

In summary, the simulation sample size will be increased to 10,000; 30 additional IREP runs will be performed using a new random number seed for each run; and the average value of the upper 99% credibility limit (CL) of the 30 runs (PoC) will determine the claim outcome.

(a) To facilitate the 30-run process, another Excel input file is used specifically for this software. This input file contains all the claims data found in the regular NIOSH-IREP input file, but are preset with 30 different random number seeds and a simulation sample size of 10,000.

18. Calculation of PoC Using NIOSH-IREP Computer Program.
(Continued)

(b) NIOSH will provide this preset file (or files, if there is more than one primary cancer) for each claim that falls into the PoC range. To perform the required calculations, this input file need only be uploaded once into NIOSH-IREP-EE.

(c) After the CE uploads the file and clicks the "Generate 30 Results" button, the input is submitted to the NIOSH-IREP-EE server where the calculations are to be performed. Upon completion, the results are displayed in the form of IREP Summary Report. They will include the average value of the upper 99% CL of the PoCs for the 30 results.

(d) While the CE waits for the results to be returned, the computer may be used for other tasks. However, clicking on an internet link in an e-mail while the file is running will disrupt the calculation process. To access the internet while waiting for the calculations to be performed, a new and separate instance of the browser should be opened.

(e) Since some calculations could take over two hours to complete, it may be best to run the NIOSH-IREP-EE at the end of the day to allow the computer to process overnight. When complete, the calculations will remain on the CE's screen to be printed and saved the next morning.

(3) For multiple primary cancers (or secondary cancers with no known primary), the CE performs the NIOSH-IREP-EE calculation for each cancer. As with the standard NIOSH-IREP, the PoC results must be printed and placed in the case file.

19. Establishing Causation for Cancer Under Part E. Coverage under Part E is limited to confirmed DOE contractor employees or RECA Section 5 uranium workers who contracted any diagnosed illness (this Chapter focuses on cancer) after beginning employment at a DOE facility or a RECA Section 5 facility. Certain RECA Section 4 eligible claimants who have not received any Section 4 benefits may also be eligible for EEOICPA benefits if otherwise eligible under EEOICPA. To establish causation under Part E, evidence must show that it is "at least as likely as not" that the exposure to a toxic substance (which may include radiation) at a DOE facility or certain RECA facilities was a significant factor in causing, contributing to, or aggravating the covered illness. In certain cases, there is a presumption of causation under Part E.

a. Presumption of Causation:

1. Approved Part B Conditions. Medical conditions approved under Part B are given a presumption of causation under Part E. As such, an acceptance for a medical condition under Part B will correlate to an automatic acceptance under Part E for the same medical condition.
2. DOE Physician's Panel. If, under former Part D, a DOE physician's panel finding signed by a DOE official provides the opinion that the employee sustained an illness or died due to a toxic substance at a DOE facility, the CE accepts the determination for causation under Part E.
3. SEC Cases. A determination that an employee is entitled to compensation based on meeting the criteria required under SEC establishes causation for that cancer under Part E (non-SEC cancers must be developed for causation). However, for claims involving survivors, evidence must establish that the covered cancer was a significant factor that caused or contributed to the death of the employee.
4. RECA Section 5. Conditions approved under Part B based on a RECA Section 5 awarded to a living employee will correlate to an automatic acceptance under Part E to the same living employee for the same medical condition. However, survivors of Section 5 RECA award

19. Establishing Causation for Cancer Under Part E. (Continued)

recipients, and survivors who are award recipients in their own right, must submit the requisite documents to establish survivorship eligibility under Part E. All Part E survivorship rules apply to RECA survivors.

b. Causation Development of Non-SEC Cancer Cases. Under Part E, non-SEC cancer cases without presumption of causation are developed for causation by evaluating the causal nexus between the cancer and potential occupational exposure to radiation and/or other toxic substances at a covered facility. While development actions for radiation and other toxic substances (non radiation) exposures have distinct paths, they are undertaken concurrently to determine whether or not a claimant meets the causation test under Part E.

(1) When developing a cancer claim for causation due to radiation, the CE refers the case file to NIOSH for dose reconstruction in accordance with the instructions in this Chapter. The CE must determine whether or not the cancer is "at least as likely as not" related to the verified covered employment at a DOE or RECA facility. The "at least as likely as not" causation standard is met if the PoC is 50% or greater.

Part E claims based on RECA Section 5 employment that are for cancers other than those accepted by DOJ (i.e., lung cancer) are also referred to NIOSH for dose reconstruction and determination of the PoC.

(2) In conjunction with the dose reconstruction, the CE develops the Part E cancer claim for causation based upon toxic substance other than radiation.

(3) A cancer claim may meet the causation test by either means:

(a) If the dose reconstruction results in a PoC of 50% or greater, the CE issues a RD to accept the claim under Part B and/or Part E. In a survivor case, the CE must also establish that the covered cancer was at least as likely as not

19. Establishing Causation for Cancer Under Part E. (Continued)

a significant factor that caused, contributed to or aggravated the death of the employee.

(b) If the CE is able to establish toxic exposure causation and no Part B benefits are claimed, the CE renders a factual determination as to acceptance under Part E only and issues the RD. If the case is pending at NIOSH for a dose reconstruction, the CE pulls the case file from NIOSH without waiting for the dose reconstruction to be completed. For example, a claimant is the survivor of a uranium miller covered under Section 5 of the RECA. The claimant is seeking survivorship benefits under Part E based upon a claim of esophageal cancer. No Part B benefits are being sought, as the survivor was awarded Part B benefits as a RECA Section 5 beneficiary, and is not eligible for Part B benefits under the esophageal cancer claim. In this case only Part E benefits are sought for the cancer claim, and should the CE establish a causal link between the esophageal cancer and exposure to a toxic substance at a RECA mine, the claim can be immediately accepted and withdrawn from NIOSH without waiting for the dose reconstruction.

If, however, Part B benefits are also claimed, the case file remains at NIOSH until the dose reconstruction is complete so a RD can be issued for both Parts B & E at the same time.

(4) In certain instances a physician might opine that a claimant's radiation and toxic substance exposure together worked in tandem to produce a synergistic or additive effect that brought about the cancer. DOL has not found scientific evidence establishing a synergistic or additive effect between radiation and exposure to a toxic substance, and if the physician presents this finding he or she must provide actual scientific or medical research evidence to support the finding before the CE may consider the assertion.

19. Establishing Causation for Cancer Under Part E. (Continued)

If a physician makes this assertion, the CE requests that the physician provide medical evidence of a synergistic or additive effect and a clearly rationalized medical opinion as to whether or not the effect is significant enough to establish that the combination of the radiation and the exposure to a toxic substance was "at least as likely as not" a significant factor in aggravating, contributing to, or causing the cancer.

If the physician provides rationalized scientific evidence revealing a synergistic or additive effect, the DO sends the case file to NO for review by a NO Health Physicist (HP), Toxicologist and/or the DEEOIC Medical Director. The HP reviews the physician's report and all evidence of file and makes a recommendation as to causation.

NIOSH Referral Summary Document (NRSD)

Enter a "X" where appropriate

<input type="checkbox"/> Initial	<input type="checkbox"/> Amendment	<input type="checkbox"/> Supplement
Remarks (if Amendment or Supplement):		

1. DOL Case Number:

Case File Contact Information

2. Energy Employee (EE):

a. Name (First-Middle-Last-Suffix)	
b. Gender (Male or Female)	
c. Date of Birth (MM/DD/YYYY)	
d. Date of Death (MM/DD/YYYY)	
e. Address (Street, City, State, Zip)	
f. Phone Number and Type	

3. Survivor(s) (SV) (If applicable, create a table for each):

a. Name (First-Middle-Last-Suffix)	
b. Address (Street, City, State, Zip)	
c. Phone Number and Type	
d. Relationship to employee	
e. Currently eligible survivor (Y/N)	

a. Name (First-Middle-Last-Suffix)	
b. Address (Street, City, State, Zip)	
c. Phone Number and Type	
d. Relationship to employee	
e. Currently eligible survivor (Y/N)	

a. Name (First-Middle-Last-Suffix)	
b. Address (Street, City, State, Zip)	
c. Phone Number and Type	
d. Relationship to employee	
e. Currently eligible survivor (Y/N)	

4. Other Contact(s)(OC)(If applicable, create a table for each):

a. Name (First-Middle-Last-Suffix)	
b. Address (Street, City, State, Zip)	
c. Phone Number and Type	
d. Relationship to employee	

Medical and Employment Information**5. EE Covered Cancer Information (create a table for each cancer):**

a. Primary [<input type="checkbox"/>] or Secondary (metastatic) [<input type="checkbox"/>]	
b. Cancer Description/Type	
c. Associated ICD-9 Code	
d. Date of Cancer Diagnosis	

6. Other Covered Condition:

a. SEC Cancer Claim, but filing for Non-SEC cancer medical benefits [<input type="checkbox"/>]
b. Other claim for benefits scenario [<input type="checkbox"/>]
c. Explain:

7. Energy Employee Verified Employment History:

(List all breaks in employment at the DOE or AWE Facility):

a. Employer / Facility Name	
b. Start Date	
c. End Date	
d. Employment Badge Number	
e. Dosimetry Badge No.	
f. Job Title	

8. Employment Verification Information Valuable to NIOSH:

a. <input type="checkbox"/> DOE could not verify employment
b. <input type="checkbox"/> Employment Verification based upon Affidavit or Other Credible Evidence.
c. <input checked="" type="checkbox"/> Worked for a contractor/sub-contractor not listed in DOE Office of Worker Advocacy facility online database.

Part 2 - Claims

9. Other information relevant to dose reconstruction, if required:

a. If the claim is for skin cancer or a secondary cancer for which skin cancer is a likely primary cancer, list one or more of the following:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian, Native Hawaiian, or Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> White-Hispanic <input type="checkbox"/> White-Non-Hispanic <input type="checkbox"/> Not given
b. If the claim is for lung cancer or a secondary cancer for which lung cancer is a likely primary cancer, select one of the following (Note: Currently refers to time of cancer diagnosis):	<input type="checkbox"/> Never smoked <input type="checkbox"/> Former smoker <input type="checkbox"/> Current smoker (? cig/day) → <input type="checkbox"/> <10 cig/day → <input type="checkbox"/> 10-19 cig/day → <input type="checkbox"/> 20-39 cig/day → <input type="checkbox"/> 40+ cig/day

10. DOL Information:

a. District Office	
b. Claims Examiner Name	
c. Claims Examiner Phone Number	
d. Claims Examiner email address	

Reviewed by:

Claims Examiner

Date

Part 2 - Claims

INSTRUCTIONS FOR COMPLETING THE NRSD				
No.	Title	Description	Example	
N/A	NRSD Type	Enter an "X" next to the type of NRSD that is being submitted. If you select Amendment or Supplement enter Remarks (the reason and or data that has created the need for an Amendment/Supplement. For an Initial NRSD include all sections, unless they will be blank (i.e. other contact if there isn't one). For an Amendment include the employee's name, DOL case number, NIOSH tracking number, the tables that include changed information, and the DOL information (including the SrCE' or journey level CE signature). For Supplements, include the DOL case number, NIOSH tracking number, and employee's name.		
1	DOL Case Number	Enter the 9 digit case number/social security number	123-45-6789	
2	Energy Employee (EE)	The employee as listed on the EE-1/EE-2.		
a	Name	Enter the Employee's name as it is listed in ECMS/Claim Form (First, Middle Initial, Last, Suffix)	Fred R. Flintstone, III	
b	Gender	Enter <i>Male</i> or <i>Female</i> as indicated in ECMS/Claim Form	Male, Female	
c	Date of Birth	Enter the date of birth in MM/DD/YYYY format	01/31/1964	
d	Date of Death	If applicable , enter the date of death in MM/DD/YYYY format	11/01/2006	
e	Address	If applicable , enter the full address of the EE (Street, City, State, and zip code) Helpful Hint: Adding the +4 zip code may speed up mail delivery by several days (visit www.usps.com to find an address' +4 zip code).	710 Bedrock Dr., Aiken, SC 26175-0454	
f	Phone Number and Type	If available/applicable , enter the employee's 10 digit phone number. Refer to ECMS for the EE-2. Type can include home, work, cell, day, evening, vacation home, etc.	865-123-9870	Home
3	Survivor(s) Data	If applicable , enter the survivor's data for each survivor that has filed a Claim for Benefits, Form EE-2. If not applicable (the employee is living), delete these tables. If there are more than 3 survivors, copy and paste one table and add to the bottom, be sure to include a space between them.		
a	Name	Enter the Survivor's name (First, Middle Initial, Last, Suffix). Refer to ECMS for the EE-2	Betty D. Flintstone	
b	Address	Enter the full address of the survivor (Street, City, State, and zip code). Refer to ECMS or the EE-2.	710 Bedrock Dr., Aiken, SC 26175-0454	
c	Phone Number and type	If available , enter the survivor's 10 digit phone number. Refer to ECMS or the EE-2. Type can include home, work, cell, day, evening, vacation home, etc.	703-999-8000	Other
d	Relationship to Employee	Enter the survivor's relationship to the employee as selected on the EE-2	Spouse, Child, Grandchild	
e	Currently eligible survivor (Yes or No)	Enter Yes or No. Entering "Yes" means the survivor has met all the requirements to establish survivorship. Also note if the survivor is a "Part E Only" survivor (i.e. a non-spousal child). In cases of multiple survivors, indicate which survivor would prefer to be contacted by entering "Primary Contact" in the space provided.	Yes (Part E Only/Non-spousal Child)/Primary Contact	
4	Other Contact	If applicable , enter the Authorized Representative/Power of Attorney (POA) data. If not, delete this table. If there is more than one contact, copy and paste the table and add to the bottom, be sure to include a space between them.		
a	Name	Enter the Contact's name (First, Middle Initial, Last, Suffix)	Ira M. Lawyer, Jr.	
b	Address	Enter the full address of the survivor (Street, City, State, and zip code)	710 Bedrock Dr., Aiken, SC 26175-0454	
c	Phone Number and Type	If available , enter the survivor's 10 digit phone number. Type can include home, work, cell, day, evening, vacation home, etc.	703-999-8000	Work

Part 2 - Claims

INSTRUCTIONS FOR COMPLETING THE NRSD			
No.	Title	Description	Example
d	Relationship to employee	If known , enter the contact's relationship to the EE	Lawyer
5	EE Covered Cancer Information	Enter the EEs verified diagnosed cancer(s). Create a table (copy, cut, paste); for each primary cancer or secondary cancer for which there is an unknown primary.	
a	Primary or Secondary	Place an "X" (by clicking) in the box that best describes the cancer (Primary or Secondary)	
b	Cancer Description/Type	Enter the cancer description from the pathology/operative report, etc.	Chronic monocytic leukemia, in remission
c	Associated ICD-9 Code	Enter the ICD-9 code that best describes the cancer	206.11
d	Date of Cancer Diagnosis	Enter the date of cancer diagnosis from pathology report, operative report, death certificate, etc. in MM/DD/YYYY format. The entire date is not required but preferred. List the month and year if the full date is not available. The year of diagnosis is required.	01/10/2001
6	Other Covered Condition	If applicable , place and "X" (by clicking) in the box(es).	
a	SEC Cancer Claim, but filing for Non-SEC cancer medical benefits	Select this box if the claim is an employee claim or a survivor claim where the employee filed initially, that is being or has been accepted for an SEC cancer; and there is a claim for a non-SEC Cancer.	Employee is accepted for SEC lung cancer; and now is filing for a non-SEC skin cancer.
b	Other claim for benefits scenario	If there is any scenario not "typical" (i.e., non SEC cancer/employment) and not covered in 6.a, select this box by clicking.	Part B survivor case accepted for CBD. Under Part E, cannot establish death link relating to CBD; death certificate lists lung cancer as cause of death.
c	Explain	Provide a detailed/specific explanation for the reason box 6.b was selected	For the example above: "Survivor already compensated under Part B, Dose Reconstruction will be to establish death link for Part E only."
7	Energy Employee Verified Employment History	Complete this section for all verified employment. Any breaks in employment seven days or more must be reported separately. Create another table by using copy, paste; remember to leave a space between them. It is not necessary to verify employment beyond the date of cancer diagnosis for the purposes of submitting the NRSD; however, once submitted, continue to complete employment verification for toxic exposure and other claimed illnesses. Remember that the verified employment may extend beyond the covered employment at a particular site. The CE must verify the covered dates for a site by going to the DOE Office of Worker Advocacy Covered Facility List (http://www.hss.energy.gov/healthsafety/fwsp/advocacy/facilst/findfacility.cfm).	
a	Employer/Facility Name	Enter the employer and Facility Name	Union Carbide/K-25
b	Start Date	Enter the start date in MM/DD/YYYY Format	01/01/1956
c	End Date	Enter the end date in MM/DD/YYYY Format	12/31/1959
d	Employment badge number	If available , list the EEs employment badge number from the EE-3 or DAR.	10349
e	Dosimetry Badge No.	If available , list the EEs dosimetry badge number from the EE-3, DAR, or ORISE	10949
f	Job Title	If available , list the EEs job title (for the specific employment period) using information from the EE-3, DAR, or ORISE	Pipefitter
8	Employment verification information valuable to NIOSH	Select these boxes, by clicking, if applicable.	
a	DOE could not verify employment	Select this box if employment wasn't verified	

Part 2 - Claims

INSTRUCTIONS FOR COMPLETING THE NRSD			
No.	Title	Description	Example
b	Employment verification based on affidavit or other credible evidence		
c	Worked for a contractor/sub-contractor not listed	If the employee worked for a contractor/subcontractor not listed on the DOE Office of Worker Advocacy Covered Facility List, select this box.	F.H. McGraw
g	Other information relevant to dose reconstruction	For skin cancer and lung cancer cases additional information regarding the following must be provided.	
a	Ethnicity selection	For skin cancers, it is required that the District Office supply NIOSH with the EEs race/ethnicity. The method used to gather this information is EE/EN-9 (Attachment 4). If the claimant does not return the questionnaire within 60 days, the case will be administratively closed. However, if the CE can obtain the information from the EE's medical information or other credible source (i.e. DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired.	
b	Smoking History	For lung cancer or a secondary cancer with an unknown primary cancer that includes lung cancer as a possible primary cancer, the CE must request the EEs smoking history using the EE/EN-8 (Exhibit 3). If the claimant does not return the questionnaire within 60 days, the case will be administratively closed. However, if the CE can obtain the information from the EE's medical information or other credible source (i.e. DAR), the NRSD may be completed using that information and forwarded to NIOSH with an explanation of where the information was acquired. If the employee is a current smoker (currently refers to time of cancer diagnosis), then the CE must select an additional box, which indicates the amount (per day) the employee smoked at the time of cancer diagnosis.	
10	DOL Information	Enter the requested information	
a	District Office	Enter the CE's District Office	Cleveland, Denver, Jacksonville, Seattle
b	Claims Examiner Name	Enter the CE's full name	Fred C. Flintstone
c	Claims Examiner Phone No.	Enter the CE's direct dial phone number (not the toll free number)	(904)357-4795 x74307
d	Claims Examiner email address	Enter the CE's DOL email address	flinstone.fred@dol.gov
Reviewed by		A SrCE or journey level CE must review the NRSD, sign, and date; affirming that to the best of her/his ability, they have reviewed the information provided and believe it to be accurate and correct.	
Note: A complete copy of the case file (including the Part D if available) will be duplicated and sent with the NRSD to NIOSH.			

