U.S. Department of Labor

RELEASE – TRANSMISSION OF REVISED MATERIAL TO BE
INCORPORATED INTO THE FEDERAL (EEOICPA) PROCEDURE MANUAL:
CHAPTER 2-2100 ENERGY CASE MANAGEMENT SYSTEM – DECISIONS.

EEOICPA TRANSMITTAL NO.10-08   July 2010

EXPLANATION OF MATERIAL TRANSMITTED:

Chapter 2-2100 has been revised to update the ECMS coding
instruction associated with reconsiderations. Post-
reconsideration decision codes now have required reason
codes associated with them.

Chapter 2-2100 has been revised to clarify the medical
status effective date for consequential illnesses including
situation where CBD develops subsequent to an acceptance of
beryllium sensitivity or asbestosis develops subsequent to
an acceptance of pleural plaques.

Chapter 2-2100 has also been revised to include instruction
on the use of the new code for consequential acceptances
(CA).

Chapter 2-2100 has also been revised to include the
addition of the new MB reopening code specific to
reopenings based on SEM database changes. The use of the
existing MI reopening code has been revised related to
these types of reopenings as well.

Rachel P. Leiton

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

FILING INSTRUCTIONS:

Remove Old Page			Insert New Pages		
Part	Chapter	Page	Part	Chapter	Page
2	2-2100	i,52-62	2	2-2100	i,52-79

File this transmittal sheet behind EEOICPA Transmittal No. 10-08 in the front of the Federal (EEOICPA) Procedure Manual.

File this transmittal behind EEOICPA Transmittal 10-07 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.

_____

TABLE OF CONTENTS

_____

1.   Purpose and Scope. This chapter describes how to use the
Energy Case Management System (ECMS) with respect to decisions
rendered by the District Offices (DOs), Secondary Claims
Examiner (CE2) Unit, and the Final Adjudication Branch (FAB).
It also addresses ECMS coding procedures as it relates to
alternative filings, reconsiderations, closure of claims, and
claims filed for new conditions after a final decision. EEOICPA
PM 2-2000 addresses ECMS coding in general, focusing on the
early and developmental stages of a claim. The information in
this chapter applies to both ECMS B and ECMS E, unless otherwise
indicated.

Decisions specify which benefits are awarded/accepted, denied,
or under development, and under which Part of the Act (B or E or
both). Recommended Decisions and Final Decisions are reflected
in ECMS by decision code/reason code combinations that relate to
the Part B portion in ECMS B, and to the Part E portion in ECMS
E. This is necessary to ensure accurate statistics about
decisions made under Parts B and E.

2.   Required Coding for Approvals. All approved claims must
contain at least one medical condition with a medical condition
type, an ICD-9 code, a diagnosis date, and an "A" for Accepted
in the cond status field. [For Part B cases, the medical
condition type must be equal to BD, BS, CN, CS, MT, OL (for
RECA), or PD (for RECA).

The medical status effective date must be equal to the claim
filing date. If the case is a B/E case with different filing
dates under Part B and E, then ECMS B and E will reflect
different filing dates and status effective dates. The earliest
of the two status effective dates for a Part B/E condition will
be transmitted to central bill pay for medical eligibility
processing.

Any verified worksite data must be updated with information from
the verification(s) received, and the Covered Employment Ind
field (case screen) and the Payee Eligibility field (located on
the payee screen) must be "Y," for "Yes."

A recommended decision code to fully or partially accept (A0,
A1, A2, A8) must be entered in the Claim Status History with an
appropriate reason code. See Paragraphs 4 and 5 below for an
in-depth discussion of recommended decision coding.

_____

3.   Required Coding for Recommended Denials. A recommended
denial claim status code (D1, D3, D4, D5, D7) and associated
reason code (for D5 and D7 only) are required in the Claim
Status History. See Paragraphs 4 and 5 below for an in-depth
discussion of recommended decision coding.

The recommended denial code must correspond with the primary
reason for recommendation of denial under that Part of the Act
(B or E). That means that the claim status code should match
with the most reasonable basis for the denial. Therefore, only
one claim status code is entered per claimant (per part – B or
E). The hierarchy is as follows:

    a.   'D3' Code. If a claimant files who is an ineligible
    survivor, the claim should be denied on the basis of being
    an ineligible survivor, regardless of any lack in medical
    or employment evidence.

    b.   'D4' Code (B only). If a claimant files only for a
    non-covered condition, the CE develops for a covered
    occupational illness. Until a covered condition is found,
    employment is not developed. If a covered occupational
    illness is never claimed, the claim should be denied on the
    basis of a non-covered condition ('D4').

    c.   'D7' Code. If a claimant files for a covered
    occupational illness, and employment is developed, but
    after development there is not enough medical evidence to
    support the covered condition, the claim is denied because
    of insufficient medical evidence to support a covered
    condition ('D7'). This is true whether or not employment
    verification has been completed and regardless of whether
    employment is covered.

    d.   'D1' Code. If a claimant files for a covered
    occupational illness and enough medical evidence is
    received to accept the medical portion of the claim, but
    the employment requirements are not met after development,
    the claim is denied due to lack of covered employment
    ('D1').

4.   General Decision Coding. When a recommended or final
decision is issued, the Claims Examiner (CE), Senior Claims
Examiner (SrCE), or Hearing Representative (HR) enters the
appropriate claim status code(s) into ECMS. The coding must
match the wording in the decision. There are three possible

_____

4.   General Decision Coding. (Continued)

outcomes for each claimed element: accept, deny, or defer.
Deferring a decision means that a decision is not being made on
that element at this time because further development is needed,
essentially holding the decision in abeyance.

It is important that decisions do not state that a decision on
additional elements is being deferred unless additional elements
have actually been claimed. For example, a decision should not
state, "A decision regarding impairment and wage loss benefits
is being deferred pending further development" if those items
have never been claimed. These types of statements in decisions
lead the claimant to believe they will be receiving decisions on
those items, which they will not, unless claimed. If matching
deferral coding is input into ECMS, it will cause reporting
problems.

        a.   Primary Decision Codes. All decisions require at
        least one 'primary' decision code. If the decision
        addresses Part B benefits only, a primary decision code is
        entered into ECMS B. If the decision addresses Part E
        benefits only, a primary decision code is entered into ECMS
        E only. If the decision addresses Part B and Part E
        benefits, there is a primary decision code entered into
        ECMS B and a separate primary decision code in ECMS E.
        Generally, there is no more than one primary decision code
        in either ECMS B or ECMS E, per decision. Exceptions will
        be listed in this chapter. The status effective date for
        the decision codes is the date of the decision.

        When selecting a primary decision code, the CE/SrCE/HR must
        look at what is happening overall on the decision for Part
        B or Part E, separately. For example, if a decision is
        accepting lung cancer under Part B and denying it under
        Part E because the survivor is ineligible, the coding must
        reflect a primary decision code in ECMS B that only
        reflects an acceptance (A0/F0), while ECMS E must only
        reflect a denial (D3/F3). It is not coded as a partial
        accept/partial deny (A8/F9) in both systems.

        Some primary decision codes also have reason codes
        associated with them that give more detail as to what is
        being accepted or denied. Primary recommended decision
        codes and their associated reason codes are discussed in
        detail in Paragraph 5. Primary final decision codes and

_____

4.   General Decision Coding. (Continued)

      their associated reason codes are discussed in detail in
      Paragraph 7.

      b.   Secondary Decision Codes. On Part E decisions that
      are more than straight acceptances or denials, it is
      necessary to enter a second claim status code that gives
      additional information on what is being denied or deferred
      in the decision. This additional claim status code is
      called a 'secondary' decision code.

      A secondary decision status code must be used in ECMS E
      only and must be used in conjunction with a 'primary'
      decision status code entered with the same status effective
      date of the primary decision status code. There should
      never be more than one of each of the secondary decision
      status codes per decision. Secondary decision status codes
      (and their reason codes) are listed and described below.

            (1)   The 'PD' [Partial Deny] secondary decision status
            code must never be used without tandem entry in ECMS E
            of a primary decision status code describing a partial
            Part E acceptance or denial. That is, 'PD' must never
            be entered without first entering, with the same
            status effective date, one of the following 'primary'
            decision status codes in ECMS E: A2/G2 (Partial
            Accept/Partial Develop/Partial Deny), A8/F8 (Partial
            Accept/Partial Deny), D5/F5 (Deny-cancer not work
            related), D7/F9 (Non-cancer causation/insufficient
            medical denial), or F6 (FAB Reversed to Accept).

            The 'PD' status code can be used in conjunction with
            the D5/F5 or D7/F9 denial code to address multiple
            types of denials, such as insufficient medical in
            addition to a non-cancer causation denials or to a
            cancer not work related denial (See example 4 below).

            The 'PD' status code can be used in conjunction with
            the 'F6' (FAB Reversed to Accept) code if at least one
            portion of the recommended decision is reversed from a
            denial to an acceptance, and there is still another
            element being denied in the final decision. The
            reason code associated with F6 would encompass
            whatever is being accepted and the reason code under

_____

4.   General Decision Coding. (Continued)

the 'PD' status code would reflect what is being
denied.

Once the 'PD' status code is entered, the CE/SrCE/HR
selects the reason code from the drop-down menu that
corresponds with the element(s) being denied. Both
the DO/CE2 Unit and FAB use this code when issuing
decisions that require partial denial coding.

(a)   IN - 'Insufficient Medical to Establish
Claimed Illness' - Used when a covered illness is
claimed under E but medical evidence is
insufficient to establish the illness.

(b)   CAU - 'Causation' - Used when a covered
illness is claimed under E, but causation cannot
be established.