Smoking History Request, Form EE/EN-8

Dear Claimant Name:

This letter is in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended.

We have reviewed the claim and have determined that one of the following potentially radiogenic cancers has been diagnosed:

- Primary Trachea
- Bronchus
- Lung

The next step in the process of determining your eligibility for any benefits is calculating the probability of causation. This is essentially a finding whether the diagnosed cancer is reasonably related to exposure to radioactive materials while employed. The calculation of probability is based on many factors, such as the length of exposure and proximity to radiological sources, the type of safety protection worn, the type of cancer diagnosed, etc.

Another factor that must be included in the calculation for these particular cancers is the smoking history of the employee. In order to proceed with the calculation of probability for a claim involving primary trachea, bronchus, or lung cancer, we will need to know certain information about the employee's smoking history immediately prior to the diagnosis of cancer. This smoking information will be used to calculate the probability of causation.

Attached to this letter is an enclosure that must be completed in order for the claim to proceed. Please fill out the enclosure fully and return it to the address that appears at the bottom. We ask that the enclosure be returned within thirty (30) days so as to avoid any delay in the claims adjudication process.

OMB No. 1215-0197

EE-8 Page 1
Expiration Date: 08/31/07

Part 2 - Claims

The attached enclosure must be completed and returned. Without the completed enclosure, we will be unable to calculate the probability of causation in your claim. Without this calculation, a determination concerning your entitlement to monetary benefits cannot be issued.

If you have any questions or concerns, please contact the District Office at toll free # or FAX to #.

Sincerely,

Claims Examiner

Enclosure: EN-8

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has received will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

PUBLIC BURDEN STATEMENT

We estimate that it will take an average of five (5) minutes to respond to this collection of information, which includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, OWCP, Room S-3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

EE-8 Page 2

Part 2 - Claims

Employee: Name _____

File Number: _____

1. What is the best description for the employee named above?

Never Smoked

Former Smoker - The employee quit smoking more than five years before the date of cancer diagnosis

Current Smoker - The employee smoked cigarettes at the time of the cancer diagnosis or quit smoking fewer than five years before the date of cancer diagnosis

2. If you selected Current Smoker, check the box that corresponds with the number of cigarettes smoked per day* at the time of the cancer diagnosis:

<input type="checkbox"/>	Less than 10 per day
<input type="checkbox"/>	10 - 19 per day
<input type="checkbox"/>	20 - 39 per day
<input type="checkbox"/>	40+ per day

* Generally 20 Cigarettes Per Pack

Any person who knowingly makes any false statement, concealment of fact, misrepresentation, or commits any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I certify that the information provided is accurate and true.

Print Name: _____

Signature: _____

Date: _____

Return Form to: OFFICE OF WORKERS' COMPENSATION PROGRAMS
 DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
 ILLNESS COMPENSATION
 District Office Address

District Office City, State, Zip

EN-8 (08/31/2007)

Ethnicity Request, Form EE/EN-9

Dear Claimant Name:

This letter is in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000, as amended.

We have reviewed the claim and have determined that a diagnosis of potentially radiogenic skin cancer has been rendered.

The next step in the process of determining your eligibility for any benefits is calculating the probability of causation. This is essentially a finding whether the diagnosed cancer is reasonably related to exposure to radioactive materials while employed. The calculation of probability is based on many factors, such as the length of exposure and proximity to radiological sources, the type of safety protection worn, the type of cancer diagnosed, etc.

For radiogenic skin cancer, the race or ethnic identification of the employee is required in order to determine the probability of causation. The information obtained will be entered into the computer program that we must use to determine whether or not the diagnosed cancer is reasonably related to employment.

Attached to this letter is an enclosure that must be completed in order for the claim to proceed. Please fill out the enclosure fully and return it to the address that appears at the bottom. We ask that the enclosure be returned within thirty (30) days so as to avoid any delay in the claims adjudication process.

OMB No. 1215-0197
Expiration Date: August 31, 2007

EE-9 Page 1

The attached enclosure must be completed and returned. Without the completed enclosure, we will be unable to calculate the probability of causation in your claim. Without this calculation, a determination concerning your entitlement to monetary benefits cannot be issued.

If you have any questions or concerns, please contact the District Office at (877) 336-4272 or FAX to (904) 357-4704.

Sincerely,

Claims Examiner

Enclosure: EN-9

PRIVACY ACT

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act (42 U.S.C. 7384 *et seq.*) (EEOICPA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has received will be used to determine eligibility for, and the amount of, benefits payable under the EEOICPA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agencies or private entities that employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters. (4) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Workers' Compensation Programs and for other purposes related to the medical management of the claim. (5) Information may be given to Federal, state, and local agencies for law enforcement purposes, to obtain information relevant to a decision under the EEOICPA, to determine whether benefits are being paid properly, including whether prohibited payments have been made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the Debt Collection Act. (6) Disclosure of the claimant's social security number (SSN) or tax identification number (TIN) is mandatory. The SSN or TIN, and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (7) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision.

PUBLIC BURDEN STATEMENT

We estimate that it will take an average of five (5) minutes to respond to this collection of information, which includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, OWCP, Room S-3524, 200 Constitution Avenue, NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THIS ADDRESS. Persons are not required to respond to this collection of information unless it displays a currently valid OMB number.

EE-9 Page 2

Employee:

File Number:

The National Institute for Occupational Safety and Health (NIOSH) has developed an Interactive Radioepidemiological Program (IREP) that is used to calculate the probability of causation between a diagnosed cancer and employment. More information can be obtained about this program by contacting NIOSH at 1-800-35-NIOSH.

For claims involving radiogenic skin cancer, racial or ethnic identification is incorporated into the NIOSH-IREP calculation. It is a required element of the program. In order to proceed with a determination of causation, please mark the box that best matches the racial or ethnic identification of the employee named above:

- American Indian or Alaskan Native
- Asian, or Native Hawaiian or Other Pacific Islander
- Black or Afro-American
- Hispanic or Latino
- White or Caucasian

Any person who knowingly makes any false statement, concealment of fact, misrepresentation, or commits any other act of fraud to obtain compensation as provided under the EEOICPA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I certify that the information provided is accurate and true.

Print Name: _____

Signature: _____

Date: _____

Return Form to: OFFICE OF WORKERS' COMPENSATION PROGRAMS
DIVISION OF ENERGY EMPLOYEES OCCUPATIONAL
ILLNESS COMPENSATION
District Office Address
District Office City, State, Zip code

EN-9
August 31, 2007

NIOSH Referral Letter to Claimant

Dear Claimant Name:

We have received the information submitted in support of your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), as amended. You do not need to submit any additional evidence to us at this time.

The next step in the adjudication of the claim is dose reconstruction. The National Institute for Occupational Safety and Health (NIOSH), an agency within the Department of Health and Human Services, administers this portion of the process. In order for NIOSH to evaluate the dose reconstruction, they must have access to your complete case record. Therefore, a copy of your case file is being referred to NIOSH.

Based on our review of your claim, we will report the following information to NIOSH:

Medical

- Cancer diagnosis type (nomenclature), ICD-9 Code, and date of diagnosis

Employment

- Employer name, facility, and dates of employment (list each individually)

*If the employee also had another primary cancer besides what is shown above, please send this District Office written medical records documenting an explicit diagnosis of the other cancer, the type of cancer, and the date of its first diagnosis as a cancer. Likewise, if the employee had other covered employment, either before or after the dates shown above, or at another covered facility, please send this District Office evidence to establish the additional employment.

Once NIOSH receives your claim packet, they will send you a letter to let you know they have received your information. The letter will contain information on dose reconstruction and what to expect from NIOSH in regard to your claim. NIOSH has informed us that the process of dose reconstruction can be time

consuming because it relies on information that must be collected from a number of sources. NIOSH's primary concern will be to ensure the collected information is valid and that the assumptions used to estimate doses are fair, consistent, and well grounded in the best available science.

When NIOSH finishes its dose reconstruction and sends us the results, we will apply a formula using the data to determine whether the claimed cancer was at least as likely as not (50% or greater chance) related to the covered employment. We will then notify you in writing regarding the status of your claim.

If you have specific questions regarding the status of the dose reconstruction, you may contact the NIOSH office by calling toll free at **1-877-222-7570**. Any other questions should still be addressed to this district office.

Sincerely,

Claims Examiner

Examples of Rework Request

These examples do not cover all scenarios. Please use your professional judgment in conveying the most accurate and pertinent information necessary concerning how the DR was performed, and what modifications need to be made.

1. Additional cancer reported to the DO (employment history unchanged):

NIOSH DR for Karen Smith, 111-11-1111, (NIOSH 3450). Ms. Smith was employed at the Paducah Gaseous Diffusion Plant for several periods between 09/28/55 to 12/28/79. The DR was performed for two cancers: BCC (left preauricular area), 173.3, diagnosed on 01/28/02; and SCC in-situ right ear, 232.2, diagnosed on 9/17/02. The POC was 38.14%.

Subsequently, the DO received evidence of an additional verified cancer: SCC (right posterior inferior pinna), 173.2, diagnosed on 07/31/03.

2. Cancers were incorrectly reported in the NRSD (employment history has not changed):

John M. Jones, 222-22-2222, (NIOSH 5678). Mr. Jones was employed at the Nevada Test Site from (09/01/65 to 03/3/73) and (11/19/79 to 09/30/87). The DR was performed for two cancers:

- Prostate cancer, 185; diagnosed on 01/01/98
- Adenocarcinoma, Barrett's Esophagus, 150.0, diagnosed on 11/15/01

The POC was 36.39%. We reviewed the case file and determined that the prostate diagnosis date and the Barrett's Esophageal cancer were incorrectly reported. The correct cancer information follows:

1. Prostate cancer, 185; diagnosed on 04/08/98 (diagnosis 4 months later than reported)
2. Adenocarcinoma, lower (distal) esophagus, 151.0, diagnosed on 11/15/01

3. Corrections to employment (cancer unchanged)

Mary Smith, 333-33-3333 (NIOSH 91264). Ms. Smith worked at NTS for four periods from the 1950's to the 1970's. The DR was performed for strocytoma, 191.3, diagnosed on 03/19/77. Based on the employment used in the DR, the POC was 35.57%.

The DR used the following NTS employment dates, as reported in the NRSD:

1. 04/24/57 - 06/24/57
2. 07/09/60 - 01/18/63
3. 01/31/63 - 07/19/65
4. 07/26/55 - 02/01/74

Subsequent to submitting the NRSD report, we received additional employment evidence to determine that employment period 4. above, should actually be 07/26/**65** - 02/01/74, resulting in about 5 years less verified employment than represented in the current DR.

4. Correction to cancers and employment history:

Tom Doe, 444-44-4444 (NIOSH 23679). The DO reported that Mr. Doe was employed at the Tonopah Test Range and Nevada Test Site (NTS) from 03/27/87 to 01/22/91. The DR was performed for esophageal cancer, 150.9, diagnosed on 03/26/93. The POC was 2.35%.

We reviewed the case file and found that the cancer and the employment site and dates reported in the original NRSD were incorrect. Please replace the originally reported esophageal cancer, 150.9, with the following two cancers:

- Squamous cell carcinoma of the right piriform fossa, 148.1, diagnosed on 01/31/90
- Squamous cell carcinoma of the distal esophagus, 150.5, diagnosed on 03/25/93

In addition, Mr. Doe was on leave without pay as of 01/22/90, although actual termination date was 01/22/91. Therefore, the correct employment is: Solely at NTS (no Tonopah employment) from 03/27/87 to 01/22/90, one less year than originally reported.

5. Correction to reported cancers, and additional cancer (no changes to employment):

DR for James Johnson, 555-55-5555 (NIOSH 0432). Mr. Johnson was employed at NTS intermittently from 09/07/54 to 12/31/95. The NRSD reported 4 primary cancer sites for dose reconstruction: two (2) prostate cancers (right and left lobes), and two (2) BCC's, 173.3, diagnosed in 10/97 and 04/99. The resultant POC was 51.05%.

Upon further review of the medical evidence, we determined that the two prostate cancers should only be reported as one, as the pathology report for both lobes was reported within the same two weeks, and there is no indication that the two lobes are separate primaries. We also determined that the 04/99 BCC was a recurrent cancer of the 10/97 BCC and should not be included in the DR. In addition, we received additional medical evidence of another verified cancer: SCC (scalp), 173.4, diagnosed on 06/12/96.

Therefore the DR should be performed for the correct cancers as follows:

1. Prostate, 185, diagnosed on 10/14/84
2. BCC (rt cheek), 173.3, diagnosed on 10/23/97
3. SCC (scalp), 173.4, diagnosed on 06/12/96.

6. Deletion of several cancers from a list of multiple cancers (no change in employment):

DR for Pete James, 666-66-6666 (NIOSH 3495). Mr. James was employed at the Pacific Northwest National Lab from 08/25/69 to 06/28/87. The DR was performed for eleven (11) cancers. The POC was 52.1%.

Upon further review of the medical evidence in the case file, we determined that only eight (8) of the original eleven (11) cancers are verifiable. Below is the list of the 11 initially reported cancers; the three (3) erroneous cancers are identified by strike through:

1. Seminoma of the R. Testicle, 186.9, 06/01/77
- ~~2. BCC R. Shoulder, 173.6, 10/30/97~~
3. BCC R. Cheek, 173.3, 10/30/97
4. SCC in situ, L. Temple, 232.3, 02/24/98
5. SCC in situ, Scalp, 232.4, 02/24/98

Part 2 - Claims

- ~~6. SCC in situ, L. Forearm, 232.6, 04/24/98~~
7. SCC in Situ, L. Dorsal Forearm, 232.6, 06/23/98
8. SCC R. Cheek, 173.3, 11/29/01
9. BCC L. Chin, 173.3, 11/29/01
- ~~10. BCC L. Cheek, 173.3, 02/07/02~~
11. SCC in situ, L. Lateral Forearm, 232.6, 06/30/03

The 8 DOL verified cancers are therefore:

1. Seminoma of the R. Testicle, 186.9, 06/01/77
2. BCC R. Cheek, 173.3, 10/30/97
3. SCC in situ, L. Temple, 232.3, 02/24/98
4. SCC in situ, Scalp, 232.4, 02/24/98
5. SCC in Situ, L. Dorsal Forearm, 232.6, 06/23/98
6. SCC R. Cheek, 173.3, 11/29/01
7. BCC L. Chin, 173.3, 11/29/01
8. SCC in situ, L. Lateral Forearm, 232.6, 06/30/03

7. Additional verified employment periods (employment in NRSD correct):

DR for Sam Jones, 777-77-7777 (NIOSH 3254). The DR was performed for liver cancer, 155.0, diagnosed on 09/03/87. The POC was 22%. The DR Coversheet (dated 06/02/05) notes Mr. Jones' Hanford employment as: "06/29/54-07/12/77 (eleven periods of employment)." This is correct based on the employment originally reported in the NRSD by the DO.

We have subsequently received evidence of additional verified Hanford employment periods:

1. 01/01/53 to 12/31/53
2. 08/07/53 to 06/28/54
3. 01/30/62 to 04/15/62
4. 01/01/79 to 12/31/79
5. 01/01/80 to 12/31/80

Review of Dose Reconstruction Letter to Claimant

Dear Claimant Name:

We recently received the results of the dose reconstruction conducted by the National Institute for Occupational Safety and Health (NIOSH) in regard to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act. After review of the dose reconstruction and the evidence received in support of your claim, it was discovered that [insert reason].

We determined that your claim must be returned to NIOSH so that they can review and revise the dose reconstruction, as appropriate, to include this information. *This may not affect the outcome of your claim*, but the information used in the dose reconstruction must accurately reflect what is shown in the evidence received by the district office. Your NIOSH tracking number xxxxx will remain the same. Your claim will receive priority consideration by NIOSH.

You will have the opportunity to review the revised dose reconstruction report, and will again be required by NIOSH to sign the OCAS-1 to acknowledge your receipt of the revised report and initial dose reconstruction results.

When NIOSH finishes its revised study and sends us the results, we will apply a formula to the dose reconstruction to determine whether the cancer(s) was at least as likely as not (50% or greater chance) related to the covered employment. We will then notify you in writing regarding the status of your claim.

If you have specific questions regarding the status of the dose reconstruction, you may contact the NIOSH office by calling toll free at **1-877-222-7570**. Any other questions should still be addressed to this district office.

Sincerely,

Claims Examiner

cc: NIOSH Public Health Advisor

Primary Cancer Sites

Secondary Cancer (ICD-9 Code)	ICD-9 Code of Likely Primary Cancers
Lymph nodes of head, face and neck (196.0)	141.0, 142.0(M), 146.0, 149.0(F), 161.0(M), 162.0, 172.0, 173.0, 174.0(F), 193(F)
Intrathoracic lymph nodes (196.1)	150.0(M), 162.0, 174.0(F)
Intra-abdominal lymph nodes (196.2)	150.0(M), 151.0 (M), 153.0, 157.0(f), 162.0, 174.0(F), 180.0(F), 185(M), 189.0, 202.0(F)
Lymph nodes of axilla and upper limb (196.3)	162.0, 172.0, 174.0(F)
Inguinal and lower, limb lymph nodes (196.5)	154.0(M), 162.0, 172.0, 173.0(F), 187.0(M)
Intrapelvic lymph nodes (196.6)	153.0(M), 154.0(F), 162.0 (M), 180.0(F), 182.0 (F), 185(M), 188.0
Lymph nodes of multiple sites (196.8)	150.0(M), 151.0(M), 153.0(M), 162.0, 174.0 (F)
Lymph nodes, site unspecified (196.9)	150.0(M), 151.0, 153.3, 162.0, 172.0, 174.0 (F), 185(M)
Lung (197.0)	153.0, 162.0, 172.0(M), 174.0(F), 185(M), 188.0 (M), 189.0
Mediastinum (197.1)	150.0(M), 162.0, 174.0 (F)
Pleura (197.2)	150.0(M), 153.0(M), 162.0, 174.0 (F), 183.0 (F) 185(M), 189.0(M)
Other respiratory organs (197.3)	150.0, 153.0(M), 161.0, 162.0, 173.0 (M), 174.0 (F), 185(M), 193
Small intestine, including duodenum (197.4)	152.0, 153.0, 157.0, 162.0, 171.0, 172.0(M), 174.0 (F), 183.0 (F), 189.0 (M)
Large intestine and rectum (197.5)	153.0, 154.0, 162.0, 174.0 (F), 183.0(F), 185 (M)
Retroperitoneum and peritoneum (197.6)	151.0, 153.0, 154.0 (M), 157.0, 162.0 (M), 171.0, 174.0 (F), 182.0(F), 183.0(F)
Liver, specified as secondary (197.7)	151.0(M), 153.0, 154.0(M), 157.0, 162.0, 174.0(F)

Part 2 - Claims

Other digestive organs (197.8)	150.0 (M), 151.0, 153.0, 157.0, 162.0, 174.0(F), 185 (M)
Kidney (198.0)	153.0, 162.0, 174.0 (F), 180.0 (F), 185 (M), 188.0, 189.0, 202.0 (F)
Other urinary organs (198.1)	153.0, 174.0 (F), 180.0 (F), 183.0 (F), 185 (M), 188.0, 189.0 (F)
Skin (198.2)	153.0, 162.0, 171.0 (M), 172.0, 173.0 (M), 174.0 (F), 189.0 (M)
Brain and spinal cord (198.3)	162.0, 172.0 (M), 174.0 (F)
Other parts of nervous system, (198.4)	162.0, 172.0 (M), 174.0 (F), 185 (M), 202.0
Bone and bone marrow (198.5)	162.0, 174.0 (F), 185(M)
Ovary (198.6)	153.0 (F), 174(F), 183.0(F)
Suprarenal gland(198.7)	153.0 (F), 162.0, 174.0 (F)
Other specified sites (198.80)	153.0, 162.0, 172.0 (M), 174.0 (F), 183.0 (F), 185 (M), 188.0 (M)

HHS Chronic Lymphocytic Leukemia Guideline Letter



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institute for Occupational Safety and Health
Robert A. Taft Laboratories
4676 Columbia Parkway
Cincinnati, OH 45226-1998
Phone: 513-841-4498
Fax: 513-458-7125

June 20, 2002

Pete Turcic
Department of Labor
Office of Energy-Related Compensation
200 Constitution Avenue, N.W.
Washington, DC 20210

RECEIVED OMC/P
2002 JUN 24 P 3:45
DIVISION OF EEOICPA
U.S. DOL
WASHINGTON, D.C.

Dear Mr. Turcic:

The Department of Health and Human Services (DHHS) published a final rule on Guidelines for Determining the Probability of Causation Under the Energy Employees Occupational Illness Compensation Program Act of 2000 on May 2, 2002 (42 CFR 81). Two sections of this final rule contain provisions dealing with chronic lymphocytic leukemia (CLL):

Section 81.21 Cancers requiring the use of NIOSH-IREP

(a) DOL will calculate probability of causation for all cancers, except chronic lymphocytic leukemia as provided under Section 81.30, using NIOSH-IREP.

Section 81.30 Non-radiogenic cancers

The following cancers are considered non-radiogenic for the purposes of EEOICPA and this part. DOL will assign a probability of causation of zero to the following cancers:

- (a) Chronic lymphocytic leukemia (ICD-9 code 204.1)

The NIOSH-IREP does not include a dose response model for CLL. This is because no elevation of CLL incidence has been observed in studies of populations exposed to external and internal ionizing radiation. In addition to these studies, most expert committees have listed CLL as a cancer that appears non-radiogenic. In summary, CLL has not been shown to be associated with radiation exposure but is strongly associated with attained age.

Because of the fact that any EEOICPA claim where CLL is the only cancer will always produce a probability of causation of zero, there is no basis for transferring such claims to NIOSH for dose reconstruction.

Sincerely,

Larry Elliott, Director, CIH, MSPH
Office of Compensation
Analysis and Support

Glossary of ICD-9 Codes and Their Cancer Descriptions

ICD-9 Code	Cancer Description
140.0	Malignant neoplasm of lip
141.0	Malignant neoplasm of tongue
142.0	Malignant neoplasm of major salivary glands
143.0	Malignant neoplasm of gum
144.0	Malignant neoplasm of floor of mouth
145.0	Malignant neoplasm of other and unspecified parts of mouth
146.0	Malignant neoplasm of oropharynx
147.0	Malignant neoplasm of nasopharynx
148.0	Malignant neoplasm of hypopharynx
149.0	Malignant neoplasm of other and ill-defined sites within the lip, oral cavity, and pharynx
150.0	Malignant neoplasm of esophagus
151.0	Malignant neoplasm of stomach
152.0	Malignant neoplasm of small intestine, including duodenum
153.0	Malignant neoplasm of colon
154.0	Malignant neoplasm of rectum, rectosigmoid junction, and anus
155.0	Malignant neoplasm of liver and intrahepatic bile ducts
156.0	Malignant neoplasm of gall bladder and extrahepatic bile ducts
157.0	Malignant neoplasm of pancreas
158.0	Malignant neoplasm of retroperitoneum and peritoneum
159.0	Malignant neoplasm of other and ill-defined sites within the digestive organs and peritoneum
160.0	Malignant neoplasm of nasal cavities, middle ear, and accessory sinuses
161.0	Malignant neoplasm of larynx
162.0	Malignant neoplasm of trachea, bronchus and lung
163.0	Malignant neoplasm of pleura
164.0	Malignant neoplasm of thymus, heart, and mediastinum
165.0	Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs

Part 2 - Claims

170.0	Malignant neoplasm of bone and articular cartilage
171.0	Malignant neoplasm of connective and other soft tissue
172.0	Malignant melanoma of skin
173.0	Other malignant neoplasms of skin
174.0	Malignant neoplasm of female breast
175.0	Malignant neoplasm of male breast
179	Malignant neoplasm of uterus, part unspecified
180.0	Malignant neoplasm of cervix uteri
181.0	Malignant neoplasm of placenta
182.0	Malignant neoplasm of body of uterus
183.0	Malignant neoplasm of ovary and other uterine adnexa
184.0	Malignant neoplasm of other and unspecified female genital organs
185	Malignant neoplasm of prostate
186.0	Malignant neoplasm of testis
187.0	Malignant neoplasm of penis and other male genital organs
188.0	Malignant neoplasm of urinary bladder
189.0	Malignant neoplasm of kidney and other and unspecified urinary organs
190.0	Malignant neoplasm of eye
191.0	Malignant neoplasm of brain
192.0	Malignant neoplasm of other and unspecified parts of nervous system
193	Malignant neoplasm of thyroid gland
194.0	Malignant neoplasm of other endocrine glands and related structures
195.0	Malignant neoplasm of other and ill-defined sites
196.0	Secondary and unspecified malignant neoplasm of the lymph nodes
197.0	Secondary malignant neoplasm of the respiratory and digestive organs
198.0	Secondary malignant neoplasm of other tissue and organs
199.0	Malignant neoplasm without specification of site
200.0	Lymphosarcoma and reticulosarcoma
201.0	Hodgkin's disease
202.0	Other malignant neoplasms of lymphoid and histiocytic tissue
203.0	Multiple myeloma and other immunoproliferative neoplasms
204.0	Lymphoid leukemia
205.0	Myeloid leukemia
206.0	Monocytic leukemia
207.0	Other specified leukemia
208.0	Leukemia of unspecified cell type

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1. Purpose and Scope. This chapter discusses the Claims Examiner's (CE) role when developing claims for consequential conditions. It also provides examples of the types of injuries, illnesses, impairments, or diseases that may be accepted as consequential conditions under EEOICPA.

2. Defining a Consequential Condition. A consequential condition covered by EEOICPA is any diagnosed injury, illness, impairment or disease that has occurred as a result of an accepted occupational illness under Part B and/or covered illness under Part E. Consequential conditions also include independent incidents related to an accepted condition.

Any illness, injury, impairment, or disease shown by medical evidence to be a consequence of an accepted Part B or Part E condition is covered for medical benefits under the Act. Additionally, under Part E, any illness, injury, impairment, or disease shown by medical evidence to be a consequence of a covered Part E condition may affect the calculation of an impairment rating and/or wage-loss.

3. Consequential Condition Claims. The claimant must make a claim for a consequential condition in writing. He or she may use any method of written notification, including a Form EE-1/2. Additionally, in some situations the CE develops a potential consequential condition upon receipt of medical evidence that discusses medical conditions other than the accepted condition that may be consequential.

4. Claim Development. Consequential condition(s) must be developed factually and medically in accordance with 20 C.F.R. 30.114(b)(3) of the EEOICPA regulations and DEEOIC procedures relating to weighing medical evidence.

There are four types of consequential conditions:

- a. Metastasized Cancer(s);
- b. Conditions resulting from medical treatment of the accepted condition/s;
- c. Independent incidents related to an accepted condition/s;
- d. Natural progression and/or development (pathogenesis).

5. Metastasized Cancer(s). Metastasized cancer(s) is a secondary cancer that originates from the primary cancer site.

a. Assessing and Developing Medical Evidence in Metastasized Cancer Claims. The CE can accept a metastatic cancer claim, if the claimant provides medical evidence, including a rationalized medical report from a physician that identifies the metastatic cancer and links the cancer to a primary site that had previously been accepted. The evidence must also establish:

- (1) The diagnosis of a secondary cancer; and
- (2) The date of diagnosis for the secondary cancer.

The date of diagnosis for the secondary cancer will be: a) subsequent to the date of diagnosis for the primary cancer; b) the same diagnosis date for the primary cancer; or c) before the date of diagnosis for the primary cancer if the primary site is not obvious.

If the medical evidence is inconclusive and the CE is unable to determine if the cancer is a metastasis, the CE seeks clarification from the treating physician and/or a District Medical Consultant (DMC).

b. Examples of Metastasized Cancers. It is widely accepted that certain carcinomas and/or sarcomas metastasize from the primary site. For example:

- (1) Carcinomas of the lung, breast, kidney, thyroid, and prostate tend to metastasize to the lungs, bone, and brain.
- (2) Carcinomas of the gastrointestinal tract, reproductive system, and abdomen tend to metastasize to the abdominal lymph nodes, liver, and lungs. Later in their course, these carcinomas can metastasize to the brain and other organs.
- (3) Sarcomas often first metastasize to the lungs and brain.

5. Metastasized Cancer(s). (Continued)

(4) Primary malignant tumors of the brain seldom metastasize to other organs, but they can spread to the spinal cord.

6. Conditions Resulting from Medical Treatment. These conditions require a fully rationalized medical report by a physician that shows the relationship between the injury, illness, impairment or disease and the compensable illness.

a. Examples of Common Consequential Conditions Resulting from Medical Treatment for Accepted Conditions. As part of a patient's medical treatment or protocol, a patient may undergo treatment and/or other drug therapy that will produce side effects that can be considered common consequential conditions.

Examples of such conditions are:

- (1) Radiation pneumonitis as a result of radiation treatment;
- (2) Skin rashes and radiation burns because of radiation treatment;
- (3) Osteoporosis (which causes weakening of the bones and injuries such as spontaneous hip fractures) as a result of steroid treatment;
- (4) Chronic Pain, extreme fatigue, anemia, and gastrointestinal conditions such as nausea, vomiting, constipation, diarrhea, and weight loss are additional examples of side effects of medical treatment.

b. Developing evidence for conditions resulting from medical treatment. When a claim is made for a consequential condition caused by medical treatment of the accepted condition, the CE investigates the submitted documentation to ensure the medical evidence supports the claim. The CE obtains the following supporting documentation from the claimant:

6. Conditions Resulting from Medical Treatment. (Continued)

(1) Medical Evidence that establishes a causal connection between the claimed consequential condition and the accepted condition. The physician discusses the causal relationship between the consequential condition and the accepted condition, and establishes that the prescribed treatment is a recognized medical response to the accepted condition.

c. Assessing the medical evidence. The CE must use reasonable judgment when assessing the medical evidence required for a claim for a consequential condition.

7. Independent Intervening Causes.

a. Condition(s) resulting from an accident during travel to a medical appointment. If the employee sustains an injury in transit to or from a medical appointment or other necessary travel, it is considered a consequential condition. The CE must obtain the following factual and medical evidence:

(1) A Personal Statement that describes the circumstances of the event that resulted in an injury during travel to or from a medical appointment.

Examples of personal statements include: The employee trips down the stairs when exiting the doctor's office and breaks an arm or leg.

The employee is assaulted in the parking lot of the doctor's office, and obtained bruises, cuts, possible concussion, etc.

The employee is involved in a motor vehicle accident while en route to the doctor's office and has whiplash. In this event, reasonable assessment of the situation is needed. If the employee's accident occurred at 8 am and the doctor's appointment was scheduled for 1 pm, the CE must determine the distance between the employee's residence and his or her doctor's office.

7. Independent Intervening Causes. (Continued)

(2) Medical Evidence must include a diagnosis of the condition being claimed as a consequence of a travel-related injury and confirmation that the scheduled appointment was for treatment or care of a previously accepted covered illness.

b. An independent intervening incident caused by, or attributed to the employee's own conduct. Injuries, illnesses, impairments or diseases suffered as a result of the employee's own actions will not be accepted as consequential conditions.

8. Natural Progression/Development (Pathogenesis). There are medical conditions that are expected to develop due to the natural progression of the accepted illness. Natural progression is an expected measurable change in the illness that occurs with the passage of time.

The CE may accept certain conditions arising as a natural progression of accepted condition(s) when he or she is notified of the existence of these secondary medical conditions. Exhibit 1 outlines secondary conditions that are known to result from Chronic Beryllium Disease and Silicosis, and can be accepted upon the receipt of notification. Notification must be in the form of a well-rationalized medical report diagnosing a secondary condition that progressed/developed from the accepted condition. When notified of such a condition listed in Exhibit 1, the CE updates ECMS and sends an appropriate letter to the employee.

However, some medical conditions could develop as a result of either the natural progression of the accepted condition or the natural aging process (see Exhibit 2). Hypertension, gout, and heart disease are examples of medical conditions that potentially result from either the aging process or natural progression of the accepted condition. When a claimant presents evidence of such a medical condition, the CE assesses the medical evidence as described below.

a. Assessing the medical evidence. The CE must use reasonable judgment when assessing the medical evidence required for a claim of consequential condition. In some

8. Natural Progression/Development (Pathogenesis). (Continued)

instances, the CE may accept conditions caused by the natural progression upon receipt of the medical evidence describing the conditions listed in Exhibit 1.

In other situations where the relationship is questionable, more medical evidence (e.g., DMC review, clarification from treating physician, or second opinion) may be required.

Given that these conditions have not yet been accepted, any bills that are initially submitted to the medical bill processing agent relating to the non-accepted condition will suspend and/or reject until ECMS is updated.

9. Psychological Conditions. Psychological conditions can arise as a consequence of the accepted condition and/or treatment of that condition. They can also arise with no physiological basis. Depression, anxiety, or chemical imbalance are a few examples of psychological conditions that have no physiological basis. In addition to a specific diagnosis, these conditions may be described as "psychogenic pain disorder," "conversion disorder," or "psychological syndrome." However described, the symptom or pain is quite real to the individual involved although there is no demonstrable physical disorder.

Unless expressly claimed by a claimant, the CE develops for psychological conditions only if the attending physician indicates that such a component is present and that it is directly related to the accepted physiological condition. In such cases, the CE refers the claimant to a Board-certified psychiatrist for evaluation and opinion concerning causal relationship.

10. Accepting or Denying the Consequential Condition. The CE is responsible for taking the appropriate steps in developing any claimed consequential condition. This includes notifying the claimant of any deficiencies in the evidence and allowing him or her an opportunity to respond and submit additional evidence.

a. Acceptances. If the consequential condition is accepted, the CE notifies the claimant in a letter decision. However, if the decision is to deny the

10. Accepting or Denying the Consequential Condition.

(Continued)

consequential condition, the CE advises the claimant of his/her determination by issuing a recommended decision. The recommended decision affords the claimant the opportunity to object to the determination, and present new evidence.

b. Issuing the Decision. When the case is in posture for the CE to accept a primary covered condition and a potential consequential condition exists, the CE proceeds with the immediate release of a recommended decision for the primary condition. A recommended decision accepting a primary covered condition must not be delayed while developing a consequential condition. However, if the case is in posture to also accept the consequential condition, this acceptance is included in the recommended decision. While the case file is at the Final Adjudication Branch (FAB), the FAB hearing representative (HR) or CE2 Unit staff pursues all development regarding consequential conditions. A letter accepting a consequential condition or a recommended decision denying a consequential condition cannot be issued before FAB issues a final decision on the primary covered condition. Decisions of this nature can be issued concurrently. Once the case file is returned to the District Office, the CE can continue development on the consequential condition and/or issue the letter accepting the consequential condition or the recommended decision denying it.

11. Impairment and Wage-Loss. Consequential conditions may cause additional impairment or wage-loss under Part E, but do not result in an additional lump sum award under Part B.

a. Impairment rating. An impairment rating assesses the functionality of the whole organ or system. DEEOIC does not apportion impairment by disease (see EEOICP PM 2-1300 for further discussion of impairment ratings). If the accepted condition and consequential condition affect the same organ or system, a rating for impairment to that organ or system should proceed. However, if the accepted condition affects one organ/system and the consequential condition involves another, the impairment rating on the

11. Impairment and Wage-Loss. (Continued)

organ/system affected by the consequential condition could be developed either concurrently with the impairment for the primary system (if the consequential condition has been accepted), or later. Ideally, the CE develops the primary and consequential conditions concurrently; however, this may not be possible if, for example, the system affected by the consequential condition has not reached maximum medical improvement (see EEOICPA PM 2-1300). As soon as an impairment rating is completed for the primary affected system an impairment decision should proceed. There would be nothing to preclude a later decision on the impairment due to the consequential condition as long as the organ or system affected by the consequential condition was not rated within the past two years. After passage of two years, the claimant can receive an impairment rating based on the consequential condition affecting the same organ system as the accepted condition.

b. Wage-Loss. The acceptance of a consequential condition may affect the claimant's entitlement to wage-loss. Wage-loss is calculated using the first day that the employee lost wages due to the covered illness (see EEOICPA PM 2-1400 for further discussion of wage-loss).

In certain instances, the consequential condition may be the initial cause of the employee's wage-loss. For example, a claimant submits medical evidence showing that pulmonary hypertension caused his or her wage-loss, and shows a diagnosis of Chronic Beryllium Disease (CBD) three years thereafter. In this instance, CBD is accepted under Parts B and E as the primary condition and pulmonary hypertension is accepted as the consequential condition under Parts B and E. Also, the claimant may receive wage-loss benefits under Part E dating from the time that the he or she first lost wages due to the pulmonary hypertension.

12. State Workers' Compensation (SWC) Claims, Lawsuits and Fraud. Prior to accepting a consequential condition, the CE collects information to determine if a claimant has filed an SWC claim, lawsuit, or if the claimant has been convicted of fraud in connection with the consequential condition.

Medical Conditions with Likely Secondary Disorders

Disorders secondary to Chronic Beryllium Disease (CBD)

- Hypoxemia (low oxygen levels at exercise, rest or with sleep)
- Airflow obstruction/wheezing (asthma-like presentation of CBD)
- Right heart failure, Cor pulmonale
- Pulmonary hypertension
- Respiratory infections (Pneumonia, Acute Bronchitis)
- Spontaneous Pneumothorax
- Deconditioning secondary to chronic lung disease
- Joint Aches (this is a symptom)
- Hyperurecemia, Gout
- Hypercalcemia/hypercalcuria
- Granulomatous Hepatitis
- Skin Nodules/Ulceration
- Aggravation of sleep apnea due to hypoxemia of CBD

Disorders secondary to Silicosis

- Hypoxemia
- Right heart failure, Cor pulmonale
- Pulmonary Hypertension
- Deconditioning secondary to chronic lung disease
- Progressive Massive Fibrosis
- Silicotuberculosis

Conditions that Require Additional Development

Disorders secondary to prednisone treatment

- Cataracts
- Glaucoma
- Visual acuity changes
- Diabetes Mellitus
- Osteoporosis
- Osteopenia
- Gastric reflux
- Peptic ulcers
- Elevated blood pressure
- Elevated cholesterol
- Abnormal lipid profiles
- Sleep disorders
- Weight gain
- Myopathy, dermal atrophy
- Increased intracranial pressure

Other disorders

- Oral thrush and other fungal infections secondary to inhaled steroids, immunosuppression
- Folic acid depletion secondary to Methotrexate
- Infections due to immunosuppression (bacterial and viral)
- Post-herpetic neuralgia secondary to Herpes Zoster
- Flare due to immunosuppression

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1. Purpose and Scope. Part 3 describes the policies and procedures related to the financial aspects of claims under the EEOICPA. Topics include bills for medical care and ancillary medical expenses; tort offset; state workers' compensation coordination; compensation for beneficiaries in disability and death cases; verifying continued entitlement to benefits; and overpayments.