(c)   WAG - 'Wage Loss' - Used when claimed wage
loss is being denied.

(d)   CAW - 'Causation and Wage Loss' - Used when
a covered illness is claimed under Part E, but
causation cannot be established and claimed wage
loss must also be denied.

(e)   IM0 - 'Impairment - 0%' - Used when the
claim for impairment is being denied because the
impairment rating is 0% based upon the AMA Guides
or because a claim for impairment was filed, but
the claimant failed to provide the necessary
medical documentation.

(f)   IMN - 'Impairment - Not Ratable' - Used when
the claim for impairment is being denied because
the claimed impairment is non-ratable, such as
certain psychiatric conditions.

(g)   IMR - 'Impairment - Resolved' - Used when
the claim for impairment is being denied because
the claimed impairment was resolved (i.e., does
not exist anymore) prior to the issuance of the
decision.

_____

4.   General Decision Coding. (Continued)

      (h) I0W – 'Impairment (0%) and Wage Loss' - Used when wage loss and impairment are both the only portions being denied. The claim for impairment is denied because it has a 0% rating based upon the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

      (i) INW – 'Impairment (Not Ratable) and Wage Loss' -Used when wage loss and impairment are being denied. Impairment is denied because the condition being claimed is not ratable for impairment, such as certain psychiatric conditions.

      (j) IRW – 'Impairment (Resolved) and Wage Loss' - Used when wage loss and impairment are both being denied. The claim for impairment is being denied because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

      (k) C0W – 'Causation, Impairment (0%) and Wage Loss' - Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment is denied because the impairment rating is 0% based upon the AMA Guides or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

      (l) CNW – 'Deny Causation, Wage Loss, & Impairment (Not Ratable)' - Used when claims are made for causation, wage loss, and impairment, all of which are being denied. The impairment is being denied because it is for a non-ratable condition, such as certain psychiatric conditions.

      (m) CRW – 'Causation, Impairment (Resolved), and Wage Loss' - Used when claims for causation, impairment and wage loss are being denied simultaneously as portions of the claim as a whole. The impairment claim is being denied

_____

4.   General Decision Coding. (Continued)

because the impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

(n)   CA0 – 'Causation and Impairment (0%)' – Used when causation and 0% impairment based upon the AMA Guides are being denied simultaneously or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(o)   CAN – 'Causation and Impairment (Not Ratable)' – Used when causation and a non-ratable impairment are being denied simultaneously.

(p)   CAR – 'Causation and Impairment (Resolved)' – Used when causation and impairment, that is resolved prior to the issuance of the decision, are being denied simultaneously.

(q)   MBM – Maximum Payable Benefit Met' – Used when the maximum payable benefit is already paid and a decision is required for an impairment and/or wage loss claim.

(2)   The 'DV' [Partial Develop] secondary decision status code is used exclusively in ECMS E to record findings in a decision that describe a partial deferral for a claimed element under Part E. The 'DV' status code is entered in conjunction with a primary decision status code. Both the primary and secondary decision codes have the same status effective date (the date the decision is issued).

The 'DV' status code must be used in conjunction with one of the following 'primary' decision status codes in ECMS E: A2/G2 (Partial Accept/Partial Develop/Partial Deny) or A1/G1 (Partial Accept/Partial Develop); and can be used with D5/F5 (Deny-cancer not work related), D7/F9 (Non-cancer causation/ insufficient medical denial), or F6 (FAB Reversed to Accept).

_____

4.   General Decision Coding. (Continued)

          The 'DV' status code can be used in conjunction with
          the D5/F5 or D7/F9 denial codes to address partial
          deny/partial develop decisions. The reason code
          associated with D5/F5 or D7/F9 would encompass
          whatever is being denied and the reason code under the
          'DV' status code would reflect what is being deferred.

          The 'DV' status code can also be used in conjunction
          with the 'F6' (FAB Reversed to Accept) code if at
          least one portion of the recommended decision is
          reversed from a denial to an acceptance and there is
          still a decision on another element being deferred in
          the final decision. The reason code associated with
          F6 would encompass whatever is being accepted and the
          reason code under the 'DV' status code would reflect
          what is being deferred.

          The associated primary decision code could also be in
          ECMS B if the decision only addresses Part B benefits
          and completely defers the adjudication of any pending
          Part E element(s). (See example 1 below).

          Once the 'DV' status code is entered, the CE/SrCE/HR
          selects the reason code from the drop-down menu that
          corresponds with the element(s) being held in abeyance
          for further development. Both the DO/CE2 Unit and the
          FAB use this code when issuing decisions that require
          partial development or deferral codes.

              (a) CAU – 'Causation' - Causation for another
              claimed condition requires further development.

              (b) CAW – 'Causation and Wage Loss' - Causation
              for another claimed condition and wage loss
              require further development.

              (c) CAI – 'Causation and Impairment' - Causation
              for another claimed condition and impairment
              require further development.

              (d) IMP – 'Impairment' - Claimed impairment
              requires further development.

_____

4.   General Decision Coding. (Continued)

                (e)   WAG – 'Wage Loss' - Claimed wage loss
                requires further development.

                (f)   IMW – 'Impairment and Wage Loss' - Claimed
                impairment and claimed wage loss require further
                development.

                (g)   CIW – 'Causation, Impairment, and Wage Loss'
                -    Causation for another claimed condition,
                claimed impairment and claimed wage loss require
                further development.

        c.   Examples. A decision that accepts a claimed condition
        under E and denies a second claimed condition under B is
        not considered a 'partial' decision outcome for coding
        purposes. Instead, the 'A0' acceptance status code in ECMS
        E and the appropriate 'D_' denial status code in ECMS B
        should be used. It is incorrect to consider the ECMS E
        outcome as 'A8' [Partial Accept/Partial Deny] because the
        partial deny outcome does not apply to Part E. The
        following examples further illustrate these rules.

        Example 1: If there is a recommended decision to deny
        cancer for Probability of Causation (PoC) under Part B, and
        the Part E case has yet to be developed for causation based
        on toxic exposure, so that the Part E decision is deferred,
        the coding would be: 'D5' [Recommended Deny - Cancer not
        work related/PoC<50%], with Reason Code 'B' [Part B] in
        ECMS B, and 'DV' [Partial Develop] with no primary
        recommended decision status code in ECMS E (the tandem
        primary code is in ECMS B).

        The final decision code, if upheld by FAB, would be: 'F5'
        [Final Deny - Cancer not work related/PoC<50%] in ECMS B,
        with Reason Code 'B' [Part B] and 'DV' [Partial Develop]
        with no primary final decision status code in ECMS E
        (assuming the Part E claim is still under development).

        Example 2: If there is a recommended decision to accept
        CBD for both Parts B and E, but the claims for wage loss
        and impairment are being deferred under Part E, the coding
        would be: 'A0' [Recommended Accept] in ECMS B, with Reason
        Code 'B' [Part B] (since all of the medical conditions are
        accepted and completed in Part B), and 'A1' [Recommended

_____

4.   General Decision Coding. (Continued)

      Partial Accept/Partial Develop] in ECMS E, with Reason Code
      'CAU', since the CBD is being partially accepted (for
      causation).

      To record in ECMS E that the claims for wage loss and
      impairment are being deferred (the case is only deferred if
      there is an actual claim for wage loss/impairment in the
      case file), status code 'DV' [Partial Develop], with Reason
      Code 'IMW' [Impairment and Wage Loss], would be entered.

      The final decision coding, if upheld by FAB, would be: 'F0'
      [Final Accept] in ECMS B, with Reason Code 'B' [Part B] and
      'G1' [Final Partial Accept/Partial Develop] in ECMS E, with
      Reason Code 'CAU.' To record in ECMS E that the claims for
      wage loss and impairment are being deferred, status code
      'DV' [Partial Develop], with Reason Code 'IMW' [Impairment
      and Wage Loss], would be entered.

      Example 3: If there is a recommended decision to accept
      Asbestosis in Part E, and defer wage loss and impairment,
      and also to deny cancer in both Parts B and E (because the
      claimant did not prove he or she had cancer), the coding
      would be: 'D7' [Recommended Deny - medical information
      insufficient to support claim/non-cancer causation denial],
      with Reason Code 'B' [Part B] in ECMS B (since the cancer
      was denied for insufficient medical evidence), and 'A2'
      [Recommended Partial Accept/Partial Deny/Partial Develop]
      in ECMS E, with Reason Code 'CAU' (for accepting Asbestosis
      for causation).

      To record in ECMS E that the claims for wage loss and
      impairment related to Asbestosis are being deferred, status
      code 'DV' [Partial Develop], with Reason Code 'IMW'
      [Impairment and Wage Loss], would be entered. To record in
      ECMS E that the claim for cancer is being denied, status
      code 'PD' [Partial Deny], with Reason Code 'IN'
      [Insufficient Medical to establish claimed illness], would
      be entered.

      The final decision coding, if upheld by FAB, would be
      nearly identical to the recommended decision coding: Status
      Code 'F9' [Final Deny - medical information insufficient to
      support claim/non-cancer causation denial] with Reason Code
      'B' in ECMS B and 'G2' [Final Partial Accept/Partial

_____

4.   General Decision Coding. (Continued)

      Deny/Partial Develop] with Reason Code 'CAU' in ECMS E,
      along with status codes 'DV', with Reason Code 'IMW'; and
      'PD', with Reason Code 'IN'.