Claims staff and fiscal officers are jointly involved in fiscal actions, and a medical bill processing agent is responsible for processing all medical bills.

2. Structure of Part 3.

a. Medical Bills. PM 3-0200 addresses medical bill processing in general, while PM 3-0300 addresses entitlement to and payment for ancillary medical services.

b. Payments and Offsets. PM 3-0400 discusses lawsuits and the effects of recovery from them on payments of benefits under EEOICPA, while PM 3-0500 addresses state workers' compensation benefits and the effect of their receipt on EEOICPA benefits.

PM 3-0600 discusses payment of compensation, to include exception processing of payments to terminal claimants; while PM 3-0700 describes the requirements for verifying continued entitlement to medical benefits.

c. Overpayments. PM 3-0800 provides an overview of the overpayment process and describes the actions taken when an overpayment is identified. PM 3-0900 addresses the debt collection process.

3. Reference Materials. A list of references available to staff is shown in EEOICPA PM 2-0100.

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1. Purpose and Scope. This chapter describes the roles of the Claims Examiner, Fiscal Officer, and District Medical Scheduler, in the medical bill process; and outlines the procedures for evaluating and approving requests from employees and their families who are in need of medical services, supplies, or reimbursement of expenses related to medical care.

2. Roles and Responsibilities. Upon issuance of a final decision approving a specific medical condition, the Claims Examiner (CE), the Bill Processing Agent (BPA), the Fiscal Officer (FO), and the Medical Scheduler (MS) must ensure that the basic medical needs of the claimant, as they relate to his or her accepted medical condition, are reasonably provided for.

a. Medical Bill Processing Agent (BPA). The use of a contractor for processing medical bills allows the DEEOIC to provide a high level of service to eligible claimants and their providers. Once a claimant has been accepted for a covered condition under the EEOICPA, an eligibility file is automatically generated in ECMS and sent to the BPA electronically.

(1) When the BPA receives the eligibility file, the BPA sends a medical bill identification card (MBIC) and general information about the medical bill process to the claimant.

(2) DEEOIC sends all medical bills, treatment notes, and requests for claimant reimbursement directly to the contractor for scanning and keying into their system.

(3) The BPA maintains a customer call center, medical staff, and bill resolution units.

b. Point of Contact Claims Examiner. The Point of Contact Claims Examiner (POC CE) is a specialized claims examiner responsible for reviewing, developing, and approving or denying requests for in-home health care. Each District Director is to appoint one to

2. Roles and Responsibilities. (Continued)

three CEs (as appropriate) to serve in this role.

c. Claims Examiner. The Claims Examiner (CE) considers for approval those Level 4 services (see Para. 3), appliances, supplies, modifications, or travel expenses that are recommended or prescribed by a licensed physician, and necessary to cure, give relief, or aid in reducing the overall cost of services required by the employee for an accepted condition. (Refer to EEOICPA PM 3-0300 for detailed information on approval of durable medical equipment, hospice services, in-home health care, gym memberships, extended medical travel, and other ancillary medical services.)

(1) The CE considers the level of care prescribed by the treating physician as it relates to the accepted medical condition and the facts of the case. The CE must then make an informed judgment based on the level of care prescribed by the doctor.

(2) This decision must take into account the overall desires and needs of the patient, as well as those of the family. DEEOIC will not dictate or demand what option an employee must accept, nor will decisions be made based solely upon cost.

The CE must also consider what level of care or services satisfy the patient's needs.

(3) The CE is responsible for communicating all decisions (approval/denial) to the requestor.

(a) If a request for services or payment originates from the BPA, the fiscal officer notifies the CE via e-mail. These requests may come to the CE as a prior authorization request, or may come after submission of a

2. Roles and Responsibilities. (Continued)

charge to the BPA.

The CE's determination are communicated via e-mail to the fiscal officer, input into ECMS notes, and communicated to the BPA via letter explaining the decision.

(b) If the request originates from a claimant or provider, the CE immediately sends a copy via facsimile to the BPA, and concurrently begins development for approval or denial of the request. All approvals or denials are communicated to the requestor as outlined above.

d. Fiscal Officer. The Fiscal Officer (FO) acts as liaison between the CE and the Medical BPA, serves as coordinator for medical bill issues between the District Offices and the National Office, and maintains a District Office record of persons authorized to access the BPA website. The FO does not determine eligibility or authorize payments.

e. Medical Scheduler. The Medical Scheduler (MS) coordinates all requests for both internal and external District Medical Consultant reviews. The Medical Scheduler serves as the primary assistant to District Medical Consultants who are assigned to the District Office on a part-time basis.

f. District Medical Consultant (DMC). The DMC reviews and evaluates the medical evidence of record and provides medical opinions about various aspects of cases, such as:

(1) Causation: The DMC determines medical causation by reviewing medical, employment and exposure evidence to determine if the medical history is indicative of toxicity (arising out of exposure to a toxic substance) or of an

2. Roles and Responsibilities. (Continued)

organic/other nature (arising out of a natural medical occurrence, such as hereditary factors, or a lifestyle illness). The DMC may also be called upon to determine the likely role of an accepted condition as it relates to a cause of death, or the appearance of secondary or consequential illnesses or diseases.

(2) Explanation of treatment modalities, the interpretation of clinical test results, and the clarification of other physician's reports.

(3) Determining the level of impairment in a given case in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition, subject to DEEOIC's guidance.

3. Parameters for Payment. OWCP procedures employ four levels of review in the medical bill process, only two of which DEEOIC currently uses. The BPA automatically processes charges for Level 1 services and the CE is not required to approve. Any higher level of service (i.e. two, three or four) is treated as a Level 4 service in our program and requires that the CE review the proposed procedures or service(s), the proposed charges if applicable, and the supporting medical documentation, prior to approving or denying the request. All of the following services (Paragraphs 4 through 11) are Level 4 services.

4. Mailbox for Medical Bill Inquiries. The Policy, Regulations and Procedures Unit (PRPU) of the DEEOIC Policy Branch, located in the National Office (NO), has created an electronic mailbox (email) for use in resolving medical bill questions. This mailbox is to be used when submitting inquiries concerning medical bills, travel reimbursement, treatment suites, provider outreach, or policy questions regarding medical bill processing.

The Fiscal Officers (FO) in each respective district office serve as liaison for Claims Examiners (CE) with questions

4. Mailbox for Medical Bill Inquiries. (Continued)

that require review by the PRPU, at the NO. CE2 staff submit questions to the mailbox through the CE2 Unit Manager. The Fiscal Officers and CE2 Unit Managers act as the District Office Point of Contact (DO POC) for purposes of communicating medical bill issues to the PRPU. A Medical Bill Processing POC at the National Office (Medical Bill POC) is responsible for routing email inquiries to the proper party at the NO.

Use of this mailbox provides for expedited resolution of medical bill issues as they arise, and provides a more uniform process for responding to these questions and issues, program wide. The email address is DEEOICbillpay@dol.gov, and is to be used exclusively by the DO POCs, upon completion of the following steps:

- a. When a CE receives an inquiry regarding reimbursement of a medical bill, for an accepted condition, the CE first reviews the bill in the Achieve medical bill inquiry system, and/or the Stored Image Retrieval(SIR)system, available at: <http://owcp.dol.acs-inc.com/portal/main.do> in order to verify that the supporting medical documentation is on file. If, after reviewing the supporting documentation in the ACS web portal and in the case file, the CE still has questions related to medical bill processing, travel reimbursement, treatment suites, provider outreach, or a policy question regarding medical bill processing, additional assistance may be requested through the medical bill inquiries mailbox.
- b. The CE prepares an email to the DO POC, or the CE2 prepares an email to the CE2 Unit Manager. In order to maintain consistency and to provide clarity in the communication process, it is imperative that the CEs provide sufficient information in the email, clearly defining the nature of the question, so that it can be routed to the proper entity at the NO. Inquiries to the mailbox should be categorized using

4. Mailbox for Medical Bill Inquiries. (Continued)

the subject headings below, and the subject line of the email must contain one of the following four subject headings:

(1) Policy Questions. Questions regarding policy interpretation or implementation are answered by the Medical Bill POC.

(2) Treatment Suites. The treatment suites and ICD-9 codes utilized by the DEEOIC are contained within a database, administered by medical professionals within the OWCP. This database compares an ICD-9 coded diagnosis, and associated services being billed by a provider, with a group (or suite) of acceptable, allowable treatments or services for that accepted condition. The use of treatment suites allows bills to be paid automatically when the treatment being billed is reasonable and customary for the accepted condition. Often, issues arise when a claimant is trying to obtain payment for a consequential illness and the medical bills are being denied because the consequential illness is not being recognized within the treatment suite(s) for the accepted condition. Inquiries of this nature will be directed to the Medical Bill POC, for a response.

(3) Provider Outreach. Questions from medical providers regarding assistance with enrollment, submission of bill(s), or understanding DEEOIC's medical billing process, must be forwarded to the Medical Bill POC, who will then coordinate with the Resource Center (RC) Manager on these issues. Provider outreach issues must be coordinated through the Medical Bill POC.

(4) Bill Payment Processing. Questions regarding reimbursement of medical bills should use this subject heading, and will be routed to

4. Mailbox for Medical Bill Inquiries. (Continued)

Payment Systems Manager for a response.

The body of the email itself must contain the following information (as applicable):

- District Office Location;
- CE Name;
- Employee's Name;
- DOL File Number(not to be used in the subject line);
- Accepted Condition(s) with ICD-9 code(s);
- Billed Amount(s);
- Date(s) of Service(s)or Travel day(s);
- Medical Provider Name(s);
- Type of Service(s) (i.e., Pharmacy, In-Home Health);
- Question(s) or issue(s) to be resolved.

c. Upon receipt of an email question being posed, the DO POC reviews the email carefully and determines whether the issue warrants review by the NO. If the question does warrant such review, the POC forwards the inquiry to DEEOICbillpay@dol.gov.

d. The Medical Bill POC reviews all submissions received in the medical bill inquiries email box and determines the proper course of action. As noted above, all policy, treatment suite, and medical provider outreach questions will be evaluated and answered directly by the Medical Bill POC. Issues related to medical bill payments will be forwarded to the NO Payment Systems Manager, who is responsible for evaluating each inquiry and providing a response. Some referrals to the mailbox may have elements related to several topics in the inquiry, and the Medical Bill POC ensures that the question is evaluated by the proper individual(s), and coordinates the response to the DO.

e. In the case of a policy or treatment suite issue,

4. Mailbox for Medical Bill Inquiries. (Continued)

the Medical Bill POC researches the inquiry and provides an answer to the requesting DO within five (5) business days. If a policy question requires additional research, a reasonable extension of time is granted by one of the PRPU Policy Unit Chiefs. Complex policy issues might require the involvement of the Policy Branch Chief before a response can be generated, and the Medical Bill POC must monitor such issues to ensure that they are resolved in a timely manner.

f. The Medical Bill POC forwards all medical bill payment inquiries directly to the Payment Systems Manager, who assesses each question and provides an answer directly to the inquiring DO within five (5) business days of receipt of inquiry.

g. The Medical Bill POC refers all medical inquiries to the RC Manager for response. The RCs serve as the primary point of contact for DEEOIC's provider enrollment inquiries. The RC Manager will provide a response to the Medical Bill POC within three (3) business days of receipt detailing the planned response to these types of inquiries. The Medical Bill POC will relay the proposed response(s) to the inquiring DO so the DO is aware that resolution is being sought.

h. Upon receipt of inquiry responses, the DO POC forwards the response to appropriate CE/CE2 via e-mail. The CE/CE2 is responsible for notifying the employee, claimant, authorized representative and or provider (if applicable), via telephone or in writing, of appropriate response to the issue at hand. All telephone activity is documented in the Energy Case Management System (ECMS) Telephone Management System (TMS) and a copy of the email response from the Medical Bill POC or Payment Systems Manager is placed in the case file.

4. Mailbox for Medical Bill Inquiries. (Continued)

- i. Policy decisions rendered through this process, which have the potential for program-wide impact, are treated like policy teleconference notes, and are placed on the shared drive for use by all DEEOIC staff. It is the responsibility of the Medical Bill POC to ensure that such issues, as identified by the PRPU Unit Chiefs/Policy Branch Chief, are added to the policy teleconference answers, on the shared drive.
5. District Medical Consultant Reviews. For detailed information on the DMC referral process, refer to DEEOIC procedures on weighing medical evidence.
6. Medical Records Procurement. DEEOIC pays cost associated with obtaining medical records regardless of whether a claim has been approved for benefits. This reimbursement is payable only to a hospital, physician's office, or other medical facility that charges a fee to produce records. The maximum allowable reimbursement is \$100 per employee.
- a. Form of Request. The provider provides the CE with the written fee request on official letterhead or billing statement. The request includes the tax identification number of the facility, total amount charged for the record request, and the provider enrollment number. If the provider is not enrolled, the CE forwards an enrollment package to the provider with a letter requesting that the provider enroll, and after completion of the enrollment process, the provider informs the CE of their new provider number.
 - b. Approval of Payment. Upon receipt of the required information, the CE approves the payment of the bill by completing a Form OWCP-1500, sending an approval letter to the requestor, and completing ECMS coding as required in DEEOIC procedures. The CE then forwards the completed Form OWCP-1500, approval letter, and invoice to the Fiscal Officer for payment processing.

7. Psychiatric Treatment. Prior to approval of psychiatric treatment, the CE must conduct the necessary medical development to substantiate a psychiatric condition as a consequential condition of an accepted illness; and the consequential condition must be accepted.

a. Expense of support groups that meet on a periodic basis, for individuals with a similar covered illness, are acceptable for reimbursement under the EEOICPA.

b. For ongoing therapy or for personalized care for a psychiatric condition, the CE obtains medical records and reports that support the need for these specific services as treatment for a consequential condition of the covered illness.

c. A narrative medical report from a licensed psychologist or psychiatrist must be submitted which includes:

(1) Diagnosis (with correct code);

(2) Medical rationale in support of how the psychiatric condition is related to the approved illness.

d. After appropriate development the CE decides whether to approve a psychiatric condition as a consequential illness. The CE advises the claimant of the decision to accept (via letter) or deny (via a Recommended Decision followed by a Final Decision), and updates ECMS as appropriate.

8. Hearing Aids (above \$5000). The CE approves hearing aids in excess of \$5,000 when hearing loss has resulted from an accepted illness, if the treating physician so recommends. DEEOIC may authorize maintenance of hearing aids, including batteries, repairs, and replacement as needed. For hearing aids under \$5,000, see DEEOIC procedures regarding durable medical equipment.

9. Chiropractic Services. Chiropractic services may be authorized, but are limited to treatment for correction of a spinal subluxation, along with the tests performed or required by a chiropractor to diagnose such subluxation. A diagnosis of spinal subluxation must be documented with an x-ray in the chiropractor's report prior to the CE considering payment.

10. Acupuncture Treatments. Acupuncture treatments may be authorized when recommended by the treating physician to provide relief. Such treatment shall be supervised by the treating physician, who shall submit periodic reports to show progress or any relief of the symptoms. If the treatment continues beyond six months and/or the results are questionable, the case should be referred to the DEEOIC Medical Director.

11. Organ Transplants (including Stem Cell). Treating physicians send all requests for organ transplants to DEEOIC's bill processing agent (BPA) via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such requests, and initiates a thread to the district office FO, advising of a new, pending organ transplant request. The FO alerts the CE of the request for a transplant, and the CE ensures that the case file contains the necessary documentation, including a letter describing the necessity of the transplant from the treating physician, laboratory and diagnostic test results, CT or MRI scan results, and a transplant protocol. Once the CE has verified that this information is on file, and is contained in the thread, the CE forwards the information to the Medical Bill POC. The Medical Bill POC forwards all pertinent information to the DEEOIC Medical Director, who prepares a memorandum approving or denying the transplant for signature by the DEEOIC Director. The signed memorandum is returned to the DO following signature by the DEEOIC Director. All approved requests for organ transplants must be performed at a CMS (Center for Medicare and Medicaid Services) approved facility. See

<http://www.cms.hhs.gov/ApprovedTransplantCenters/>

11. Organ Transplants (including Stem Cell). (Continued)

An organ donor is not considered an "employee" or "claimant" within the meaning of DEEOIC and is not entitled to compensation for wage-loss or permanent impairment, nor is a donor entitled to benefits for any complications resulting from the transplant. Only those medical and related expenses of the donor which are necessary to secure treatment for the employee are allowable.

a. In-Patient or Out-Patient. Depending upon the transplant center, the condition of the patient, and geographic limitations, transplant procedures may be performed on an in-patient or out-patient basis. Once a treating physician has requested approval for an organ transplant of any type, the CE forwards a letter to the transplant center requesting a detailed schedule of the procedures to be performed, and whether the procedure(s) require in-patient stay.

(1) Autologous transplants may be performed on either an in-patient or out-patient basis, depending upon the transplant center. This type of transplant requires stem cells that have been gathered and stored, coming directly from the patient. No unrelated donor, related donor, or cord blood search needs to be authorized.

(2) Allogenic transplants may also be performed on either an in-patient or out-patient basis. Allogenic transplants require that donor-blood stem cells be drawn, stored, and then transplanted into the patient.

b. Choice of Donors.

(1) The first choice of a donor is generally a family member or relative. If the transplant facility approves a related donor, transportation expenses and the cost of required medical procedures for obtaining the organ(s) or blood stem cells are reimbursable. The transplant

11. Organ Transplants (including Stem Cell). (Continued)

facility bills DEEOIC, referencing the employee's (recipient) SSN, in addition to pertinent information pertaining to the donor. Travel is reimbursed following the same guidelines established for companion medical travel, and is paid to the employee.

(2) If no suitable match is available through a relative, an unrelated donor search must be authorized. The transplant center coordinates with the National Donor Program for the testing of each potential donor. The transplant center bills for all such tests and procedures. The average time waiting for an unrelated donor is four months. Unrelated donors are not paid for their donation; the only coverage is for the medical expenses related to the organ donor procedure. These procedures are billed by the transplant facility, the same as with related donors, referencing the covered employee's social security number on all bills.

c. Long-Term Living Expenses. In many cases, transplants involve prolonged out-patient procedures requiring the patient to remain within a short distance of the transplant center. If the transplant procedure is authorized, and if it requires extended residency near the facility, lodging, per diem, companion, and other travel-related expenses may have to be authorized on a long-term basis. (Refer to Chapter 3-0300 for additional guidance on reimbursement for extended medical travel.)

12. Experimental Treatment and Clinical Research.

Experimental treatments, or those which are generally not accepted, will be considered if: the accepted condition is life-threatening; established therapy has been tried to no avail; and a significant body of data supports the view that the experimental procedure is indeed beneficial.

12. Experimental Treatment and Clinical Research.

(Continued)

All such requests are forwarded to the DEEOIC Medical Director for concurrence using the same procedures for organ transplants as outlined above, with the exception of the documents needed to approve the treatment. To request experimental treatment, the treating physician must send the treatment protocol, medical rationale, and peer reviewed documents supporting the treatment to the CE, to be forwarded to the NO for review.

13. Treatment Suites. At the core of the medical bill reimbursement process is the use of treatment suites. The treatment suites used by the DEEOIC are contained in a database maintained by medical professionals within the OWCP. They compare an accepted (ICD-9 coded) diagnosis for which a provider has billed, with acceptable, allowable treatments for that condition. The use of treatment suites allows automatic payment of bills, for authorized services, when the amount billed is reasonable and customary for an accepted condition.

14. Eligibility Files. In order for a claimant's bills to be paid, an eligibility file is automatically generated in ECMS and sent to the bill processing agent once a condition has been accepted. This eligibility file contains the accepted condition for which a claimant is entitled to medical treatment. When the accepted condition(s) are coded and billed with the correct ICD-9 Code, the volume of suspended and denied bills is significantly reduced. Consequently, accurate code selection expedites provider reimbursement for all approved medical services rendered to the claimant.

15. ICD-9-CM. The International Classification of Diseases, 9th Revision, and Clinical Modification, (referred to simply as ICD-9 codes), is a statistical classification and coding system used to assign appropriate codes for signs, symptoms, injuries, diseases, and other medical conditions.

15. ICD-9-CM. (Continued)

These codes are assigned, based on the claimants' medical documentation (records), including, but not limited to physician notes, diagnostic tests, and surgical reports. ICD-9 codes are composed of numbers with 3, 4, or 5 digits. Three-digit category codes are generally subdivided by adding a fourth and/or fifth digit to further specify and clarify the nature of the disease or medical condition. The CE entering an ICD-9 code must identify and enter the code that references the disease, illness or medical condition that was reported, and should identify the organ(s) or portion of the body affected by the condition.

In general, three-digit codes identify a category of illness, while codes with fourth digits are called subcategory codes, and those with fifth digits are referred to as sub-classifications.

When a specific condition, illness, etc., contains a 4th or 5th digit, the CE uses all available digits to identify the condition. In addition to providing further specificity of the anatomical site, the 4th and 5th digits also provide additional pertinent clinical information related to the injury or medical condition. Therefore, when selecting ICD-9 codes, the CE should always use the code that most specifically describes the medical condition reported.

a. Examples of valid 3-digit codes:

(1) 496- Chronic Obstructive Pulmonary Disease (COPD).

(2) 501- Asbestosis.

b. Examples of 4-digit and 5-digit codes:

(1) 162.5- malignant neoplasm, lower lobe, bronchus or lung (requires a 4th digit).

(2) 508.0- Acute pulmonary manifestation due to radiation (requires 4th digit).

15. ICD-9-CM. (Continued)

(3) 205.10- Myeloid leukemia, chronic, in remission (requires a 5th digit).

(4) If an employee was diagnosed with diabetes mellitus, it would be incorrect to assign code 250, since all codes in the diabetes series (250) have five digits.

16. Coding Software. Claims examiners are to utilize the coding software which is available at <http://www.ingenixexpert.com/expert>. This is an online tool that helps to identify the appropriate ICD-9-CM code. These guidelines are to be used as a supplement to the ICD-9-CM Coding books.

17. Prompt Pay. The Prompt Payment Act requires federal agencies to pay vendors in a timely manner. The Act requires assessment of late interest penalties against agencies that pay vendors after a payment due date. The DEEOIC has identified three classes of bills that fall under the Prompt Pay Act: Reviews by a District Medical Consultant, Second Opinion/Referee Medical Examinations, and Impairment Rating Examinations. These bills must be processed within seven calendar days from date of receipt in the District Office. (Refer to PM 2-800 for the specific actions to be taken by the CE and the Medical Scheduler in the processing of DMC bills.)

18. Time Limits for Submission of Medical Bills. DEEOIC pays providers and reimburses employees promptly for all bills that are properly submitted on an approved form and which are submitted in a timely manner. No such bill is paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred, or the service or supply was provided; or, more than one year beyond the end of the calendar year in which DEEOIC first accepted the claim, whichever is later.

19. Fee Schedule. For professional medical services, OWCP maintains a schedule of maximum allowable fees for procedures performed in a given locality.

The schedule consists of:

- a. An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class.
- b. An index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs.
- c. A monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

Generally, bills submitted using HCPCS/CPT codes can not exceed the fee schedule. If the time, effort and skill required to perform a particular procedure varies widely from one occasion to the next, DEEOIC may choose not to assign a fee schedule limitation. In these cases, the allowable charge is set individually based on consideration of a detailed medical report and other evidence. At its discretion, DEEOIC may set fees without regard to schedule limits for specially authorized consultant examinations, and for other specially authorized services.

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

- a. When the BPA receives a fee appeal request letter, the BPA stores an electronic copy of the

20. Fee Schedule Appeal Process. (Continued)

appeal letter in the Stored Image Retrieval system (SIR), linked to the remittance voucher, and sends a printed copy of the letter to DEEOIC Central Bill Processing, through the NO Payment Systems Manager (PSM).

b. For each fee schedule appeal letter received, the PSM creates a record, and maintains them in a tracking system (spreadsheet or database) created for this purpose.

c. The PSM reviews the fee appeal request to determine if the provider has met any of the conditions below which justify a reevaluation of the amount paid. These three conditions, as found in 20 C.F.R. 30.712, are:

(1) The service or procedure was incorrectly identified by the original code; or

(2) The presence of a severe or concomitant medical condition made treatment especially difficult; or

(3) The provider possesses unusual qualifications (i.e. possesses additional qualifications beyond board-certification in a medical specialty, such as professional rank or published articles.)

d. Within 30 days of receiving the request for reconsideration, the PSM prepares a response to the medical provider outlining DEEOIC's decision to either:

(1) Approve an additional payment amount: In this instance, the PSM generates a draft letter for the District Director's (DD) signature, informing the provider of the approval for additional payment. [Where an additional amount

20. Fee Schedule Appeal Process. (Continued)

is found to be payable based on unusual provider qualifications, the DD determines whether future bills for the same or similar service from that provider should be exempt from the fee schedule.] The PSM also prepares a memorandum for the case file stating the findings and the basis for the approval of the additional amount, or;

(2) Deny any additional payment: In this instance the PSM prepares a draft letter-decision for the DD's signature, advising that additional payment is denied, based upon the provider's failure to establish one of the conditions listed above, in Item c above(1,2,3). Where additional payment is denied, the letter decision must contain a notice of the provider's right to further review, similar to the following:

If you disagree with this decision, you may, within 30 days of the date of this decision, apply for additional review. The application may be accompanied by additional evidence and should be addressed to the Regional Director, District _____, Office of Workers' Compensation Programs, U.S. Department of Labor, [Insert appropriate Regional Office address and Zip Code.]

e. The draft approval or denial letters are prepared by the PSM, for the signature of the District Director (DD) whose office has control of the claim file(s) being addressed in the decision(s). The PSM sends the draft letter (via email) to the District Director for review, signature, and mailing. The DD places a copy of the signed letter in the case file and also returns (via email) a scanned copy of the signed letter, to be retained by the PSM.

f. The PSM continues to track the status of any

20. Fee Schedule Appeal Process. (Continued)

fee schedule appeal case, and maintains an electronic copy of all correspondence. This includes a copy of the draft letter and a scanned copy of the signed letter mailed by the DD.

g. If a denial is subsequently appealed to the Regional Director (RD), the RD must consult with the PSM to obtain copies of relevant bills and documents, and to discuss the appeal. The PSM also provides the RD with a copy of the denial letter signed by the DD. This can be handled via email.

h. After consultation with the PSM, the RD prepares a written response to the provider within 60 days of receipt of the request for review. Where additional payment is denied at the regional level, the letter decision from the RD advises the provider that the decision is final and is not subject to further administrative review. The RD forwards a scanned copy of the signed letter decision to the PSM. The PSM also retains that response as part of the appeal record.

i. The final outcome of each appeal letter is recorded in the PSM tracking system to indicate:

- (1) Additional payment made.
- (2) DD Denial letter.
- (3) RD Appeal letter.
- (4) Time limit (30 days) has expired for appeal to RD.
- (5) The final disposition date for each appeal letter.

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1. Purpose and Scope. This chapter describes the procedures for evaluating and approving requests from claimants who need ancillary medical services and supplies, and who seek reimbursement of expenses related to ancillary services. The roles and responsibilities of those who authorize such expenses are described in EEOICPA PM 3-0200.

2. In-Home Health Care. This section provides clarification with regard to the evidence needed to authorize in-home health care, as well as procedural guidance with regard to the process for review, development, and authorization of in-home health care services.

a. All requests for in-home health care must be submitted to DEEOIC's bill processing agent (BPA) via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office Fiscal Officer (FO), advising of a new pending in-home health request. FO is the point of contact with DEEOIC's BPA for all in-home health care requests.

b. All requests for in-home health care require prior authorization from the POC Claims Examiner (expedient review occurs under certain emergency situations - see "q" below for further information), including authorization for initial nurse assessment. If a physician requests that an initial in-home assessment be performed to determine the need for in-home health care, the request for that initial assessment must be submitted to the BPA with appropriate supporting medical documentation.

c. Written requests that are received in the district office from the claimant, the authorized representative, the treating physician, or a service provider, must be faxed by the POC CE to the BPA to begin the authorization process. Concurrently, the POC CE begins development on any such request while awaiting an acknowledgement from the BPA.

d. If the POC CE receives a request for an initial assessment without a physician's signature or

2. In-Home Health Care. (Continued)

recommendation, the POC CE must fax it to the BPA and begin concurrent development, the same as in step "c" above. The POC CE sends a letter to the claimant advising that a request for an initial in-home assessment was received without a physician's recommendation. In the letter, the POC CE provides 30 days for receipt of a physician's authorization or request for the assessment. If medical documentation is not received within 30 days, the POC CE denies the request for assessment pursuant to the instructions in "y" below.

e. Telephone requests for in-home health care must be documented in ECMS. Except in cases of an emergency nature (See "r" below), the POC CE may provide information and answer questions pertaining to in-home care covered by DEEOIC, however all callers should be advised that they must submit their requests in writing before the authorization process can begin. Written requests must include a medical rationale and a detailed explanation of the type and level of service the patient requires.

f. Valid requests do not always have to be initiated by a claimant to be considered valid requests. Requests for an in-home assessment of a patient's needs, and/or requests for in-home care can be initiated by an authorized representative, or any licensed doctor or medical provider.

g. Upon receipt of an authorization request for in-home health care from the BPA, the FO forwards the information to the appropriate POC CE for review and adjudication.

h. Upon receipt of such request, the POC CE must determine the particular in-home health services or care being requested. Generally, the types of requests that are submitted include: a physician's request for authorization of an initial in-home assessment; discharge summary from a hospital requesting specific in-home health care services; or requests from a

2. In-Home Health Care. (Continued)

physician for continuing in-home health care services (following expiration of a previous authorization).

i. Upon receipt of a request, the POC CE reviews the medical evidence to determine if the initial assessment or in-home health care was requested by the treating physician. If the request comes from the treating physician, or another appropriate doctor, the POC CE approves the initial assessment only (if applicable). When an initial assessment request precedes a request for in-home health care, the POC CE may not approve in-home health care until after the initial assessment has been completed and a plan of care has been submitted. Once the POC CE approves the initial assessment, the POC CE sends an email to the FO, who sends a thread to the BPA authorizing the request (see "p" for more information concerning approvals).

j. Upon receipt of a plan of care, discharge summary, or physician's recommendation delineating a specific request for in-home health care services, the CE must conduct a complete review of the case file to determine if there is any recent medical documentation from the primary care physician (or treating specialist for the accepted condition), describing the need for in-home medical care as it relates to the covered medical condition. The primary information that the treating physician must provide (often contained in the plan of care signed by a physician) should include:

(1) Description of the in-home medical needs of the patient arising from the covered medical condition. This includes a narrative of the patient's medical need for assistance while in the home and how this is linked to the covered medical condition. The physician must describe the findings upon physical examination, and provide a complete list of all medical conditions (those accepted by DEEOIC and those not accepted by DEEOIC). If a claimant has one or more non-covered conditions, medical evidence must

2. In-Home Health Care. (Continued)

demonstrate how the requirement for in-home health care is related to the accepted conditions. The physician should also describe laboratory or other findings that substantiate a causal relationship between the accepted condition(s) and the need for assistance or skilled nursing care in the home. Generally, approved in-home services include: administration of medication, medical monitoring, bathing and personal hygiene, meal preparation and feeding, wound dressing changes, and medical equipment checks.

(2) Level of care required, i.e. Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Health Aide (HHA), etc. The doctor must specify the appropriate type of professional who will attend to the patient. Services requiring specialized skills such as administration of medication and medical monitoring generally require a RN or LPN, while services of a general nature (typically referred to as activities of daily living), such as bathing, personal hygiene, and feeding are generally performed by home health aides and attendants.

(3) Extent of care required (months, days, hours, etc). A written medical narrative must describe the extent of care to be provided in allotments of time. (Example: RN to administer medication and check vitals once a day, every three days, with a home health aide to assist with bathing, personal hygiene, and feeding, eight hours a day, seven days a week for three months.)

k. If upon review the POC CE finds that the medical evidence is incomplete and the file does not contain an adequate description of the in-home health care needs of the patient, the POC CE prepares a letter to the claimant advising that the DEEOIC has received a request for in-home health care. In the letter to the

2. In-Home Health Care. (Continued)

claimant, the POC CE advises that additional medical evidence is required before services can be authorized. Additionally, the POC CE forwards a copy of the claimant letter to the treating physician, requesting a narrative medical report that includes all of the information described in "j" (above). In addition, the physician is asked to estimate the length of time for which the patient will ultimately require in-home health care assistance. The POC CE advises in the letter that the medical report is required within 30 days. (see Exhibit 1 for sample letter) The POC CE also faxes a copy of the letter to the treating physician's office.

1. Upon mailing the request to the claimant (copy to the treating physician) the POC CE enters an ECMS note describing the action and inserting a 15-day call-up. If on the fifteenth day the physician has not responded, the CE contacts the physician's office to inquire if the letter was received, and to ask if there are any questions regarding the request for information. The call is documented in TMS and another 15-day call-up inserted in ECMS.

m. After 30 days has passed with no satisfactory response from the treating physician, or no response from the claimant, the POC CE prepares a second letter to the claimant (accompanied by a copy of the initial letter), advising that following the previous letter, no additional information has been received from the treating physician. The POC CE advises that an additional period of 30 days will be granted for the submission of necessary evidence, and if the information is not received in that time, the request for in-home care may be denied by the DEEOIC (see Exhibit 2 for a sample letter).

n. If the claimant or the physician does not provide a response to the second request for information within the 30-day period allowed, the POC CE issues a letter decision to the claimant denying the claim for in-home health care. (See "y" below for more details.) The POC CE further sends an email to the FO, who sends

2. In-Home Health Care. (Continued)

a thread to the BPA advising that the service has been denied.

o. If the claimant calls and states that he/she does not require in-home health care, the POC CE requests that the claimant put this in writing. Upon receipt of any written statement from the claimant stating that he/she is not requesting in-home health care, the POC CE writes a letter to the claimant with a copy to the treating physician advising that the claimant is not requesting in-home health care and thus the matter is closed. In this situation, the POC CE sends an email to the FO, who sends a thread to the BPA advising that this service is denied.

p. If medical evidence is received, the POC CE must determine if it is of sufficient probative value to authorize in-home health care. It is absolutely critical that the POC CE undertake appropriate analysis of any documentation pertaining to in-home services before authorizing such care.

The underlying function of the POC CE is to ensure that the covered employee receives the necessary medical care for the accepted medical condition and that any such request for care reasonably corresponds with the medical evidence in the case file. If the physician does not provide sufficient details concerning the claimant's physical condition, relationship to accepted conditions, or specific reasons for in-home health care, the POC CE must refer the case to a District Medical Consultant (DMC) for review. Upon receipt of a DMC's opinion, the CE weighs the medical evidence in the file. If the DMC opinion is clearly in conflict with the recommendations of the treating physician, and the POC CE attempts to resolve the situation by communicating with the treating physician have not been successful, the POC CE is to arrange for a second medical opinion or referee evaluation, depending on the circumstances. In evaluating the medical evidence, the POC CE must base any determination solely on the weight of medical evidence in the case file. The POC CE must not under

2. In-Home Health Care. (Continued)

any circumstances deny or reduce in-home health care services without a medical basis for such denial.

q. In certain emergency claim situations (see "r" for a full discussion of the types of emergencies), the CE may authorize in-home health care for a preliminary 30-day period while additional development is undertaken.

(1) Under these circumstances, the physician or hospital staff contacts DEEOIC's BPA for immediate attention. The physician or hospital employee must notify the BPA that the situation is of an emergency nature (e.g., the claimant is being released from the hospital and requires immediate in-home care). The BPA obtains any pertinent documentation and assesses the emergency nature of the request. Once the medical evidence is obtained, the BPA contacts the FO immediately, advising of the situation and providing electronic copies of documentation obtained. The BPA does not make a decision regarding the request, but simply obtains the pertinent documentation and advises the FO of the emergency request.

(2) Upon receipt of the documentation, the FO forwards the information to the POC CE for review. If discharge information from a treating physician supports the need for immediate authorization, the CE provides approval for 30 days pending additional development. The POC CE concurrently sends an email to the FO advising of this approval. The FO sends a thread to the BPA with the approval information and places a telephone call to the BPA, alerting them of an impending emergency request.

(3) After the initial approval for 30-day emergency care, the POC CE sends a letter to the treating physician with a copy to the claimant requesting necessary evidence to fully substantiate that the care being provided is

2. In-Home Health Care. (Continued)

medically necessary to give relief for the accepted medical condition. This should occur within the preliminary 30-day authorization period. Extensions may be granted in increments of 30 days, but should generally never exceed a total of 120 days without the collection of the necessary evidence to fully document that the care being provided is medically warranted and necessitated by the accepted medical condition.

(4) In some situations the request for emergency home health care may not be accompanied by evidence supporting the emergency nature of the request. For example, the claimant's condition may be stable, or he/she is not being discharged from a hospital. In these situations, the POC CE sends a letter to the claimant, with a faxed copy to the requestor if other than the claimant. The letter advises that no evidence was submitted to support the request for emergency care, and that additional medical evidence is required. In addition, the POC CE sends an email to the FO advising that the request for emergency care is under development. The FO sends a thread to the BPA advising of this determination and places a telephone call to the BPA, alerting them of an impending emergency request.

r. Emergency situations warranting short-term preliminary authorization for in-home health care include:

(1) Requests for in-home health care for terminal patients with six months or less to live. Terminal status must be based on the opinion of a physician.