      Example 4: If there is a recommended decision to deny
      cancer and asbestosis in Part E because causation could not
      be established and peripheral neuropathy is denied because
      medical evidence was not provided to support a diagnosis of
      the claimed illness and wage loss is also being denied, the
      coding would be 'D5'[Recommended Deny - Cancer not work
      related] with Reason Code 'CAW' [to encompass the cancer
      and asbestosis causation denials and wage loss denial]
      followed by 'PD' [Partial Denial], with Reason Code 'IN',
      to capture the denial of peripheral neuropathy because of
      the lack of evidence of a diagnosis.

      The final decision coding, if upheld by FAB, would be
      nearly identical to the recommended decision coding:
      'F5'[FAB Affirmed Deny - Cancer not work related] with
      Reason Code 'CAW' [to encompass the cancer and asbestosis
      causation denials and wage loss denial] followed by 'PD'
      [Partial Denial], with Reason Code 'IN', to capture the
      denial of peripheral neuropathy because of the lack of
      evidence of a diagnosis.

5.   Recommended Decision Codes. The CE/SrCE must enter the
appropriate recommended decision code when issuing a recommended
decision. The status effective date of the code equals the
recommended decision issuance date.

      a.   A0 - 'Recommended Accept - Sent to FAB'. When the
      CE/SrCE renders a recommended decision on a claim for
      approval for benefits, where there are no other pending
      elements on the claim (including additional medical
      conditions, wage loss, or impairment), the DO/CE2 Unit
      enters the 'A0' code. The status effective date is the
      date of the recommended decision.

      Upon entering the 'A0' code, the CE/SrCE must select a
      specific reason code from the "reason cd" field, which is a
      drop-down box corresponding to the 'A0' claim status code.

_____

5.   Recommended Decision Codes. (Continued)

     To record any accepted Part B component of the decision,
     the CE must select reason code 'B' [Part B] for entry in
     ECMS B.

     To record any accepted Part E component of the decision,
     the CE must select one of the following reason codes from
     the drop-down menu to record all claimed elements
     (causation, wage loss, and/or impairment) being accepted in
     the current decision. These drop-down codes are required
     exclusively for Part E ECMS.

          (1) CAU – 'Causation Accepted' - Used when causation
          is established under Part E, which results in medical
          benefits for an employee or death benefit for an
          eligible survivor.

          (2) CAW – 'Causation and Wage Loss Accepted' - Used
          when causation and wage loss are being accepted
          simultaneously under Part E.

          (3) CAI – 'Causation and Impairment Accepted' - Used
          when causation and impairment are being accepted
          simultaneously under Part E.

          (4) IMP – 'Impairment Only Accepted (Causation
          Previously Accepted)' - Used when causation was
          established on a previous decision and impairment is
          all that is being accepted in this decision under Part
          E.

          (5) WAG – 'Wage Loss Only Accepted' - Used when
          causation was established on a previous decision and
          wage loss is all that is being accepted in this
          decision under Part E.

          (6) IMW – 'Impairment and Wage Loss Accepted' - Used
          when causation was established in a previous decision
          and the current decision accepts for wage loss and
          impairment.

          (7) CIW – 'Causation, Impairment, and Wage Loss
          Accepted' - Used when causation, impairment, and wage
          loss are all being accepted in the current Part E
          decision.

_____

5.   Recommended Decision Codes. (Continued)

            (8) DEF – 'Decision Deferred' - Deactivated. This
            code was only to be entered by the FAB in certain rare
            circumstances where a decision to accept was made
            without the DO/CE2 Unit having issued a recommended
            decision. **This code has been deactivated with the
            potential to be reactivated if the need arises.**

      b.   A1 - 'Recommended Partial Accept/Partial Develop'.
      When the CE/SrCE renders a recommended decision where part
      of the claim is approved for benefits, while another part
      of the claim needs further development (including
      additional medical conditions, wage loss, or impairment),
      the DO/CE2 Unit enters the 'A1' code. The status effective
      date is equal to the date of the recommended decision.
      This code allows benefit disbursement, if FAB upholds the
      decision, while other development continues.

      For Part B cases only, the CE/SrCE should use status code
      'A1' with reason code 'B' [Part B] for Recommended
      decisions that describe a partial acceptance for at least
      one claimed condition under Part B and partial development
      for one or more other conditions under Part B.

      For Part E cases only, the CE/SrCE must select the
      appropriate reason code from the drop-down menu for input
      into ECMS E. The reason code for the decision explains
      only what is being accepted in the current decision. These
      are the Part E reason codes available in the drop down
      menu:

            (1) CAU – 'Causation' - Used when causation for a
            claimed condition is accepted for benefits and
            additional development of another claimed element is
            required.

            (2) CAW – 'Causation and Wage Loss' - Used when
            causation and wage loss are being accepted and
            additional development of another claimed element is
            required.

            (3) CAI – 'Causation and Impairment' - Used when
            causation and impairment are being accepted and
            additional development of another claimed element is
            required.

_____

5.   Recommended Decision Codes. (Continued)

          (4) IMP – 'Impairment' - Used when causation has been
          previously accepted and impairment alone is being
          accepted and the additional development of another
          claimed element is required.

          (5) WAG – 'Wage Loss' - Used when causation has been
          previously accepted and wage loss alone is being
          accepted and additional development of another claimed
          element is required.

          (6) IMW – 'Impairment and Wage Loss' - Used when
          causation has been previously accepted, impairment and
          wage loss are both currently being accepted, and
          additional development of another claimed element is
          required (e.g., a cancer that is undergoing dose
          reconstruction at the National Institute of
          Occupational Safety and Health (NIOSH).

          (7) CIW – 'Causation, Impairment, and Wage Loss' -
          Used when causation is accepted along with both
          impairment and wage loss and additional development of
          another claimed element is required (e.g., a cancer
          that is undergoing dose reconstruction at NIOSH).

     The portion(s) of the claim being held in abeyance for
     additional development is/are identified by the secondary
     decision status code 'DV' [Partial Develop] and
     corresponding reason code set out in Paragraph 4 above.

     c.   A2 - 'Recommended Partial Accept/Partial Deny/Partial
     Develop'. When the CE/SrCE renders a recommended decision
     where part of the claim is approved for benefits, while
     another part of the claim is denied, and yet another part
     of the claim needs further development (including
     additional medical conditions, wage loss, or impairment),
     the DO/CE2 Unit enters the 'A2' code . The status
     effective date is the date of the recommended decision.
     This code allows for benefits to be administered, if FAB
     upholds the decision, while other development continues.

     For Part B cases only, status code 'A2' is used with reason
     code 'B' [Part B] in ECMS B for recommended decisions that
     describe a partial acceptance for at least one claimed

_____

5.   Recommended Decision Codes. (Continued)

      condition under Part B and partial denial and partial
      development for one or more other conditions under B.

      For Part E cases only, the CE/SrCE must select the
      appropriate reason code from the drop-down menu in ECMS E.
      The reason code for the decision explains only what is
      being accepted in the current decision. These are the Part
      E reason codes available in the drop down menu:

            (1) CAU – 'Causation' - Used when causation for a
            claimed condition is accepted for benefits, a portion
            of the claim is being denied, and a portion of the
            claim requires additional development.

            (2) CAW – 'Causation and Wage Loss' - Used when
            causation and wage loss are being accepted, a portion
            of the claim is being denied, and a portion of the
            claim requires additional development.

            (3) CAI – 'Causation and Impairment' - Used when
            causation and impairment are being accepted, a portion
            of the claim is being denied, and a portion of the
            claim requires additional development.

            (4) IMP – 'Impairment' - Used when causation has been
            previously accepted, impairment alone is being
            accepted, a portion of the claim is being denied, and
            a portion of the claim requires additional
            development.

            (5) WAG – 'Wage Loss' - Used when causation has been
            previously accepted, wage loss alone is being
            accepted, a portion of the claim is being denied, and
            a portion of the claim requires additional
            development.

            (6) IMW – 'Impairment and Wage Loss' - Used when
            causation has been previously accepted, impairment and
            wage loss are both currently being accepted, a portion
            of the claim is being denied, and a portion of the
            claim requires additional development.

            (7) CIW – 'Causation, Impairment, and Wage Loss' -
            Used when causation is accepted along with impairment

_____

5.   Recommended Decision Codes. (Continued)

              and wage loss, a portion of the claim is being denied,
              and a portion of the claim requires additional
              development (e.g., a cancer is undergoing dose
              reconstruction at NIOSH).

        The portion(s) of the claim being denied or held in
        abeyance for additional development are identified by the
        secondary decision status codes 'PD' [Partial Denial] and
        'DV' [Partial Develop] and corresponding reason codes set
        out in Paragraph 4 above.

        d.   A8 – 'Recommended Partial Accept/Partial Deny'. When
        the CE/SrCE renders a recommended decision where part of
        the claim is going to be approved for benefits, while
        another part of the claim is going to be denied, the DO/CE2
        Unit enters the 'A8' code in ECMS. The status effective
        date is equal to the date of the recommended decision.
        This code allows for benefit administration, if FAB upholds
        the decision, while development continues.

        For Part B cases only, the CE/SrCE should use status code
        'A8' with reason code 'B' [Part B] in ECMS B for
        recommended decisions that describe a partial acceptance
        for at least one claimed condition under Part B and partial
        denial for one or more other conditions under B.

        For Part E cases only, the CE/SrCE must select the
        appropriate reason code from the drop-down menu. The
        reason code for the decision explains only what is being
        accepted in the current decision. These are the Part E
        reason codes available in the drop down menu:

              (1) CAU – 'Causation' - Used when causation for a
              claimed condition is accepted for benefits and a
              portion of the claim is being denied.

              (2) CAW – 'Causation and Wage Loss' - Used when
              causation and wage loss are being accepted and a
              portion of the claim is being denied.

              (3) CAI – 'Causation and Impairment' - Used when
              causation and claimed impairment are being accepted
              and a portion of the claim is being denied.