(2) Patients discharged from in-patient hospital care with need for assistance. The CE must carefully evaluate these situations to ensure the medical documentation clearly indicates that the patient's care and well-being is dependent on the

2. In-Home Health Care. (Continued)

assignment of a medical professional in the home, (normally following a hospital stay). If the BPA has not already obtained this, the POC CE requests the attending physician discharge summary and discharge planning summary, which is normally available within 72 hours of discharge.

When pre-authorization of emergency in-home care is to be granted, the POC CE prepares a memorandum for the case file documenting the rationale applied in authorizing care. For each subsequent 30-day pre-authorization granted, a new memo is prepared outlining the basis for such authorization. In addition, the POC CE notifies the claimant and provider in writing of additional periods of authorization. The POC CE sends an email to the FO advising of any authorizations, and the FO forwards the information to the BPA in the form of a thread.

s. For all requests, if upon review of the medical evidence the POC CE decides that in-home health care is required, authorization is to be granted. The POC CE prepares a letter notifying the claimant and the home health care provider of the decision, and delineating the following information (see Exhibit 3 for a sample authorization letter):

- (1) Covered medical condition(s) for which care is being authorized.
- (2) A specific narrative description of the service approved (e.g. in-home assistance in administering medicine, monitoring accepted conditions, assistance in/out of bed, preparing meals and feeding, and medical equipment checks).
- (3) Level and duration of the specialized care to be provided, i.e. RN 1 hour per day and Home Health Aide 8 hours per day, 7 days a week for a period of 3 months.

2. In-Home Health Care. (Continued)

(4) Authorized billing codes relevant to the level of authorization (see Exhibit 4 for a description of the pertinent codes).

(5) Period of authorization with specific start and end dates.

t. The authorization must be limited to in-home medical services that are reasonably necessary for the treatment or care of the patient's covered medical condition. These services generally include: Home Health Aide or attendant for mobility, food preparation, feeding and dressing; skilled nursing should be limited to the scope of practice of an RN or LPN, as long as there is medical evidence of such. The POC CE may not authorize a lower level of care than that requested by the physician unless the weight of medical evidence supports a lower level of care and the claimant has been provided the right to a recommended decision.

u. Once the responsible POC CE sends the letter of authorization to the claimant and the provider, the POC CE prepares an email to the fiscal officer (FO).

In the email, the POC CE advises the FO of the precise level of care, billing codes, and time period of authorization. The POC CE is not required to advise the FO of the number of correlating units per billing codes. In assigning billing codes, the POC CE references Exhibit 4.

v. Once the email authorizing the services has been sent, the POC CE enters a note into ECMS detailing the level of service and time period of authorization. In addition, the POC CE enters a call-up note into ECMS for 30 days prior to the expiration date for which services have been authorized.

w. If no request for additional authorization for in-home health care is received prior to the date of the call-up, the POC CE sends a letter to the provider, with a copy to the claimant. In the letter,

2. In-Home Health Care. (Continued)

the provider is notified of the expiration date of the in-home health care services. The provider is further advised of the medical evidence required if additional services are necessary. If the POC CE does not receive an additional request, further action is unnecessary. However, if the provider or the claimant submits an additional request for ongoing services, the POC CE evaluates the evidence as above.

x. Upon receipt of the email authorization from the POC CE, the FO prepares a thread to the BPA authorizing the specific level of care, billing codes (with units), and period of authorization. The FO calculates the authorized number of units based upon the POC CE's description of the level of care, weekly authorized amount for each level of care, and the time period of authorization.

y. If upon review of the medical evidence in the file, and if after appropriate development as outlined above, the POC CE determines that there is insufficient evidence to warrant authorization of in-home health care, the POC CE sends a detailed letter-decision to the claimant (with a copy to the in-home provider). The letter-decision must include a sentence at the end with language as follows:

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.

z. In the event that the claimant does request a Recommended Decision, the POC CE prepares a Recommended Decision (see Exhibit 5 for a sample decision).

aa. At any time after a period of authorized services and after the POC CE has undertaken any medical development (i.e. letter to the claimant requesting additional documentation, referral to DMC or second

2. In-Home Health Care. (Continued)

opinion) the POC CE may receive new medical evidence that warrants a change in the level of in-home care currently authorized. If this occurs, the POC CE must review that evidence, employing the same decision-making process described in "p." If the new medical evidence supports a denial of services, or reduction in the level of services currently being authorized, that reduction or denial must be communicated to the claimant in a detailed letter as discussed in "y", (with a copy to the in-home care provider) explaining the change.

bb. Letters that advise of a reduction or termination of services must be copied to the in-home care provider and must specifically advise the claimant that:

(1) Any reduction in the current level of service being provided will occur 15 days from the date of the letter. This letter must also contain information describing the new level of care being authorized; or,

(2) Any termination of services will occur 30 days from the date of the letter.

cc. After the expiration of the 15 or 30 day periods, the POC CE sends a letter-decision to the claimant advising as to the final action taken on the request for in-home health care services. In this letter the POC CE advises the claimant of his/her rights of action as delineated in action item "y" above.

In addition, the POC CE sends an email to the FO advising of the new level of care or the termination of current level of services. The FO then sends a thread to the BPA advising of the determination. It is very important for the POC CE to note that only a single authorization can exist at any one time. If the POC CE has authorized a certain level of care that subsequently changes, it is essential that this information be clearly communicated in an email to the FO. The FO sends a thread to the BPA advising of any

2. In-Home Health Care. (Continued)

change in the level of care being authorized, or of any additional period of authorization beyond the existing expiration date. The POC CE must also document the information in the notes section of ECMS when a thread is sent to the BPA.

dd. If the claimant requests a recommended decision on a termination of services, the POC CE proceeds with a recommended decision. If the claimant requests a recommended decision on a reduction in the level of care, the POC CE proceeds with a recommended decision.

ee. If, after initial approval of services, the claimant's treating physician sends in medical documentation (without prior POC CE development) recommending a lower level of care, the POC CE authorizes the new level of care via letter to the claimant (with a copy to the provider). Since the new level of care is requested by the treating physician without development by the POC CE, the POC CE does not need to provide the claimant with a right to a recommended decision. The POC CE concurrently sends an email to the FO advising of the new level of care. The FO sends a thread to the BPA advising of this change.

(1) Period of Service. In-home health care may be authorized for a period of up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

3. Attendant Services. This section provides clarification with regard to the evidence needed to authorize attendant services. Refer to item 2 of this chapter for guidance regarding development of attendant services.

a. Section 7384t of the EEOICPA authorizes payment for personal care services whether or not such care

3. Attendant Services. (Continued)

includes medical services, as long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly trained individual.

(1) Attendant services are non-skilled services routinely provided in an in-home setting. These services assist claimants with activities of daily living (i.e. bathing, feeding, dressing, etc). Attendant services must be provided by a trained individual.

(2) The POC CE may authorize attendant services to a claimant when a treating physician determines that these services are required for an accepted condition. The physician must provide a written statement, prescription or plan of care to that effect.

b. A claimant's relative may provide attendant care (if properly trained), but may not be reimbursed for care that falls within the scope of household duties and other services normally provided by a relative. Duties such as maintaining a household, washing clothes, or running errands are not considered attendant services, and will not be authorized. A claimant's relative who provides attendant care services to a claimant can be authorized for reimbursement up to 12 hours per day.

c. All requests for attendant services must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of new, and pending attendant service requests. Upon receipt of an authorization request for attendant services from the BPA, the FO forwards the information to the appropriate POC CE for review and adjudication.

3. Attendant Services. (Continued)

(1) Period of Service. Attendant services may be authorized up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

(2) Billing. Attendant care services should be billed weekly or monthly. Supporting documentation (i.e., weekly or monthly notes) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards weekly/monthly notes to the district office for review. In assigning billing codes, the POC CE references Exhibit 4.

4. Hospice Care. This section provides clarification with regard to the evidence needed to authorize hospice care services. Refer to item 2 for guidance regarding the development of hospice care.

a. Hospice care is generally requested and authorized when a claimant is determined to be terminally ill and has no more than six months to one year of life remaining.

(1) When a treating physician determines that hospice care is required for an accepted condition and provides a written statement, prescription or plan of care to that effect, the CE may authorize the services.

(2) Hospice, once authorized, is responsible for assessing the claimant's needs and providing all levels of care to the claimant.

b. All requests for hospice care in the home must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of a new, pending hospice request. All requests for hospice care require prior

4. Hospice Care. (Continued)

authorization from the CE. Upon receipt of an authorization request for hospice care from the BPA, the FO forwards the information to the appropriate CE for review and adjudication.

(1) Period of Service. Hospice services may be authorized for up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

(2) Billing. Supporting documentation (i.e., medical notes) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards monthly notes to the district office for review. In assigning billing codes, the CE references Exhibit 4.

5. Extended Care Facilities. This section provides clarification with regard to the evidence needed to authorize placement in an extended care facility.

a. Care in a nursing home, skilled nursing facility and assisted living facility may be authorized when the claimant does not need acute care but does require medical services and assistance with daily activities of living.

b. All requests for extended care must be submitted to DEEOIC's BPA via fax, mail, or electronically, to begin the authorization process. The BPA creates an electronic record of all such documents and requests, and initiates a thread to the district office FO, advising of a new, pending extended care facility request. All requests for extended care require prior authorization from the CE. Upon receipt of an authorization request for extended care from the BPA, the FO forwards the information to the appropriate CE for review and adjudication.

When a treating physician determines that extended care is required for an accepted condition, and

5. Extended Care Facilities. (Continued)

provides a written statement to that effect, the CE may authorize the services. The claimant should remain under continuing medical supervision of a physician while residing in an extended care facility.

(1) Period of Service. Extended Care facilities may be authorized up to six months. Recertification is required for any period of time beyond six months. Recertification should be completed before the current authorization expires, to allow for care to continue uninterrupted.

(2) Billing. Supporting documentation (i.e., medical notes and itemization of charges,) must be submitted with the bill to the DEEOIC's BPA. The DEEOIC's BPA then forwards supporting documentation to the district office for review. DEEOIC will reimburse the rates for standard accommodations according to the requirements of the medical condition. In assigning billing codes, the CE references the Current Procedural Terminology (CPT) manual.

6. Durable Medical Equipment. This section describes procedures to be followed when a claimant requests authorization for durable medical equipment (DME), appliances and supplies. All DME, appliances, and or supplies must be purchased from a DME supplier.

a. DME is primarily and customarily used to serve a medical purpose only. DME can withstand repeated use, and is appropriate for use in the home. Some examples of DME include hospital beds, walkers, wheel chairs, and oxygen tents.

b. The District Office has broad discretion in approving DME, appliances, or supplies provided under the EEOICPA.

(1) Most appliances, supplies and or DME purchases under \$5,000.00 do not need CE approval

6. Durable Medical Equipment. (Continued)

and are automatically paid by the DEEOIC's BPA in accordance with the OWCP fee schedule.

(2) Requests for DME, appliances and or supplies equal to or over \$5,000 (excluding mobility devices) must be approved by the CE, and that approval must be communicated to DEEOIC's BPA through the FO.

(3) Requests for mobility devices, such as a scooter or a motorized wheelchair, including its components and accessories, which are medically necessary to provide basic mobility, under \$10,000, do not need approval and are paid automatically by DEEOIC's BPA.

(4) Requests for mobility devices equal to or over \$10,000 must be approved by the CE, and that approval must be communicated to DEEOIC's BPA through the FO.

c. When authorizing purchase requests for DME equipment equal to or over \$5,000 and mobility devices equal to or over \$ 10,000, the CE must obtain the following information:

(1) From the treating physician:

(a) The treating physician must provide either a detailed letter of medical necessity or another means of justification for the medical equipment required, relating the need to the accepted condition.

(b) A full, specific description of the basic equipment.

(c) The anticipated duration of the need for the item (to determine whether rental or purchase is appropriate).

(d) The full name and address of two suppliers.

6. Durable Medical Equipment. (Continued)(2) Claimant:

(a) Claimant must submit two estimates from two different DME suppliers. These estimates must be for exactly the same type of DME appliances and or supplies.

(3) From the Supplier:

(a) From each potential supplier, a signed statement describing in detail the DME equipment item, a breakdown of all costs including delivery and installation, and the current Healthcare Common Procedure System (HCPCS) code for each DME item needed.

e. Estimates. The CE must authorize the lowest estimate provided that no exceptional circumstances warrant the higher estimate, (e.g., inability to provide the equipment in a timely fashion).

f. Repair/Maintenance Cost: Cost for repairs and maintenance to DME equipment is covered.

g. DME add-ons or Upgrades: Add-ons or upgrades are not covered; when they are intended primarily for the claimant's convenience, and do not significantly enhance DME functionality.

h. Communicating the decision. Upon receiving a request for DME, appliances or supplies, the CE takes one of the actions below:

(1) Approval: If the CE approves the request, he/she writes a letter to the claimant advising him/her of the decision. The letter includes the following: the date DO received the request; the type of service or appliance being approved; and a statement that the reimbursement amount will be based on the OWCP fee schedule. The CE also communicates this decision to the DEEOIC's BPA, through the fiscal officer. The claimant should be instructed to submit a copy of

6. Durable Medical Equipment. (Continued)

this approval letter, along with the request for reimbursement or payment, to the DEEOIC's BPA.

(2) Additional Information: If upon review the CE determines that additional information is necessary, he/she writes to the claimant requesting specific documentation that is necessary to continue the processing of the payment.

(3) Follow-up. If the provider and/or claimant do not respond to the development letter, or if he/she fails to provide sufficient documentation to support their request, the CE has the discretion to either take additional steps to develop the evidence, or to deny the request. The CE must review the evidence in accordance with the guidance in this chapter, properly weighing the medical rationale provided.

(4) Denials. If the CE denies the request he/she writes a detailed letter decision to the claimant detailing the reason(s) for the denial. The letter-decision must include a sentence at the end with language as follows:

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.

(5) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

7. Vehicle Modifications and Purchases. This section provides clarification with regard to the evidence needed to approve vehicle modifications and purchases; as well as procedural guidance with regard to the process for review, development, and authorization of vehicle modifications and purchases.

7. Vehicle Modifications and Purchases. (Continued)

a. When it becomes necessary to provide the claimant with some form of private transportation, other than taxis or hired services, modification to, or replacement of the claimant's privately owned vehicle can be approved. Upon receipt of a letter of medical necessity from the treating physician, detailing the physical limitations involved, and the specific transportations needs of the claimant as related to the accepted medical condition. The CE must gather two estimates from certified or licensed dealers for the cost of vehicle modifications recommended by the claimant's treating physician. The CE has the latitude to approve an estimate that the claimant favors, if the estimates are reasonably similar in scope and cost.

(1) Criteria for Modifications. If the claimant's transportation needs can be met by modifying or adding accessories and equipment to the claimant's present vehicle, the CE explores this option first, before consideration is given to replacing the existing vehicle. When considering modifications to an existing vehicle, the CE takes into consideration the type of vehicle currently owned, its age, and condition. Modifications must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as is practical.

(2) Proposals. If the CE determines that the claimant's needs warrant vehicle modification, the CE advises the claimant in writing to submit a detailed written proposal containing the following information:

(a) The year, make, model, and body style of the vehicle to be modified, as well as current mileage, description of general mechanical condition, and any repairs currently needed or anticipated. The same applies regardless of whether the vehicle to be modified is new or used.

7. Vehicle Modifications and Purchases. (Continued)

(b) An itemization of all vehicle modifications proposed, to include parts, labor and their respective costs. The itemization should also specify the amount of time required for the modifications.

(3) After considering the proposal for modification to an existing vehicle, the CE accepts or rejects the proposal, in writing, within a reasonable time frame.

(4) Approval. If upon review of the evidence the CE approves the request, the CE writes a detailed letter decision to the claimant advising of the approval.

(5) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the appropriate homegrown code (e.g. VH MDF, VHPUM) for a vehicle modification or purchase and the amount approved. The fiscal officer communicates this approval to DEEOIC's BPA.

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

(7) Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows:

If you disagree with this decision and wish to request a formal decision, please

7. Vehicle Modifications and Purchases. (Continued)

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.

(8) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

(9) Purchase. If it is established that the claimant's currently owned vehicle is no longer acceptable for his or her transportation needs, and if modifications to that vehicle are not possible or practical, then the CE reviews the case with a supervisor and may authorize the purchase of a suitable replacement vehicle, taking credit (see (e) below) for the value of the claimant's existing vehicle. Purchase options include the following:

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

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

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

(d) Whether a new or used vehicle is purchased, it must be a vehicle of similar quality as the vehicle that the claimant already owns (i.e. a vehicle in a price range that closely approximates the level of income and/or standard of living of the claimant).

7. Vehicle Modifications and Purchases. (Continued)

For example if the claimant owns a mid-priced Chevrolet, Ford, Honda or Toyota, purchase of a Cadillac or Lincoln SUV, to be modified for their needs, would not be of comparable value. A vehicle of comparable value would have to be selected. Once the baseline cost of a comparable quality vehicle has been established, the claimant may (at his or her option) choose to upgrade the baseline model, by adding additional equipment, with the difference in cost being paid for by the claimant.

(e) After determining the baseline cost of a comparable vehicle, the CE must take credit for (deduct) the wholesale value of the claimant's existing car, when determining the allowance to be paid for a replacement vehicle. The wholesale value of the existing vehicle can be determined through a number of internet websites that make this information available free-of-charge. The CE should advise the claimant of the source of their information, once the wholesale value of the claimant's current vehicle has been determined.

(f) Sales Tax: State sales tax should be included in the cost of obtaining a replacement vehicle.

(g) Equipment that is medically necessary for the accepted condition should be factory-installed whenever possible.

(10) Maintenance Costs. The CE authorizes necessary maintenance on the specialized equipment in a modified vehicle, whether installed in a new or used vehicle.

a) Replacement cost of the specialized equipment, due to normal wear and tear, may be considered as well. Other parts of the

7. Vehicle Modifications and Purchases. (Continued)

vehicle will be maintained at the owner's expense, even if the vehicle purchase was reimbursed by DEEOIC.

(b) Replacement of the vehicle, and all authorized equipment, can be considered if the claimant can establish that the age, mileage, and condition of the vehicle warrant such replacement. Any residual value remaining in the vehicle to be replaced would be applied as a credit toward the cost of a replacement vehicle.

(11) Proof of Insurance. The claimant is required to obtain adequate insurance and to maintain current registration of the vehicle in the state of residence. Claimants are required to carry comprehensive (fire, theft, vandalism, etc.) and collision insurance on any vehicle for which DEEOIC has authorized reimbursement, unless the fair market value of the vehicle and its equipment is less than \$2,500. The claimant may select the deductible of the insurance policy but will be responsible for any such deductible should an accident occur.

(12) Vehicle No Longer Needed. When the claimant no longer needs the vehicle, DEEOIC is entitled to recover the fair market value of the modified vehicle, less any percentage contribution the claimant made to the overall purchase price of the vehicle and its modifications. If the fair market value of the modified vehicle is less than \$5,000, no reimbursement will be due DEEOIC.

(a) Example 1. The claimant owns a \$10,000 vehicle that is not suitable for modification. The purchase price of a suitable replacement vehicle is \$30,000. The claimant contributes \$10,000 toward the purchase of the new \$30,000 vehicle, as this represents the value of the vehicle he or she owned, which is being replaced. DEEOIC

7. Vehicle Modifications and Purchases. (Continued)

then pays an additional \$20,000 in reimbursement toward the purchase price of the modified vehicle.

(b) Example 2. The claimant has a \$30,000 vehicle, for which he or she has contributed one-third of the purchase price. At the time of sale, the claimant would be entitled to one-third of the proceeds and DEEOIC would recover two-thirds. However, if at the time of sale, the fair market value was determined to be \$4,995 (less than \$5000); the DEEOIC would recover zero dollars.

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

a. Modifications must be prescribed by a treating physician whose medical specialty qualifies him or her to offer a medical opinion on the specific architectural needs of a medically disabled person. Modifications must be in conformity with applicable building codes and must conform to the standard of décor that existed prior to the disability.

(1) Modifications to Owned Property.

Modifications to a house must be consistent with the claimant's pre-injury standard of living and should approximate that standard insofar as practical, with respect to the quality of construction materials and workmanship.

(a) Modifications may include certain additions where warranted. For example, if a ground-floor recreation room is converted to a bedroom, to accommodate a wheelchair-bound individual, and if no ground-floor bathroom facilities exist, then the addition of a bathroom on the ground floor could be approved. Similarly, if there is no suitable

8. Housing Modifications. (Continued)

space for conversion to a bedroom on the ground floor, then the addition of a bedroom on the ground floor could be approved, if no other reasonable alternative exists.

(b) Modifications may include certain accessories. The addition of appliances such as air conditioning or air filtration equipment can be considered, if found to be medically necessary for the relief of certain accepted medical conditions.

For example, if the claimant suffers from respiratory or cardiac conditions that have been accepted, his or her physician may order that the claimant be kept in an air conditioned environment, in which case the expense for these modifications would be allowed.

(c) Maintenance expenses. The CE approves maintenance expenses for equipment furnished to the claimant, as well as replacement costs after normal wear and tear.

(d) The Government is entitled to reimbursement for the value of any special equipment that can be removed and sold separately, when no longer needed by the claimant. Reimbursement shall also be owed for any increase in overall value of the property resulting from permanently installed special equipment, or for any architectural modifications of a permanent nature, that improve the value of the property.

The value of such permanent equipment or modifications may be determined in any reasonable, equitable manner, such as written estimates from real estate sources, or by comparing the recent sales prices of similar houses without the special

8. Housing Modifications. (Continued)

equipment. No reimbursement to the claimant should be considered for any reduction in the value of the property resulting from modifications which may inconvenience prospective purchasers.

(2) Modifications to Non-Owned Property. Any modifications to property not owned by the claimant and his or her family are subject to approval by the landlord or owner. *This is in addition to the preceding guidelines established for owned property.* When presented with a request for modifications to non-owned property, the CE considers the following points:

(a) Rental property may be subject to federal (Americans with Disabilities Act), state or local statutes that mandate barrier-free accessibility for persons with disabilities. The claimant should discuss any change in housing needs with his or her landlord, who may be able to offer modifications or alternative accommodations better suited to the needs of the individual.

(b) If the landlord is unable or unwilling to pay for modifications, or offer other suitable accommodations, approval must still be obtained from the landlord prior to making any changes or alternations to the non-owned property. Any such changes must be made at the claimant's expense, and are subject to review and approval by DEEOIC, prior to any reimbursement.

(c) If the landlord/owner will not permit modifications, or if the costs are excessive, and if suitable housing arrangements are available elsewhere, it may be more cost-effective to consider paying relocation expenses rather than paying for modifications at the current location. If

8. Housing Modifications. (Continued)

changing locations is the most cost-effective alternative, the CE may authorize a subsidy for any increase in rent, if warranted, in addition to the relocation expense. For example, if the claimant lives in an apartment with stairs, and is no longer able to climb stairs due to his or her accepted condition(s), DEEOIC would reimburse the claimant for the most nearly comparable apartment available that offers an elevator and any other accommodations required to fulfill the claimant's medical needs arising from the claimant's accepted condition(s).

(d) The Government is entitled to reimbursement only for the value of special equipment that can be removed and sold separately, once the claimant no longer needs that equipment. Improvements or modifications, and any increase in property value resulting from such changes, accrue to the benefit of the owner.

(3) Proposals. If the CE determines that the claimant is eligible for housing modifications, the CE asks the claimant to submit a detailed written proposal for review and consideration.

The CE advises the claimant that the proposed housing modifications should be of a quality and finish consistent with his or her present residence, not superior to it. Further, the claimant should be cautioned that structural modifications must not compromise the integrity of the existing structure.

While the choice of modifications remains with the claimant, the CE does not authorize payment for any modifications that are structurally unsound.

8. Housing Modifications. (Continued)

Modifications will be no more expensive than necessary to accomplish the required purpose. For example, when remodeling a bathroom, it may be feasible to re-install an existing sink at wheelchair height, for less than the cost of discarding the sink and buying a new one.

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

Proposals must include the following information:

(a) A medical report detailing the physical limitations for which the requested modifications are necessary. This report should be prepared by a physician who is a recognized authority in the appropriate medical specialty. Reports from physical or occupational therapists may also be helpful in determining the nature of the modifications required.

(b) An itemization of all modifications proposed. Where substantial modifications are required, the detailed changes should be recommended by a medical or rehabilitation professional familiar with the needs of the disabled.

(c) If the claimant lives in a rented or non-owned premise, a written statement from the landlord/owner must be obtained, approving and authorizing the specific plans and proposed modifications.

8. Housing Modifications. (Continued)

(d) The CE reviews the itemized proposal and determines if the specified modifications are warranted. If the CE identifies technical issues regarding implementation, the CE develops the issue further to identify alternate solutions.

b. Fees and Bids.

(1) Reasonable fees may be paid for the medical or rehabilitation professional's visit to the site, and for the preparation of the detailed report. The same applies to any architectural drawings that are required for significant structural changes.

(2) No fee will be paid for attorneys or similar representatives engaged by the claimant to assist with the proposal. Any fee charged by an Approved Representative remains the claimant's obligation.

(3) Two or more bids must be obtained by the CE for the proposed changes from licensed and/or certified contractors. These bids must be for exactly the same modifications so that a true comparison of the competitive bids can be obtained.

(a) If construction work is required, the bids obtained must be for binding estimates of the cost. No fees will be paid for the bids or estimates.

(b) If special accessories or devices are required, the CE stipulates that the price quoted by the vendor includes any necessary installation.

(4) The CE reviews the bids and selects the one which combines any acceptable alternative means of achieving the desired results with the lowest cost, unless there is a sound reason for a

8. Housing Modifications. (Continued)

higher-cost alternative, such as increased durability.

(5) Approval. If upon review of the evidence the CE approves the request, the CE writes a detailed letter decision to the claimant advising of the approval.

(6) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the homegrown code (e.g. HSMDF) for housing modifications and the amount approved. The fiscal officer communicates this approval to DEEOIC's BPA.

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

(8) Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows:

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.

8. Housing Modifications. (Continued)

(10) Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

9. Health Facility Membership/Spa Membership. This section describes procedures to be followed when a claimant requests authorization for reimbursement of fees to join a commercial health club or spa.

a. Authorization. Membership in a health club or exercise facility, or treatment at a spa, may be authorized when recommended by the treating physician as likely to treat the effects, cure or give relief from a covered illness. All requests for reimbursement of health facility and spa fees require prior authorization from the CE.

In all cases where such membership is requested, the CE determines whether the membership is likely to be effective and cost-efficient.

b. Payment. Whenever a request for payment of health club/spa membership is received, the CE obtains the following information:

(1) Information from Physician. The CE obtains the following information from the treating physician:

(a) A description of the specific therapy and or exercise routine needed to address the effects of the covered illness, including the frequency with which the exercises should be performed.

(b) The anticipated duration of the recommended regimen (i.e. weeks, months, etc.).

(c) An opinion as to the actual/anticipated effectiveness of the regimen, treatment, goals attained/sought, and frequency of

9. Health Facility Membership/Spa Membership. (Continued)

examinations to assess the continuing need for the regimen.

(d) A description/list of the specific equipment and or facilities needed to safely perform the regimen.

(e) The nature and extent of supervision, if any, required for the safety of the claimant while performing the exercises.

(f) An opinion stating whether exercise can be performed at home, as part of a home exercise program, or a recommendation as to what kind of public or commercial facility could provide the prescribed exercise routine.

(2) Information from Claimant. In addition, the CE obtains the following information from the claimant:

(a) The full name, address, and distance from the claimant's home or work location, of any public facilities (no membership required) and those commercial facilities (membership required) able to accommodate the prescribed regimen.

(b) If applicable, the specific reason(s) membership in a commercial health club/spa is required when public facilities are available, and or where the doctor indicates the regimen can be performed at home.

(c) A signed statement from the health club/spa manager stating that the club/spa can fully provide the exercise regimen prescribed by the treating physician, and a breakdown of the fees and charges for various membership options and terms. The statement should describe all facilities,

9. Health Facility Membership/Spa Membership. (Continued)

services, and special charges not included in the membership fee.

c. Approval.

(1) For all requests, if upon review of the evidence the CE approves the request, CE must write a letter to the claimant advising of the approval. The letter must include the following:

(a) The date the DO received the request.

(b) The period of time which the approval will cover.

(c) The amount approved (i.e. monthly or annual fee, etc.).

(d) The type of membership approved.

(e) Two copies of a blank OWCP-957

(2) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the specific services being approved, citing the homegrown code (i.e. GYMME) and the amount to be reimbursed. The FO communicates this approval to DEEOIC's BPA.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting additional documentation that is necessary to continue with the review process. In the letter, the CE provides 30 days for receipt of the requested information.

e. Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient documentation to support the request, after considering all relevant evidence, the CE issues a detailed letter decision informing the

9. Health Facility Membership/Spa Membership. (Continued)

claimant of the denial. The CE also informs DEEOIC's BPA through the FO of this denial. The letter-decision must include a sentence at the end with language as follows:

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.

- f. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.
- g. Reimbursement Request. If a request for reimbursement of a health facility membership or spa membership, not previously approved, is submitted for payment to DEEOIC's BPA, the DEEOIC's BPA communicates this to the DO through the FO, and waits for approval from the CE.
- h. Period of Service. Health facility membership may be authorized for up to twelve months. Recertification is required for any period of time beyond twelve months.

10. Medical Alert Systems. This section describes procedures to be followed when a claimant requests authorization for medical alert system.

- a. Definition. A Medical Alert system is an electronic device connected to a telephone line. In an emergency, the system can be activated by either pushing a small button on a pendant or pressing the help button on the console unit. When the device is activated, a person from the 24 hour central monitoring station answers the call, speaks to the claimant via the console unit, assesses the need for help, and takes appropriate action. A medical communication system qualifies as a Medical Alert system if it includes the following requirements:

10. Medical Alert Systems. (Continued)

(1) An in-home medical communications transceiver;

(2) A remote, portable activator (Personal Pendant, etc.);

(3) A central monitoring station staffed by trained attendants 24 hours a day, seven days a week (optional).

b. Authorization. All requests for medical alert systems require prior authorization from the CE. A request for a medical alert system must be documented with a letter of medical necessity from the treating physician, linked to the accepted condition, which includes a statement that the claimant has an acute or chronic condition which can require urgent or emergency care.

(1) Period of Service. The CE may authorize the medical alert system for up to twelve months at a time. The need for such equipment should be recertified by the prescribing physician prior to the expiration of the authorization period.

(2) Billing. Systems that require a one-time connection fee and monthly monitoring fee may be approved, based on the claimant's needs and the medical justification. The equipment provided is leased and must be returned when no longer needed to avoid further charges. DEEOIC is not responsible for any additional charges incurred for failure to return equipment or failure to timely return the equipment in a timely manner.

c. Approval.

(1) For all requests, if upon review of the evidence the CE approves the request, the CE writes a letter to the claimant advising of the approval. The letter includes the following:

(a) The date the DO received the request;

10. Medical Alert Systems. (Continued)

(b) The period of time which the approval will cover;

(c) The amount approved.

(2) Notifying the BPA. Once the CE sends the letter of approval to the claimant, the CE prepares an email to the FO. In the email, the CE advises the FO of the approval, citing the HCPS code for a medical alert system and the amount approved. The fiscal officer communicates this approval to DEEOIC's BPA.

d. Additional Information. If the CE determines that additional information is necessary, the CE sends a letter to the claimant (with a copy to the treating physician) requesting specific documentation that is necessary to continue with the approval process. In the letter, the CE provides 30 days for receipt of the requested information.

e. Follow-up. If the claimant does not respond to the development letter, or if he or she fails to provide sufficient medical documentation to support the request, the POC CE sends a detailed letter decision to the claimant. The CE also informs DEEOIC's BPA through the FO of this denial. The letter decision must include a sentence at the end with language as follows:

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.

f. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

g. Reimbursement Request. If a request for reimbursement of a medical alert system not previously

10. Medical Alert Systems. (Continued)

approved is submitted for payment to DEEOIC's BPA, the DEEOIC BPA communicates this to the DO through the FO, and awaits approval from the CE.

11. Medical Expense Reimbursement for Extended Travel.

This section describes procedures to be followed for authorizing medical travel requests over 200 miles round trip, and the process for approving claims for reimbursement, regardless of whether the claimant obtained prior approval for the trip.

a. Travel Claims. All claims for travel reimbursement must be sent to DEEOIC's BPA. Should the CE receive a reimbursement request directly from the claimant for an authorized trip, the CE forwards it immediately to DEEOIC's BPA to begin the reimbursement process. In the event the CE receives a claim for travel reimbursement that was not approved in advance, the CE immediately forwards the claim to the DEEOIC's BPA, and concurrently begins the process of approving or denying the trip. This ensures that all claims are adjudicated promptly and are properly recorded and tracked by DEEOIC's BPA, throughout the reimbursement process.

b. Authorization. DEEOIC requires pre-authorization for reimbursement of transportation, lodging, meals, and incidental expenses incurred when a claimant travels in excess of 200 miles round trip for medical care of an approved condition. DEEOIC's BPA processes reimbursement claims for claimant travel without pre-authorization when travel is less than 200 miles round trip.

c. Processing. DEEOIC's BPA processes reimbursement claims in accordance with GSA travel guidelines. Per diem rates for overnight stay and mileage reimbursement rates are published on GSA's website, and air fare reimbursement is based on actual ticket cost up to the amount of a refundable coach ticket (Y-Class airfare).

11. Medical Expense Reimbursement for Extended Travel.

(Continued)

d. Approval. Upon acceptance of a medical condition, the claimant receives a medical benefits package from the DEEOIC that includes instructions on how to submit a written request for prior approval of medical travel when such extended travel (over 200 miles round trip) is required. Despite these instructions, it is not uncommon for claimants to submit their request for reimbursement after a trip has been completed, and without having obtained prior approval.

e. Travel Exceeding 200 Miles. Medical expense reimbursement for travel exceeding 200 miles round trip must be authorized by the CE. Claims that are submitted to DEEOIC's BPA, for reimbursement of travel expenses arising from medical travel in excess of 200 miles roundtrip, will not be processed for payment unless authorization has been provided by the district office.

(1) Requests. Upon receipt of a travel authorization request from the claimant, the claims examiner (CE) takes immediate action to ensure that the request meets one basic requirement: that the medical treatment or service is for the claimant's approved medical condition(s). The medical provider's enrollment in the DEEOIC program is not a prerequisite to approving medical travel if the claimant chooses to receive medical services from a non-enrolled provider.

(2) Companion. If the travel request involves authorization for a companion to accompany the claimant, the claimant must provide medical justification from a physician. That justification must be in written form, relating the treatment to the accepted condition and rationalizing the need for the companion. If the doctor confirms that a companion is medically necessary, and provides satisfactory rationale, then the CE may approve companion travel. In the

11. Medical Expense Reimbursement for Extended Travel.
(Continued)

alternative, the CE can authorize the claimant to stay overnight in a hospital or medical facility, and can approve payment for a nurse or home health aide if a companion is not available. The CE must use discretion when authorizing such requests and may approve one of the above alternatives when there is a definite medical need, accompanied by written justification from the physician.

(3) Mode of Travel. The claimant is allowed to specify his/her desired mode of travel. It is the CE's role to authorize the desired mode of travel for the time period(s) requested. When a request is received from the claimant that does not identify the mode of transportation, the CE contacts the claimant by telephone and assists in determining the desired mode of travel. (Resource Center staff may be assist in this process.)

f. Approval. Once the basic requirements for travel over 200 miles are met, as outlined above, the CE prepares and sends the claimant a travel authorization letter following the guidelines below. The CE may approve an individual trip, or any number of trips within a specified date range, all in one letter to the claimant. Once an initial authorization letter has been sent, future visits to the same doctor or facility may be approved by telephone, and confirmed by a follow-up letter.

g. Authorization Letter. The authorization letter delineates the specifics of the trip being authorized, based upon the mode of travel the claimant has selected. In the travel authorization letter, the CE advises the claimant that travel costs are reimbursable only to the extent that the travel is related to obtaining medical treatment. In the letter CE also invites the claimant to contact the nearest Resource Center for assistance prior to or upon completing any trip and to complete Form OWCP-957,

11. Medical Expense Reimbursement for Extended Travel.

(Continued)

Request for Reimbursement, in accordance with the information and conditions as outlined in Exhibit 6.

h. Adjudication. When adjudicating claims submitted after the trip has been completed, but for which prior approval was not obtained, the CE follows the same steps as for pre-authorized trips, to the point of sending an authorization package. At that point the CE sends only the authorization (or denial) letter to the claimant, not an entire authorization package.

i. Denials. If a travel request is denied (either before or after a trip), the CE notifies the claimant in writing, detailing the reason(s) for the denial. *The CE's unit supervisor must provide sign-off for all denials of claimant travel before the denial letter is sent to the claimant.* The following wording is included in the denial letter: "This is the final Program decision on your request for approval of travel expense reimbursement. *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.*"

j. Recommended Decision. If the claimant requests a recommended decision, the CE proceeds with a recommended decision.

k. Notifying the BPA. In conjunction with sending the claimant an approval or denial of a travel request, the CE conveys his/her decision to DEEOIC's BPA via the office's Fiscal Officer (FO), who is the point of contact with DEEOIC's BPA for such issues. The CE prepares an email to the FO, who in turn generates an electronic thread to the BPA. In the email the CE provides the information specified below. The CE must also enter this information into the case notes field of ECMS (Select the note type of "T" for Travel Authorization):

11. Medical Expense Reimbursement for Extended Travel.

(Continued)

- (1) Approved dates for a single trip or in the alternative, a date range and number of trips authorized within that time frame.
 - (2) Approved mode of transportation
 - (3) Starting point and destination, e.g., claimant address and provider address (city & state at a minimum).
 - (4) Authorization for rental car reimbursement, if appropriate.
 - (5) Companion travel if approved.
- l. Approval Package. The approval package must include the following:
- (1) Two copies of the detailed authorization letter.
 - (2) Two copies of a blank OWCP-957.
 - (3) *A prepaid express mail envelope, addressed to DEEOIC's BPA, for the claimant's use.*
- m. Prompt Pay. DEEOIC's BPA promptly pays any approved claims directly to the claimant, not to any other party. However, if the claimant completes the form in error or neglects to submit the proper information, DEEOIC's BPA attempts to resolve the issue by accessing the authorization letter or the pre-approval notification (thread) from the FO. If DEEOIC's BPA is unable to issue payment based on information provided in one of these two sources, DEEOIC's BPA contacts the FO, requesting clarification and/or assistance.
- n. DO Review. The FO and responsible CE take immediate action to review the claim as submitted, contact the claimant when appropriate, make a

11. Medical Expense Reimbursement for Extended Travel.

(Continued)

determination as to the correct amount of reimbursement or denial, and send an authorization notification or correction (electronic thread) back to DEEOIC's BPA.

o. District office CEs and FOs responsible for travel authorization processing must keep management apprised of issues impacting prompt and accurate processing of travel authorizations and reimbursements. Claims staff should be especially vigilant to identify any real or perceived problems with the processing interfaces between and among the district office, the Resource Center and DEEOIC's BPA.