_____

5.   Recommended Decision Codes. (Continued)

        (4) IMP – 'Impairment' - Used when causation has been
        previously accepted, claimed impairment alone is
        currently being accepted, and a portion of the claim
        is being denied.

        (5) WAG – 'Wage Loss' - Used when causation has been
        previously accepted, wage loss alone is currently
        being accepted, and a portion of the claim is being
        denied.

        (6) IMW – 'Impairment and Wage Loss' - Used when
        causation has been previously accepted, impairment and
        wage loss are both currently being accepted, and a
        portion of the claim is being denied.

        (7) CIW – 'Causation, Impairment, and Wage Loss' -
        Used when causation is accepted along with impairment
        and wage loss, and a portion of the claim is being
        denied (another claimed medical condition).

The portion(s) of the claim being denied is identified by
the secondary decision status code 'PD' [Partial Deny] and
corresponding reason code set out in Paragraph 4 above.

e.   D1 - 'Recommended Deny – Non-Covered Employment'.
When the CE/SrCE renders a recommended decision to deny
benefits due to employment that is not covered, the CE/SrCE
enters the 'D1' code. The status effective date is equal
to the date of the recommended decision. There are no
associated reason codes.

f.   D3 - 'Recommended Deny - Survivor Not Eligible'. When
the CE/SrCE renders a recommended decision to deny benefits
because the claimed survivor is not eligible, the DO/CE2
Unit enters the 'D3' code. The status effective date is
equal to the date of the recommended decision. There are no
associated reason codes.

g.   D4 – 'Recommended Deny – Condition Not Covered'(B
only). When the CE/SrCE renders a decision to deny Part B
benefits because the condition is not covered under Part B,
the DO/CE2 Unit enters a 'D4' code. The status effective
date is equal to the date of the recommended decision.
There are no associated reason codes.

_____

5.   Recommended Decision Codes. (Continued)

      h.   D5 - 'Recommended Deny - Cancer Not Work Related
      (PoC)'. When the CE/SrCE renders a recommended decision to
      deny benefits based wholly or in part on the PoC result
      from NIOSH being less than 50%, the DO/CE2 Unit enters the
      'D5' code. The status effective date is equal to the date
      of the recommended decision. This means if more than one
      condition is being denied, but at least one of them is a
      cancer case that went to NIOSH, the 'D5' primary decision
      code must be selected. This is also the only decision
      status code approved for use when denying a cancer claim
      based upon the PoC being less than 50% under both B and E.
      This code is also to be used in cases of CLL-cancer only,
      wherein the PoC is presumed to be zero.

      Upon entry of the 'D5' code, the CE/SrCE selects a specific
      reason code from the "reason cd" field, which is a drop-
      down box that corresponds with the 'D5' claim status code.
      The only reason code allowable for ECMS B is 'B' [Part B].
      The remaining reason codes available for the 'D5' claim
      status code are to be used in ECMS E.

      Note 1: In ECMS E, the 'D5' code can also be used in
      conjunction with the 'DV' code to capture partial
      deny/partial develop decisions, for which there isn't a
      single, unique primary decision status code. The CE/SrCE
      enters the 'D5' code with a reason code denoting what is
      being denied. The CE/SrCE then enters the 'DV' status code
      and appropriate associated reason code listed in Paragraph
      4 above to identify which benefits are being held for
      further development. The status effective date of both
      codes is the date of the decision.

      Note 2: If there is also a finding in the Part E decision
      to deny one or more claimed conditions because medical
      evidence was not provided to support diagnosis of the
      claimed condition, in addition to the cancer(s)
      specifically included in the NIOSH PoC determination
      (described by using the 'D5' code), it is appropriate to
      enter, in tandem with the 'D5' entry, status code 'PD'
      [Partial Deny] with 'IN' reason code to describe/record the
      additional denial. Essentially, the coding would be
      deny/partial deny. This captures one or more conditions
      were denied because causation could not be established and
      at least one other condition had insufficient medical to

_____

5.   Recommended Decision Codes. (Continued)

      establish the diagnosis of the claimed illness. Additional
      elements being denied, such as impairment, wage loss, and
      other causation denials can be captured in the reason code
      for 'D5', unless specifically requested in relation to the
      condition(s) being denied under 'PD'.

      For example, if prostate cancer and wage loss are denied
      for lack of causation (PoC and toxic exposure) and
      asbestosis is denied because medical evidence was not
      provided, the Part E case would be coded 'D5/F5-CAW' and
      'PD-IN'.

      The reason codes associated with the 'D5' code are:

           (1) B – 'Part B' (B only) – Used when cancer is
           claimed under Part B, but is being denied based on the
           NIOSH PoC.

           (2) CAU – 'Causation' (E only) – Used when cancer is
           claimed under Part E, but causation cannot be
           established (through dose reconstruction or toxic
           exposure development).

           (3) WAG – 'Wage Loss' (E only) – Used in the rare
           circumstance when a wage loss claim is received and
           adjudicated after a cancer denial.

           (4) CAW – 'Causation and Wage Loss' (E only) – Used
           when cancer and wage loss are claimed under Part E,
           but causation cannot be established (through dose
           reconstruction or toxic exposure development) and wage
           loss must also be denied.

           (5) IM0 – 'Impairment – 0%' (E only) – Used in the
           rare circumstance when an impairment claim is received
           and adjudicated after a cancer denial. The impairment
           rating may not have been completed because causation
           was not established or if one was provided with a 0%
           impairment rating.

           (6) IMN – 'Impairment – Not Ratable' (E only) – Used
           in the rare circumstance when an impairment claim is
           received and adjudicated after a cancer denial and

_____

5.   Recommended Decision Codes. (Continued)

        the claim for impairment is for a non-ratable
        condition, such as certain psychiatric conditions.

        (7) IMR – 'Impairment – Resolved' (E only) - Used in
        the rare circumstance when an impairment claim is
        received and adjudicated after a cancer denial and the
        claimed impairment was resolved (i.e., does not exist
        anymore) prior to the issuance of the decision.

        (8) I0W – 'Impairment (0%) and Wage Loss' (E only) –
        Used when wage loss and impairment related to a
        previously denied cancer are both being denied. The
        claim for impairment is denied because it has a 0%
        rating or because an impairment rating was not
        completed due to lack of causation.

        (9) INW – 'Impairment (Not Ratable) and Wage Loss' (E
        only) - Used when wage loss and impairment are both
        being denied related to a previously denied cancer.
        The claim for impairment is denied because the
        condition being claimed is not ratable for impairment,
        such as certain psychiatric conditions.

        (10) IRW – 'Impairment (Resolved) and Wage Loss' (E
        only) - Used when wage loss and impairment are both
        being denied related to a previously denied cancer.
        The claim for impairment is being denied because the
        impairment was resolved (i.e., does not exist anymore)
        prior to the issuance of the decision.

        (11) C0W – 'Causation, Impairment (0%) and Wage Loss'
        (E only) - Used when claims for causation, impairment,
        and wage loss are denied simultaneously. Impairment
        is denied because the impairment rating is 0% or
        because the claimant failed to provide the necessary
        medical documentation or because the impairment rating
        was not performed because causation could not be
        established.

        (12) CNW – 'Causation, Impairment (Not Ratable), and
        Wage Loss' (E only) - Used when a claim is made for
        causation, wage loss, and impairment, all of which are
        being denied simultaneously. The impairment claim is

FEDERAL (EEOICPA) PROCEDURE MANUAL   Chapter 2-2100
Energy Case Management
Part 2 – Claims   System (ECMS)--Decisions

_____

5. <u>Recommended Decision Codes</u>. (Continued)

being denied because it is for a non-ratable condition.

(13) <u>CRW – 'Causation, Impairment (Resolved), and Wage Loss' (E only)</u> – Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment claim is denied because the impairment was resolved (i.e., does not exist anymore) prior to issuance of the decision.

(14) <u>CA0 – 'Causation and Impairment (0%)' (E only)</u> – Used when causation and 0% impairment are being denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

(15) <u>CAN – 'Causation and Impairment (not ratable)' (E only)</u> – Used when causation and an impairment for a non-ratable condition, such as certain psychiatric conditions, are being denied simultaneously.

(16) <u>CAR – 'Causation and Impairment (Resolved)' (E only)</u> – Used when causation and an impairment that is resolved (i.e., does not exist anymore) prior to the issuance of the decision are being denied simultaneously.

h. <u>D7 – 'Recommended Deny – Medical Information Insufficient to Support Claim/Non-Cancer Causation Denial'</u>. This code is used when the CE/SrCE renders a recommended decision to deny benefits because, after developing the claimed covered condition(s), there is insufficient medical evidence to support an acceptance; the decision is for a non-cancer causation denial; the maximum payable benefit is met; or the decision solely addresses impairment and/or wage loss claims where the related condition was not previously denied under D5.

The status effective date is the date of the recommended decision. Upon entry in ECMS of the 'D7' code, the CE/SrCE selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'D7'

_____

5.   <u>Recommended Decision Codes</u>. (Continued)

      claim status code. The reason codes available for the 'D7' claim status code are listed below. The reason code 'B' [Part B] is only to be used in ECMS B.

      <u>Note 1</u>: In ECMS E, the 'D7' code can also be used in conjunction with the 'DV' code to capture partial deny/partial develop decisions, for which there isn't a single, unique primary decision status code. The CE/SrCE enters the 'D7' code with a reason code denoting what is being denied. The CE then enters the 'DV' status code and appropriate associated reason code listed in Paragraph 4 above to identify which benefits are being held for further development. The status effective date of both codes is the date of the decision.

      <u>Note 2</u>: If the decision contains findings to deny multiple claimed conditions, and one denial is for insufficient medical evidence to establish the claimed illness and another denial is for inability to establish causation, impairment or wage loss, the CE/SrCE should enter 'D7' with the reason code describing the causation/impairment/wage loss denial. In tandem with the 'D7' entry, the CE/SrCE should enter 'PD' [Partial Deny] with reason code 'IN' to record the denial for insufficient medical to establish illness.

          (1) <u>B – 'Part B'(B only)</u> - Used when a condition is denied in ECMS B.

          (2) <u>DMB - 'Deny Specific Medical Benefits on Accepted Condition'</u> (B and/or E) - Used when a specific medical benefit is being denied on an accepted condition in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

          (3) <u>RMB – 'Reduce Medical Benefits on Accepted Condition'</u> (B and/or E) - Used when a medical benefit on a previously paid item for a covered condition is reduced in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

          (4) <u>IN – 'Insufficient Medical to Establish Claimed Illness'(E only)</u> - Used when a covered illness is

_____

5.   Recommended Decision Codes. (Continued)

              claimed under Part E but medical evidence is
              insufficient to establish the illness.

              (5) R4C – 'RECA 4 Cancer'(E only) – Used when a Part E
              cancer case is denied because the claimant had
              received benefits under RECA Section 4.

              (6) CAU – 'Causation' (E only) – Used when a covered
              illness is claimed under Part E, but causation cannot
              be established.

              (7) WAG – 'Wage Loss' (E only) – Used when the claim
              for wage loss is being denied due to lack of medical
              evidence to support the claimed period of wage-loss is
              causally related to the covered illness.

              (8) CAW – 'Causation and Wage Loss' (E only) – Used
              when a covered illness is claimed under Part E, but
              causation cannot be established and claimed wage loss
              must also be denied.

              (9)   IM0 – 'Impairment – 0%' (E only) – Used when the
              claim for impairment is being denied because the
              impairment rating is 0% under the AMA Guides or
              because a claim for impairment was filed, but the
              claimant failed to provide the necessary medical
              documentation.

              (10) IMN – 'Impairment – Not Ratable' (E only) – Used
              when the claim for impairment is being denied because
              the claimed impairment is non-ratable, such as certain
              psychiatric conditions.

              (11) IMR – 'Impairment – Resolved' (E only) – Used
              when the claim for impairment is being denied because
              the claimed impairment was resolved (i.e., does not
              exist anymore) prior to the issuance of the decision.

              (l2) I0W – 'Impairment (0%) and Wage Loss' (E only) –
              Used when wage loss and impairment are both being
              denied. The claim for impairment is denied because it
              has a 0% rating or because a claim for impairment was
              filed, but the claimant failed to provide the
              necessary medical documentation.

_____

5.   Recommended Decision Codes. (Continued)

            (13) INW – 'Impairment (Not Ratable) and Wage Loss'
            (E only) - Used when wage loss and impairment are both
            being denied. The claim for impairment is denied
            because the condition being claimed is not ratable for
            impairment, such as certain psychiatric conditions.

            (14) IRW – 'Impairment (Resolved) and Wage Loss' (E
            only) - Used when wage loss and impairment are both
            being denied. The claim for impairment is being
            denied because the impairment was resolved (i.e., does
            not exist anymore) prior to the issuance of the
            decision.

            (15) C0W – Causation, Impairment (0%) and Wage Loss'
            (E only) - Used when claims for causation, impairment,
            and wage loss are denied simultaneously. Impairment
            is denied because the impairment rating is 0% or
            because a claim for impairment was filed, but the
            claimant failed to provide the necessary medical
            documentation.

            (16) CNW – 'Causation, Impairment (Not Ratable), and
            Wage Loss' (E only) – Used when a claim is made based
            on causation, wage loss, and impairment, all of which
            are being denied. The impairment is being denied
            because it is for a non-ratable condition.

            (17) CRW – 'Causation, Impairment (Resolved), and Wage
            Loss' (E only) - Used when claims for causation,
            impairment, and wage loss are being denied
            simultaneously. The impairment claim is being denied
            because the impairment was resolved (i.e., does not
            exist anymore) prior to the issuance of the decision.

            (18) CA0 – 'Causation and Impairment (0%)' (E only) –
            Used when causation and impairment are being denied
            simultaneously. Impairment is denied because the
            impairment rating is 0% or because a claim for
            impairment was filed, but the claimant failed to
            provide the necessary medical documentation.

            (19) CAN – 'Causation and Impairment (Not Ratable)' (E
            only) - Used when causation and an impairment that is
            not ratable are being denied simultaneously.

_____

5.　　Recommended Decision Codes. (Continued)

　　　　　(20) CAR – 'Causation and Impairment (Resolved)' (E
　　　　　only) - Used when causation and an impairment that is
　　　　　resolved prior to the issuance of the decision are
　　　　　being denied simultaneously.

　　　　　(21) MBM – 'Maximum Payable Benefit Met' (E only) –
　　　　　Used when the maximum payable benefit is already met
　　　　　and a formal decision is required for an impairment
　　　　　and/or wage loss claim.

6.　　Between Recommended and Final Decisions.　When the FAB
receives a case from the DO, the case is transferred in ECMS
using the codes discussed in EEOICPA PM 1-0700, Exhibit 2. The
date the file is "transferred in" is the date the transfer sheet
is date stamped in.

When the case is transferred in, the 'FD' (FAB Received RD) code
is entered into the Claim Status History for each active
claimant with a status effective date of the date FAB received
the case.

At this time, ECMS automatically generates a docket number for
each claim, viewable at the top of the ECMS claim screen and
payee screen.　This number is generated the first time the case
goes to FAB.　Subsequent decisions that go to the FAB for review
are not given new docket numbers.　This number is referenced on
decisions issued by the FAB and is used on published decisions.

　　　a.　'FN' – FAB Initial Review Complete.　After the case is
　　　transferred into FAB and coded 'FD'/"docketed", it is
　　　assigned to the appropriate CE or Hearing Representative
　　　(HR).　The CE/HR completes an initial review of the case,
　　　assigns a CE2 if necessary, and enters an 'FN' (FAB Initial
　　　Review Complete).　The status effective date of the 'FN'
　　　code is the date the CE/HR completes the initial review.

　　　b.　'FJ' – FAB Received Waiver of Objections.　When FAB
　　　receives a waiver of objections, a 'FJ' code is entered
　　　into the claim status history for the claimant who provided
　　　the completed waiver.

　　　The status effective date of the 'FJ' code is the date that
　　　the waiver is received and date stamped into any FAB office
　　　only (not the DO, National Office, or a Resource Center).

_____

6.   Between Recommended and Final Decisions. (Continued)

      ECMS requires the selection of a reason code from the
      associated drop-down box. The reason codes available for
      the 'FJ' status code are:

           (1) 'PW'- Partial Waiver – Used when a bifurcated
           waiver is received, waiving the right to object to a
           portion of the decision and reserving the right to
           object to another.

           (2) 'WF' - Full Waiver – Used when a waiver is
           received waiving the right to object to all findings
           and conclusions in the recommended decision.

      When choosing between a full waiver and a partial waiver,
      the CE/HR must look at what is being done in Parts B and E
      separately (as with the decisions). Here are some sample
      scenarios illustrating the use of this code:

      Example 1: If a decision grants benefits under Part E and
      denies under Part B, and a partial waiver is received
      (waiving the Part E decision and reserving the right to
      object to the Part B decision), the CE/HR would enter an
      'FJ-WF' (full waiver) in ECMS E and nothing in ECMS B.
      Essentially there is a full waiver on the Part E decision
      and no waiver on the Part B decision.

      Example 2: If the Part B decision is an acceptance and the
      Part E decision is a partial accept/partial deny, and a
      bifurcated (partial) waiver is received, the CE/HR would
      enter a 'FJ-WF' (full waiver) into ECMS B and an 'FJ-PW'
      (partial waiver) into ECMS E. Please note that if a
      bifurcated waiver is received for a recommended decision
      pertaining to one part of the Act and the final decision to
      accept is issued prior to the final decision to deny
      because the claimant has reserved his or her right to
      object to the denial, that decision must be coded as a
      "partial develop" because a portion of the decision has
      been deferred. In this particular example the Part B
      decision would be coded 'F0-B' and the first Part E
      decision would be coded 'G1' (partial accept/partial
      develop) with an appropriate reason code + 'DV' (partial
      develop) with an appropriate reason code. The second Part
      E decision that would be issued after the objection period

_____

6.   <u>Between Recommended and Final Decisions</u>. (Continued)

      expired, would be coded as a denial (assuming nothing
      changed from the recommended decision).

      c.   <u>Coding Objections</u>. If the claimant submits an
      objection, it must be coded into ECMS. While every
      claimant is affected by an objection, the objection only
      needs to be coded for the claimant who submits it.

      However, based on the portion of the decision (Part B or
      Part E) to which the claimant is objecting, it is coded
      only into ECMS B or ECMS E. If it is unknown whether the
      objection pertains to Part B or E, or the claimant
      specifies both, the objection will be coded into both ECMS
      B and ECMS E.

      A claimant who objects may request either a review of the
      written record or an oral hearing. In either case, the
      Appeals screen must be completed. To access the appeals
      screen, the CE/HR clicks on the "Appeals/Recons" button on
      the claim screen. The CE/HR then goes to the section
      marked appeals, selects an area in that field and clicks
      "Insert". This will take the CE/HR to the appeals screen,
      for which completion is discussed below. These fields are
      completed as the appropriate information becomes available:

           (1)   <u>Rec Decision</u> – This field will be populated with
           the recommended decision code entered by the DO/CE2
           Unit. If multiple recommended decisions have been
           issued, select the one referenced in the objection
           from the drop-down menu.