Problems must be elevated (reported via email) immediately to the National Office to the attention of the Branch Chief for Policy, with a copy of the notification to the Branch Chief for the Branch of ADP Systems (responsible for oversight of DEEOIC's BPA).

SAMPLE INITIAL MEDICAL DEVELOPMENT LETTER

Date:

Claimant Name (or auth rep)
Street Address
City, State, Zip

File Number
Accepted Conditions

Dear Claimant Name:

I am writing to you concerning your benefits under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA). We have received a request to provide you with in-home medical care. In order to properly evaluate and respond to this request, we need additional medical evidence.

Please have your treating physician prepare a written narrative report, providing our office with detailed information describing findings upon physical examination, your medical needs, the specific level of in-home nursing care required, the time period for which services are requested and a description of the specific services that the home health care provider is expected to provide. Additionally, the physician should provide medical rationale for the recommended care, relating the requested services to the accepted medical condition(s) listed above.

The following is an example of a narrative describing the type of care required: *For the medical condition of (fill in the blank), the claimant requires the care of an RN or LPN, three times weekly to administer and/or monitor medications and medical equipment, and to assist in respiration therapy for the next 3 months. The claimant also requires the daily services of a home health aide during waking hours (total of 16 hours per day) to assist in ambulating, dressing, bathing and trips to the toilet. This service is required for the next 3 months, at which time the claimant's physical condition will be reevaluated.*

By copy of this letter, your physician is requested to contact this office immediately if there are any problems with our request. If you (or your physician) already have the name of an in-home medical services provider you wish

to have perform the initial assessment, please provide me with that information.

In the interest of expediting the request for care, by copy of this letter your physician is requested to please fax and mail a response to my office within 30 days, or contact me sooner if there are questions regarding this request.

If for any reason you are not requesting in-home health care, please advise me immediately in writing.

Thank you for your assistance. Please contact me at the number listed below if you have additional questions or concerns.

Sincerely,

(Insert PoC CE Name and Signature)
Insert PoC CE telephone & fax numbers

Cc: *(Physician's name and address)*

SAMPLE FOLLOW-UP DEVELOPMENT LETTER

Date:

Claimant Name (or auth rep)
Street Address
City, State, ZIP

File Number
Accepted Conditions

Dear Claimant Name:

This letter affects medical benefits you have requested and requires your immediate attention and response.

We have received a request to provide you (or the claimant that you represent) with in-home medical care for the accepted condition(s) shown above, arising out of your claim with the Energy Employees Occupational Illness Compensation Program (EEOICP), administered by the Division of Energy Employees Occupational Illness Compensation (DEEOIC). We are currently evaluating this request. In a letter dated (*date of first letter*) we requested additional medical information. As of this date, we have not received a response.

Without the additional information your request for home health care may be denied. It is imperative that we receive a response from your doctor. We need an updated verification of the type and level of in-home care that you require, and verification that this care is for the accepted condition(s) that have been approved for benefits through the EEOICP.

Please contact your treating physician's office immediately, and ask your doctor to provide us with this information. Extra copies of our previous letter concerning this matter are attached for your use. This information must be received within 30 days or the request for in-home health care may be denied. If you are unable to contact your doctor, and/or if you have questions

regarding this verification process, you may call me at the telephone number listed below.

Sincerely,

(Insert PoC CE Name, Signature and Telephone Number)

Enclosure

SUPERSEDED

SAMPLE AUTHORIZATION LETTER

Date:

Claimant Name (or auth rep)

Street Address

City, State, ZIP

Re: Claim Number (*Insert Claim Number*)

Dear(*Insert Claimant or Auth Rep Name*):

This letter is in reference to your claim for compensation under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) recently received a request for authorization of in-home medical care for the following covered medical conditions:

Pulmonary Fibrosis

Silicosis

Chronic Obstructive Pulmonary Disease (COPD)

After a thorough review of your case file including communication with your treating physician [*if applicable*] the following authorization is granted for the period of December 4, 2006 through June 4, 2007:

Registered Nurse [Billing Codes T1030 (per diem) and S9123 (hourly)] to administer medication and conduct physical evaluation 1 hour per day, every 5 days.

Home Health Aid or equivalent [Billing Codes S5126 (per diem) and S9122 (hourly)], 16 hours per day, seven days per week, to assist with ambulating, bathing, general personal hygiene, food preparation and feeding, and oxygen canister replacement.

You are free to select any licensed provider willing to perform the authorized services; however, the DEEOIC requires that the provider be enrolled in our medical bill payment system. Providers may call toll free 1-866-272-

2682 for program enrollment information or for answers to payment questions. If you have any questions or concerns regarding this authorization please call your claims examiner at (XXX) XXX-XXXX.

Sincerely,

(Insert PoC CE Name)
DEEOIC Claims Examiner

cc: Provider

SUPERSEDED

Billing Codes**T1001: Nursing Assessment in-home Initial Evaluation:**

A physician's written report and a Claims Examiner's prior authorization is required before the in-home assessment is conducted. Typically only one (1) in-home initial evaluation is authorized for a claimant. Once an authorization is approved by the DEEOIC, an assessment can be performed.

T1017: Targeted Case Management Per Unit (15 minutes = 1 Unit): This service requires prior authorization from the DEEOIC Claims Examiner for a Registered Nurse to perform targeted case management. This is limited to the clinical impact of a claimant's accepted work-related condition on his/her current medical status. The skill level of a Registered Nurse is required for this targeted case management activity. The Claims Examiner's authorization will specify the number of hours authorized for a case management visit. Each unit of a T1017 code is equal to 15 minutes; therefore, if a nurse case manager is at the claimant's home for an assessment for one hour, the proper number of units to bill for this T1017 code is 4 units.

T1019: Personal Care Services (PCA) Per Unit (15 Minutes = 1 Unit): This service requires prior authorization from the Claims Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist claimants with activities of daily living (i.e. bathing, feeding, dressing, etc). Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

Each unit of a T1019 code is equal to 15 minutes; therefore, if an attendant provides services for one hour, the proper number of units to bill for this T1019 code is 4 units.

T1020: Personal Care Services (PCA) Per Diem (8 hrs):

This service requires prior authorization from the DEEOIC Claims Examiner. Attendant services are non-skilled services routinely provided in an in-home setting. These services assist claimants with activities of daily living (i.e. bathing, feeding, dressing, etc). Attendant services must be provided by a home health aide, licensed practical nurse, or similarly trained individual. A family member who is also a trained personal care attendant can only be approved for up to 12 hours of care per day.

An attendant can only be approved for care if there is sufficient medical rationale from a physician stipulating the specific need for personal care services related to the accepted work related condition that requires an attendant.

12-hour care: For personal care services approved for 12 hour care, the bill must be submitted with one unit of a T1020 code, which covers the 8-hour period of provided services, and 16 units T1019 which cover the 4-hour period of provided services. Under no circumstance should a per diem code be used for less than 8 hours of care.

T1030: Nursing Care, in-home, by Registered Nurse

(RN), Per Diem (8 Hour Shift): This service requires prior authorization from the DEEOIC Claims Examiner for a Registered Nurse to perform in home health care (per 8 hour shift). An RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an RN for an 8 hour shift(s).

24-hour care: If this code is approved for 24 hour care, the bill must be submitted with 3 units of a T1030 code which covers the 24 hour period of provided services, regardless of the number of RNs

assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1030 code. Under no circumstances should a per diem code be used for less than 8 hours of care.

T1031: Nursing Care, in-home, by Licensed Practical Nurse (LPN) Per Diem (8 Hour Shifts): This service requires prior authorization from the DEEOIC Claims Examiner for a Licensed Practical Nurse to perform in-home health care (per 8 hour shift). An LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that require an LPN for an 8 hour shift(s).

24-hour care: If this CPT code is approved for 24 hour care, the bill must be submitted with 3 units of a T1031 code which covers the 24 hour period of provided services, regardless of the number of LPNs assigned. For example, if two nurses are utilized for two 12 hour shifts, the bill must reflect three units of the authorized T1031 code. Under no circumstances should a per diem code be used for less than 8 hours of care.

S5126: Attendant: Home Health Aide (HHA), Certified Nurse Assistant (CNA), Per Diem (8 Hour Shift): This service requires prior authorization from the DEEOIC Claims Examiner. A HHA/CNA can only be authorized for care if there is sufficient medical rationale from a physician documenting the medical necessity of the service for the accepted work-related condition. If a HHA/CNA is authorized and a RN/LPN is utilized, bills should be submitted with the S5126 code.

24-hour care: If this CPT code is approved for 24 hour care and the care is provided, the bill must be submitted for 3 units which cover the 24 hour period of provided services, regardless of the number of HHA/CNAs assigned. For example, if two HHA/CNAs are utilized for two 12 hour shifts, the service provided still covers the authorized three 8 hour shifts and the bill should reflect 3 units of the

authorized S5126 code. Under no circumstances should a per diem code be used for less than 8 hours of care.

S9122: Home Health Aide (HHA) or Certified Nurse Assistant (CNA) Hourly Code (less than 8 hour care):

This service requires prior authorization from the DEEOIC Claims Examiner for a HHA or CNA to perform in home health care (per hour code only). A HHA or CNA can be approved if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a HHA or CNA.

S9123: Nursing Care in-home Registered Nurse (RN) Hourly Code (less than 8 hour care):

This service requires prior authorization from the DEEOIC Claims Examiner for a RN to perform in home care (per hour code only). A RN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a RN.

S9124: Nursing Care in-home License Practical Nurse (LPN) Hourly Rate (less than 8 hour care):

This service requires prior authorization from the Claims Examiner for a LPN to perform in home care (per hour code only). A LPN can only be approved for ongoing care if there is sufficient medical rationale from a physician stipulating the specific medical services related to the accepted work-related condition that requires a LPN.

S9126: Hospice Care, in the home, Per Diem (8 Hour Shifts):

This service requires prior authorization from the DEEOIC Claims Examiner. Hospice care is generally requested and authorized when an employee is determined to be terminally ill. Once approved, hospice is responsible for assessing the claimant's needs and providing all levels of care to maintain the comfort of the claimant.

SAMPLE RECOMMENDED DECISION TO DENY HOME HEALTH CARE

EMPLOYEE: John Doe
FILE NUMBER: 123-00-4567

NOTICE OF RECOMMENDED DECISION
(MEDICAL BENEFITS ONLY)

This is the Recommended Decision of the [*applicable district office*] District Office regarding the request for in-home medical services filed by you under the Energy Employees Occupational Illness Compensation Program Act (EEOICPA or the Act). The [*appropriate*] District Office recommends the request be denied for the reasons set forth below.

STATEMENT OF THE CASE

You filed a claim on (*Insert Date*), seeking benefits under the Act. On (*Insert Date*) the Final Adjudication Branch issued a final decision accepting the claim and awarding medical benefits for the condition of lung cancer.

On (*Insert Date*) the (appropriate) District Office received a request for in-home skilled nursing care. The level of care and/or type of service to be provided was specified in a (*Plan of Care or doctor's letter - fill in the blank*), dated (*Insert Date*).

Upon review and consideration of the request for in-home skilled nursing services it was determined that there is insufficient medical evidence to support that the nursing care services are required for the treatment of your accepted conditions. [*This paragraph is only to be used if that is the reason for the denial. Other reasons may include that the weight of medical evidence is with the DMC or second opinion, lack of any medical evidence. The decision should specifically discuss the medical evidence in the case file related to the issue.*] On (*Insert*

Date) the district office claims examiner (CE) sent a letter to you with a copy to your physician, requesting detailed information regarding the type and level of care required for the accepted condition(s). Your doctor did not respond to this letter. On *(Insert Date)*, the CE called Dr. *(Insert Name)*'s office to confirm that he received the *(Insert Date)* letter, and the CE questioned the doctor regarding the level of care you required. By follow-up letter dated *(Insert Date)* you were requested to provide the needed medical evidence. As of this date, we have not received medical evidence sufficient to establish that the request for in-home health care services is required as a result of your accepted condition under the EEOICPA.

FINDINGS OF FACT

1. You filed a claim under the EEOICPA on *(Insert Date)*.
2. On *(Insert Date)*, the FAB issued a decision awarding you compensation in the amount of *(Fill in amount)* and medical benefits for the treatment of your *[accepted condition]*.
3. On *(Insert Date)*, the district office received a request for in-home medical care.

CONCLUSIONS OF LAW

You do qualify as an "individual with cancer" [*if applicable*] as defined in 42 U.S.C. § 73841 (9) (B) (*or Insert Appropriate Illness and Statutory Citation.*)

42 U.S.C. § 7384t states that The United States shall furnish, to an individual receiving medical benefits under this section for an illness, the services, appliances, and supplies prescribed or recommended by a qualified physician for that illness which the President considers likely to cure, give relief, or reduce the degree or the period of the illness;

and

20 CFR Part 30 § 30.403 states that OWCP will authorize payment for personal care services under section 7384t of the Act, whether or not such care includes medical services, as long as the personal care services have been determined to be medically necessary and are provided by a home health aide, licensed practical nurse, or similarly

trained individual. The Office of Workers Compensation Programs (OWCP) will make the determination if personal care services are or are not medically necessary.

Sufficient medical evidence, necessary to make a determination as to the type of services and/or the level of care to be provided, has not been forthcoming from your treating doctor. Without this medical evidence, your request for in-home medical care cannot be granted. Therefore, the claim for in-home medical services is denied.

{Note: Depending upon the circumstances, the language in this sample decision can be modified for use in reducing or limiting services currently being provided, or in denying new requests for in-home care. The usual cover letter for recommended denials should be used, which outlines the claimant's rights following such a decision.}

Part 3 - Fiscal

Prepared by:

(Name)

Claims Examiner

Date

Reviewed and Certified by:

(Name)

Senior Claims Examiner

Date

SUPERSEDED

[Sample Travel Authorization Letter]

Date:

Claimant Name(or auth rep)
Street Address
City, State, Zip

Dear Claimant Name(or auth rep):

This letter is in reference to your request for medical travel authorization under the Energy Employees Occupational Illness Compensation Program Act. You (or you and your companion) are **authorized** to travel for medical treatment with (*Insert name of doctor or medical facility*) in (*City / State*). Outlined below are the itemized travel allowances approved for your trip:

- Dates of Trip: (*Insert authorized travel dates*)
[Or in the alternative]
- Multiple Trips Authorized (*Insert Authorized travel date range*)
- Trip Origin & Destination: (*Insert starting City/State and ending points*)
- Authorized mode of travel (*Insert approved mode: auto, air, etc.*)
- Meals & Incidental Expenses (M&IE) See below.
- Lodging (single or double occupancy) See below.
- Airfare allowance See below.
- Mileage allowance for personal vehicle (*Insert appropriate mileage rate or N/A*)
- Companion approved to travel: (*Insert name of companion or N/A*)
- Rental car reimbursement *Indicate "YES" or N/A*

Companion Travel: If you have been authorized a companion to accompany you on this trip, you will be reimbursed at twice the daily M&IE rate and lodging will be based upon double-occupancy, unless otherwise approved. If travel is by commercial airline, then the companion airfare will be reimbursed as well. The expenses for your companion will be paid to you; not to the companion or any other party.

Travel Changes: We understand your travel may not happen as originally planned. If you encounter a change in your travel plans (such as an extended stay) that may result in additional expenses, please contact me or the DEEOIC Resource Center identified below at your earliest convenience to let us know the specific changes. We will be glad to assist you with any adjustments to your authorization so you won't encounter any delays in your reimbursement.

How to File for Travel Reimbursement: Reimbursement requests must be submitted using the enclosed Form OWCP-957. Only travel costs that are directly related to obtaining medical treatment for your accepted condition(s) will be reimbursed. Receipts are required for all lodging, airfare, rental car (if authorized), and gasoline purchases (for approved rental car only). Any other expenses under \$75.00 do not require receipts. The OWCP-957 form includes an instruction sheet; however, I would like to provide you with some additional information to help you with your reimbursement request:

M&IE: Itemization of expenses and submission of receipts is **not** required for meals and incidental expenses (MIE). The MIE expenses are reimbursed as a fixed-rate, daily allowance, regardless of what you actually spend, and are determined by the Government Services Administration (GSA) published rate for the geographic location of your stay on any given day.

By GSA rule, reimbursement for the first and last days of travel is 75% of the daily fixed-rate for MIE.

Lodging: Daily lodging rates are also based on applicable GSA rates for the location of your stay and may change due to seasonal fluctuations so be sure to check the current rates. State and local lodging taxes are not included in the daily lodging rate and will be reimbursed separately. All receipts must be submitted.

Rental Car: When a rental car has been approved, reimbursement will be based upon an economy-sized vehicle, unless otherwise approved. Gasoline

purchases for the rental car are reimbursable. All receipts must be submitted.

Airfare: Airfare reimbursement will be based upon the actual cost incurred, but not to exceed the cost of a refundable coach or economy class fare (Y-Class airfare). All receipts must be submitted.

GSA Rates: The daily allowances for MIE and lodging are determined by GSA, for specific cities and geographic areas around the country, and they vary by region. These rates are revised occasionally by GSA. For more information on these GSA-published rates, please visit the GSA Website at: www.gsa.gov ; or contact your nearest resource center for assistance.

Where to Send Your Reimbursement Forms: Send a copy of this authorization letter, along with your itemized Form OWCP-957, along with any required receipts, to our bill processing agent. For your convenience, I have enclosed a pre-paid envelope and an extra copy of this authorization letter. Please send your information to:

(Insert Name and Address of the DEEOIC Bill Processing Agent)

Where to go for Help: For assistance in completing your travel reimbursement form, or in determining applicable MIE and lodging rates, or if you need other assistance related to this travel authorization or reimbursement process, please contact your nearest DEEOIC Resource Center, or call me. Below is the address of your nearest Resource Center.

*Insert complete RC address
Telephone Number*

Additional information and forms are also available on our website at: <http://www.dol.gov/esa/>. Please have a safe trip and let me know if you have any other concerns that are not

addressed in this letter. I can be reached, toll free, at:
(Insert toll free number).

Sincerely,

John Doe
Claims Examiner

Enc: OWCP-957 (2 blank forms)
Prepaid envelope addressed to bill processing agent
Copy of Authorization Letter (2 copies)

SUPERSEDED