           (2)   <u>Auth Rep</u> – This field is completed with the name
           of the claimant's authorized representative, if any.
           If there is no authorized representative, this field
           is left blank.

           (3)   <u>FAB Rep</u> – This field is completed with the ID of
           the FAB employee assigned to the case by using the
           drop-down menu.

           (4)   <u>Appeal Rcpt Dt</u> – This field is completed with the
           date that the objection was received in any FAB office
           only (not the DO, National Office, or a Resource
           Center).

_____

6.   Between Recommended and Final Decisions. (Continued)

           (5) Dist Office – This field is automatically
           populated with the office location of the FAB
           representative.

           (6) Ext Thru – This is an optional field used for the
           CE/HR's information if an extension is granted. If
           time allows, the CE/HR can grant one extension, at the
           claimant's request, for submission of additional
           evidence.

           (7) Appeal Type – This field is used to indicate how
           the objection is being addressed. The following
           reasons are available via the drop-down menu:

                (a) 'FQ – Hearing' – Selected when the claimant
                has requested an oral hearing.

                (b) 'FT – Hearing Teleconference' – Selected when
                the claimant requests a telephonic hearing.

                (c) 'FW – Review of the Written Record' –
                Selected when the claimant requests a review of
                the written record or if the claimant objects and
                fails to specify that a hearing is desired.

           (8) Objection – This field is used to specify the
           main reason that the claimant is objecting. There is
           a drop-down box that describes several types of
           objections, such as more evidence available, secondary
           exposure, general, etc. The CE/HR selects the one
           that best applies to the claimant's objection.

           (9) Date to FAB Rep – This field is completed with
           the date the objection is assigned to the CE/HR.

           (10) AckReq Dt – This field is completed with the
           date FAB sends a letter to the claimant acknowledging
           that the objection has been received.

           (11) Hearing Scheduled Dt – This field is completed
           only for hearing requests, using the date the hearing
           arrangements were made.

_____

6.   Between Recommended and Final Decisions. (Continued)

              (12) Notice Sent Dt – This field is completed only for
              hearing requests, using the date the hearing
              notification letter was sent to the claimant.

              (13) Hearing Dt – This field is completed only for
              hearing requests, using the date of the hearing.

              (14) Date RWR – This field is completed only for
              reviews of the written record (RWR), using the date
              the RWR is completed/the date of the final decision.

              (15) Location and State – These fields are completed
              only for oral hearing requests, using the city where
              the hearing is to take place. The state where the
              hearing is to occur can then be selected from the
              drop-down menu associated with the state field.

              (16) Appeal Status and Appeal Status Date – The CE/HR
              selects the current status of the objection process
              (such as "Hearing Convened" or "Appeal Request
              Untimely") along with completing the date of the
              current status in the appeal status date field.

              (17) Notes – This is an optional field where any notes
              regarding the objections can be listed. For example,
              if the received date for an appeal appears untimely
              because the appeal receipt date is more than 60 days
              after the recommended decision, but the postmark date
              is within 60 days, the timely postmark date would be
              mentioned in the notes section.

              (18) Final Decision – This field is completed when the
              final decision is issued. On cases where objections
              have been filed and an oral hearing or RWR was
              performed, the Final Decision Code is entered through
              the appeals screen. To enter the final decision code
              in these circumstances, the CE/HR selects the button
              next to the final decision field on the appeals screen
              and enters the appropriate final decision code (see
              Paragraph 7 below).

_____

7.   <u>FAB Decision Codes</u>. The FAB CE/HR must ensure that all
coding throughout the claim file is correct when a FAB decision
is issued. If FAB must enter missing codes on behalf of the
DO/CE2 Unit, the FAB CE/HR must select the appropriate office's
"dist office cd" on the claim status code (update) screen to
reflect the office that actually took the action. The FAB CE/HR
must ensure that the status effective date of any added or
updated codes have the correct status effective date.

When issuing final decisions, the appropriate final decision
code (see list below) is entered into ECMS. The status
effective date of the code will be the date the final decision
was issued.

Currently there are two systems for ECMS separately tracking
Part B and Part E activity. The final decision coding is entered
with a decision code/reason code combination that relates to the
'Part B' portion in ECMS B, and a decision code/reason code
combination that relates to the 'Part E' portion in ECMS E. This
is necessary to ensure accurate statistics about what decisions
were made in relation to the 'Part B' and 'Part E' portions of
the case. For example, if a decision is issued that accepts
Part B and denies Part E, it would not be coded as a partial
accept/partial deny in both systems. It would be coded as an
acceptance in ECMS B and a denial in ECMS E.

Under Part E, "causation" for employee claimants means that the
claimed covered illness was caused by exposure to a toxic
substance at a covered Part E facility or site. "Causation" for
a survivor claimant means that exposure to a toxic substance at
a covered Part E facility or site was a significant factor in
aggravating, contributing to, or causing the death of the
employee.

     a.   <u>F0 - 'Final Accept'</u>. When the CE/HR renders a final
     decision on an approved claim for benefits, where there are
     no other pending elements on the claim (including
     additional medical conditions, wage loss, or impairment),
     the CE/HR enters the 'F0' code. The status effective date
     is the date of the final decision.

     Upon entering the 'F0' code, the CE/HR must select a
     specific reason code from the "reason cd" field, which is a
     drop-down box corresponding to the 'F0' claim status code.

_____

7. FAB Decision Codes. (Continued)

    To record any accepted Part B component of the decision,
    the CE/HR must select reason code 'B' [Part B] for entry in
    ECMS B.

    To record any accepted Part E component of the decision,
    the CE/HR must select one of the following reason codes
    from the drop-down menu to record all of the claimed
    elements being accepted in the current decision. These
    reason codes are to be entered exclusively in ECMS E:

        (1) CAU – 'Causation Accepted' - Used when causation
        is established under Part E, which results in medical
        benefits for an employee or death benefit for an
        eligible survivor.

        (2) CAW – 'Causation and Wage Loss Accepted' - Used
        when causation and wage loss are being accepted
        simultaneously under Part E.

        (3) CAI – 'Causation and Impairment Accepted' - Used
        when causation and impairment are being accepted
        simultaneously under Part E.

        (4) IMP – 'Impairment Only Accepted (Causation
        Previously Accepted)' - Used when causation was
        established on a previous decision and impairment is
        all that is being accepted in this decision under Part
        E.

        (5) WAG – 'Wage Loss Only Accepted' - Used when
        causation was established on a previous decision and
        wage loss is all that is being accepted in this
        decision under Part E.

        (6) IMW – 'Impairment and Wage Loss Accepted' - Used
        when causation was established in a previous decision
        and the current decision accepts for wage loss and
        impairment.

        (7) CIW – 'Causation, Impairment, and Wage Loss
        Accepted' - Used when causation, impairment, and wage
        loss are all being accepted in the current Part E
        decision.

_____

7. FAB Decision Codes. (Continued)

    b.   G1 - 'Final Partial Accept/Partial Develop/Defer'.
    When the CE/HR renders a final decision where part of the
    claim is going to be approved for benefits, while another
    part of the claim needs further development/deferral
    (including additional medical conditions, wage loss, or
    impairment), the CE/HR enters the 'G1' code. The status
    effective date is the date of the final decision.

    This code allows for benefits to be administered while
    development continues. Status code 'G1' is used with
    reason code 'B' [Part B] in ECMS B for final decisions that
    describe a partial acceptance for one claimed condition
    under Part B and partial development/deferral for one or
    more other conditions under B.

    For Part E cases only, the CE/HR must select the
    appropriate reason code from the drop-down menu for input
    into ECMS E. The reason code for the decision explains
    only what is being accepted in the current decision. These
    are the Part E reason codes available in the drop down
    menu:

        (1) CAU - 'Accept Causation' - Used when causation
        for a claimed condition is accepted for benefits and
        additional development of another claimed element is
        required.

        (2) CAW - 'Accept Causation and Wage Loss' - Used
        when causation and claimed wage loss are being
        accepted and additional development of another claimed
        element is required.

        (3) CAI – 'Accept Causation and Impairment' - Used
        when causation and claimed impairment are being
        accepted and additional development of another claimed
        element is required.

        (4) IMP - 'Accept Impairment' - Used when causation
        has previously been accepted, claimed impairment alone
        is being accepted, and the additional development of
        another claimed element is required.

        (5) WAG - 'Accept Wage Loss' - Used when causation
        has previously been accepted, claimed wage loss alone

_____

7.   <u>FAB Decision Codes</u>. (Continued)

          is being accepted, and the additional development of
          another claimed element is required.

          (6) <u>IMW – 'Accept Impairment and Wage Loss'</u> - Used
          when causation was previously accepted, impairment and
          wage loss are both claimed, a decision is being issued
          that accepts both impairment and wage loss for
          benefits, and the additional development of another
          claimed element is required.

          (7) <u>CIW – 'Accept Causation, Impairment, and Wage
          Loss'</u> - Used when causation is accepted along with
          both claimed impairment and wage loss, and the
          additional development of another claimed element is
          required (e.g., a cancer claim is pending dose
          reconstruction at NIOSH).

     The portion(s) of the claim being held in abeyance for
     additional development or because the decision cannot be
     issued at this time (possibly because of a partial waiver)
     are identified by the secondary decision status code 'DV'
     [Partial Develop] and corresponding reason code as set out
     in Paragraph 4 above.

     c.   <u>F1 - 'Final Deny - Employee Not Covered'</u>. When the
     CE/HR renders a final decision to deny benefits due to
     employment that is not covered, the CE/HR enters the 'F1'
     code. The status effective date is the date the final
     decision was issued.

     d.   <u>G2 - 'Final Partial Accept/Partial Deny/Partial
     Develop/Defer'</u>. When the CE/HR renders a final decision
     where part of the claim is going to be approved for
     benefits, while another part of the claim is going to be
     denied, and yet another part of the claim requires further
     development or is being deferred, the FAB CE/HR enters the
     'G2' code. The status effective date is the date of the
     final decision.

     This code allows for benefits to be administered while
     development continues. Status code 'G2' is used with reason
     code 'B' [Part B] in ECMS B for final decisions that
     describe a partial acceptance for one claimed condition

_____

7.   <u>FAB Decision Codes</u>. (Continued)

     under Part B and partial denial and partial development for
     one or more other conditions under Part B.

     For Part E cases, the CE/HR must select the appropriate
     reason code from the drop-down menu. The reason code for
     the decision explains only what is being accepted in the
     current decision. These are the Part E reason codes
     available in the drop down menu:

          (1) <u>CAU – 'Accept Causation'</u> - Used when causation
          for a claimed condition is accepted for benefits and a
          portion of the claim is being denied and a portion of
          the claim requires additional development.

          (2) <u>CAW – 'Accept Causation and Wage Loss'</u> - Used
          when causation and wage loss are being accepted, a
          portion of the claim is being denied, and a portion of
          the claim requires additional development.

          (3) <u>CAI – 'Accept Causation and Impairment'</u> - Used
          when causation and impairment are being accepted, a
          portion of the claim is being denied, and a portion of
          the claim requires additional development.

          (4) <u>IMP – 'Accept Impairment'</u> - Used when causation
          has been previously accepted, impairment alone is
          being accepted, a portion of the claim is being
          denied, and a portion of the claim requires additional
          development.

          (5) <u>WAG – 'Accept Wage Loss'</u> - Used when causation
          has been previously accepted, wage loss alone is being
          accepted, a portion of the claim is being denied, and
          a portion of the claim requires additional
          development.

          (6) <u>IMW – 'Accept Impairment and Wage Loss'</u> - Used
          when causation has been previously accepted, a
          decision is being issued that accepts both impairment
          and wage loss, a portion of the claim is being denied,
          and a portion of the claim requires additional
          development.

_____

7.   FAB Decision Codes. (Continued)

               (7) CIW – 'Accept Causation, Impairment, and Wage
               Loss' - Used when causation is accepted along with
               both impairment and wage loss, a portion of the claim
               is being denied, and a portion of the claim requires
               additional development (e.g., a cancer claim is
               undergoing dose reconstruction at NIOSH).

     The portion(s) of the claim being held in abeyance for
     additional development or because the decision cannot be
     issued at this time (possibly because of a partial waiver)
     is identified by the secondary decision code 'DV' [Partial
     Develop] and corresponding reason codes set out in
     Paragraph 4 that are only available in ECMS E. The
     portion(s) of the claim denied are identified by the
     secondary decision status codes 'PD' [Partial Denial].

     e.   F3 - 'Final Deny - Survivor Not Eligible'. When the
     CE/HR renders a final decision to deny benefits because the
     claimed survivor is not eligible, the CE/HR enters the 'F3'
     code. The status effective date is the date of the final
     decision.

     f.   F4 – 'Final Deny – Condition Not Covered'. (B only)
     When the CE/HR renders a final decision to deny Part B
     benefits because the condition is not covered under Part B,
     the FAB CE/HR enters a 'F4' code in ECMS B. The status
     effective date is equal to the date of the Final Decision.

     g.   F5 - 'Final Deny - Cancer Not Work Related (PoC)'.
     When the CE/HR renders a final decision to deny benefits
     because the PoC result from NIOSH is less than 50%, the
     CE/HR enters the 'F5' code. This means if more than one
     condition is being denied, but at least one of them is a
     cancer case that went to NIOSH, the F5 primary decision
     code must be selected. This code is also to be used in
     cases of CLL-cancer only, wherein the PoC is presumed to be
     zero. The status effective date is the date of the final
     decision. This code is used for BOTH Part B and Part E
     cancer denials based upon a PoC of less than 50%.

     Upon entry of the 'F5' code, the CE/HR selects a specific
     reason code from the "reason cd" field, which is a drop-
     down box that corresponds with the 'F5' claim status code.

_____

7. FAB Decision Codes. (Continued)

     The reason codes available for the 'D5' claim status code
     are listed below.

     The only reason code allowable for ECMS B is 'B' [Part B].

     Note 1: In ECMS E, the 'F5' code can also be used in
     conjunction with the 'DV' code to capture partial
     deny/partial develop decisions, for which there isn't a
     single, unique primary decision status code. The CE/HR
     enters the 'F5' code with a reason code denoting what is
     being denied. The CE/HR then enters the 'DV' status code
     and appropriate associated reason code listed in paragraph
     4 above to identify which benefits are being held for
     further development. The status effective date of both
     codes is the date of the decision.

     Note 2: If there is also a finding in the Part E decision
     to deny one or more claimed conditions because medical
     evidence was not provided to support diagnosis of the
     claimed condition, in addition to the cancer(s)
     specifically included in the NIOSH PoC determination
     (described by using the 'F5' code), it is appropriate to
     enter, in tandem with the 'F5' entry, status code 'PD'
     [Partial Deny] with 'IN' reason code to describe/record the
     additional denial. Essentially, the coding would be
     deny/partial deny. This captures one or more conditions
     were denied because causation could not be established and
     at least one other condition had insufficient medical to
     establish the diagnosis of the claimed illness. Additional
     elements being denied, such as impairment, wage loss, and
     other causation denials can be captured in the reason code
     for 'F5', unless specifically requested in relation to the
     condition(s) being denied under 'PD'.

     For example, if prostate cancer and wage loss are denied
     for lack of causation (PoC and toxic exposure) and
     asbestosis is denied because medical evidence was not
     provided, the Part E case would be coded 'F5'-'CAW' and
     'PD'-'IN'.

     The reason codes associated with the F5 code are:

_____

7. FAB Decision Codes. (Continued)

> (1) B – 'Part B' (B only) - Used when cancer is claimed under Part B, but is being denied based on the NIOSH PoC.
>
> (2) CAU – 'Causation' (E only) - Used when cancer is claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development).
>
> (3) WAG – 'Wage Loss' (E only) - Used in the rare circumstance when a wage loss claim is received and adjudicated after a cancer denial.
>
> (4) CAW – 'Causation and Wage Loss' (E only) - Used when cancer and wage loss are claimed under Part E, but causation cannot be established (through dose reconstruction or toxic exposure development) and wage loss must also be denied.
>
> (5) IM0 – 'Impairment – 0%' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial. The impairment rating may not have been completed because causation was not established or if one was provided with a 0% impairment rating.
>
> (6) IMN – 'Impairment – Not Ratable' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and the claim for impairment is for a non-ratable condition, such as certain psychiatric conditions.
>
> (7) IMR – 'Impairment – Resolved' (E only) - Used in the rare circumstance when an impairment claim is received and adjudicated after a cancer denial and the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.
>
> (8) I0W – 'Impairment (0%) and Wage Loss' (E only) - Used when wage loss and impairment related to a previously denied cancer are both being denied. The claim for impairment is denied because it has a 0% rating or because an impairment rating was not completed due to lack of causation.

_____

7. FAB Decision Codes. (Continued)

                (9) INW – 'Impairment (Not Ratable) and Wage Loss' (E
                only) - Used when wage loss and impairment are both
                being denied related to a previously denied cancer are
                both being denied. The claim for impairment is denied
                because the condition being claimed is not ratable for
                impairment, such as certain psychiatric conditions.

                (10) IRW – 'Impairment (Resolved) and Wage Loss' (E
                only) - Used when wage loss and impairment are both
                being denied related to a previously denied cancer.
                The claim for impairment is being denied because the
                impairment was resolved (i.e., does not exist anymore)
                prior to the issuance of the decision.

                (11) C0W – Causation, Impairment (0%), and Wage Loss'
                (E only) - Used when claims for causation, impairment,
                and wage loss are denied simultaneously. Impairment
                is denied because the impairment rating is 0% or
                because the claimant failed to provide the necessary
                medical documentation or because the impairment rating
                was not performed because causation could not be
                established.

                (12) CNW – 'Causation, Impairment (Not Ratable), and
                Wage Loss' (E only) - Used when a claim is made for
                causation, wage loss, and impairment, all of which are
                being denied simultaneously. The impairment claim is
                being denied because it is for a non-ratable
                condition.

                (13) CRW – 'Causation, Impairment (Resolved), and
                Wage Loss' (E only). Used when claims for causation,
                impairment, and wage loss are being denied
                simultaneously. The impairment claim is denied
                because the impairment was resolved (i.e., does not
                exist anymore) prior to issuance of the decision.

                (14) CA0 – 'Causation and Impairment (0%)' (E only) -
                Used when causation and 0% impairment are being denied
                simultaneously. Impairment is denied because the
                impairment rating is 0% or because the claimant failed
                to provide the necessary medical documentation or
                because the impairment rating was not performed
                because causation could not be established.

_____

7. FAB Decision Codes. (Continued)

        (15) CAN - 'Causation and Impairment (not ratable)' (E
        only) - Used when causation and an impairment for a
        non-ratable condition, such as certain psychiatric
        conditions, are being denied simultaneously.

        (16) CAR - 'Causation and Impairment (Resolved)' (E
        only) - Used when causation and impairment that is
        resolved (i.e., does not exist anymore) prior to the
        issuance of the decision are being denied
        simultaneously.

    h. F6 - 'Final Accept - Reversal From Denial.' When the
    CE/HR renders a final decision to approve benefits despite
    the recommended decision to deny, the CE/HR enters the 'F6'
    code. The status effective date is the date of the final
    decision.

    This code should also be used if the recommended decision
    is a partial accept/partial deny and the denial portion is
    reversed.

    Upon entering the 'F6' code, the CE/HR must select a
    specific reason code from the "reason cd" field, which is a
    drop-down box corresponding to the 'F0' claim status code.

    To record any accepted Part B component of the decision,
    the CE/HR must select reason code 'B' [Part B] for entry in
    ECMS B.

    If a Part B final decision reversed at least a portion of a
    recommended decision to deny, while the other Part B
    elements are accepted, the CE/HR must use an additional
    primary final decision code to capture the denial. The
    CE/HR must enter the 'F6' code with reason code 'B' and
    another applicable final decision for the element that is
    being denied.

    To record any accepted Part E component of the decision,
    the CE/HR must select one of the following reason codes
    from the drop-down menu to record all of the claimed
    elements being accepted in the current decision. These
    reason codes are to be entered exclusively in ECMS E:

_____

7. FAB Decision Codes. (Continued)

        (1) CAU – 'Causation Accepted' - Used when causation
        is established under Part E, which results in medical
        benefits for an employee or death benefit for an
        eligible survivor.

        (2) CAW – 'Causation and Wage Loss Accepted' - Used
        when causation and wage loss are being accepted
        simultaneously under Part E.

        (3) CAI – 'Causation and Impairment Accepted' - Used
        when causation and impairment are being accepted
        simultaneously under Part E.

        (4) IMP – 'Impairment Only Accepted (Causation
        Previously Accepted)' - Used when causation was
        established on a previous decision and impairment is
        all that is being accepted in this decision under Part
        E.

        (5) WAG – 'Wage Loss Only Accepted' - Used when
        causation was established on a previous decision and
        wage loss is all that is being accepted in this
        decision under Part E.

        (6) IMW – 'Impairment and Wage Loss Accepted' - Used
        when causation was established in a previous decision
        and the current decision accepts for wage loss and
        impairment.

        (7) CIW – 'Causation, Impairment, and Wage Loss
        Accepted' - Used when causation, impairment, and wage
        loss are all being accepted in the current Part E
        decision.

    If a Part E final decision reversed at least a portion of a
    recommended decision to deny to a final decision to accept,
    while other Part E elements are still being denied and/or
    deferred, the CE/HR must use the secondary decision codes
    'PD' and/or 'DV' along with the 'F6' code. The reason code
    associated with the 'F6' will show what elements are being
    accepted, including what was reversed. The reason codes
    associated with the 'PD' and/or 'DV' code(s) will reflect
    what is still being denied and/or deferred, respectively.

_____

7. FAB Decision Codes. (Continued)

    If a Part B final decision reversed at least a portion of a
    recommended decision to deny to a final decision to accept,
    while other Part B elements are still being denied and/or
    deferred, the CE/HR must use a primary decision code along
    with the 'F6' code with reason code 'B'. The primary
    decision code will reflect what is still being denied
    and/or deferred.

    i. F7 – 'FAB Remanded'. This code is entered when FAB
    remands a decision of the DO/CE2 Unit. Upon issuance of
    the remand order, the CE/HR must enter the claim status
    code 'F7' in the Claim Status History. The status
    effective date is equal to the date of the remand
    order. The CE/HR must also select the appropriate reason
    code from the drop-down menu that best describes the reason
    the case is being remanded.

    The reason code reflects whether the remand is based on a
    DO/CE2 Unit error that could have been avoided or an
    unavoidable reason that was not a DO/CE2 Unit error. The
    reason codes (listed below) give more detail to the reason
    for the remand ("other" is the catch-all if no other reason
    codes fit.)

    The FAB CE/HR codes 'F7' into the appropriate system (ECMS
    B for a B only remand, ECMS E for an E only remand, and
    both for a Part B/E remand. If the Part B and E decisions
    are remanded, an 'F7' goes into ECMS B and E, but could
    have different reason codes in each.

    Do not enter multiple 'F7's and reason codes per system to
    capture multiple types of errors, instead select the reason
    code that captures the most egregious error (per part type)
    or "other" if none really fit. If there are multiple
    reasons for a remand, some avoidable and some unavoidable,
    select the avoidable reason code.

        (1) DO/CE2 Unit Error – Any remand that the FAB
        considers to be have been avoidable by the DO/CE2
        Unit:

            (a) ERM – 'Error – Medical (Dx, Disease,
            Causation, DMC related)' – This reason code is
            selected if the remand is based on an error in

_____

7. FAB Decision Codes. (Continued)

the medical development or conclusions, such as incorrect causation determinations, DMC referrals, and diagnoses.

(b) ERE Error – 'Employment (Dates/Time Pd, Exposure, SEM Use)' – This reason code is selected if the remand is based on an error in the employment development or conclusions, such as incorrect employment dates/facilities, exposures, or SEM usage.

(c) ERS Error – 'Survivorship' – This reason code is selected if the remand is based on an error in the survivorship development or conclusions.

(d) ERO Error – 'Other (Error – Not Med, Emp, or Survivorship)' – This reason code is selected if the remand is based on a DO/CE2 Unit error that is not predominately medical, employment, or survivorship in nature.

(2) No DO/CE2 Unit Error – Any remand that FAB considers to have been unavoidable by the DO/CE2 Unit:

(a) DEA – 'No DO Error – Death of Claimant' – This reason code is selected when the FAB becomes aware of the claimant's death while the case is pending a final decision.

(b) RTN – 'No DO Error – Recommended Decision Returned by Post Office' – This reason code is selected when the recommended decision is returned by the post office and a new address cannot be obtained to re-issue the recommended decision and issue the final decision to the claimant(s).

(c) CLS – 'No DO Error – Administrative Closure (not claimant death) – This reason code is selected when the claim must be remanded to the DO/CE2 Unit for an administrative closure for a reason other than death or bad address.

_____

7. <u>FAB Decision Codes</u>. (Continued)

      (d) <u>OTH – 'Error – Other (Error – Not Med, Emp, or Survivorship)'</u> – This code is used for remands that could not be avoided for a reason other than death of claimant, bad address, or administrative closure. An example of 'OTH' errors that are unavoidable are remands based on new evidence, change in law, regulation, policy or procedure, new SECs, and new PEPs.

When issuing partial decisions that include a remand order, codes should be entered in this order:

    (1) <u>Partial Accept/Partial Remand</u> – 'F0' + reason code to show what is accepted, followed by 'F7' + remand reason code.

    (2) <u>Partial Reverse to Accept/Partial Remand</u> – 'F6' + reason code to show what is accepted, followed by 'F7' + remand reason code.

    (3) <u>Partial Deny/Partial Remand</u> – Denial code ('F1', 'F3', 'F4', 'F5', or 'F9') + reason code showing what is denied, followed by 'F7' + remand reason code.

    (4) <u>Partial Accept/Partial Deny/Partial Remand</u> –

    (a) <u>If the Partial Accept/Partial Deny/Partial Remand is for Part B</u> – code 'F8' (FAB Accept in Part/Deny in Part) + reason code 'B', followed by 'F7' + remand reason code in ECMS B.

    (b) <u>If the Partial Accept/Partial Deny/Partial Remand is for Part E</u> – code 'F8' (FAB Accept in Part/Deny in Part) + reason code that shows what is accepted, 'PD' + reason code to show what is denied, and 'F7' + remand reason code in ECMS E.

    (5) <u>Partial Accept/Partial Deny/Partial Develop/ Partial Remand</u> –

    (a) <u>If the Partial Accept/Partial Deny/Partial Develop/Partial Remand is for Part B</u> – code 'G2' (FAB Accept in Part/Deny in Part/Develop in Part)

_____

7.   FAB Decision Codes. (Continued)

                    + reason code 'B', followed by 'F7' + remand
                    reason in ECMS B.

               (b) Partial Accept/Partial Deny/Partial
               Develop/Partial Remand is for Part E – code
               'G2'(FAB Accept in Part/Deny in Part/Develop in
               Part) + reason code, 'PD' + reason code to show
               what is denied, 'DV' + reason code to show what is
               deferred, and 'F7' + remand reason code in ECMS E.

          (6) Partial Accept/Partial Develop/Partial Remand –

               (a) If the Partial Accept/Partial Develop/
               Partial Remand is for Part B – code 'G1' (FAB
               Accept in Part/Develop in Part) + reason code 'B',
               followed by 'F7' + remand reason code in ECMS B.

               (b) If the Partial Accept/Partial Develop/
               Partial Remand is for Part E – code 'G1'(FAB
               Accept in Part/Develop in Part) + reason code,
               'DV' + reason code to show what is deferred, and
               'F7' + remand reason code in ECMS E.

     The status effective date for all the primary and secondary
     decision codes is the date of the final decision.

     j.   F8 - 'Final Partial Accept/Partial Deny'. When the
     CE/HR renders a final decision where part of the claim is
     approved for benefits, while another part of the claim is
     denied, the CE/HR enters the 'F8' code. The status effective
     date is equal to the date of the final decision.

     For Part B cases, status code 'F8' is used with reason code
     'B' [Part B] in ECMS B for final decisions that describe a
     partial acceptance for one claimed condition under Part B
     and partial denial for one or more other conditions under
     B.

     For Part E cases, the CE/HR must select the appropriate
     reason code from the drop-down menu and enter it into Part
     E ECMS. The reason code for the decision explains only
     what is being accepted in the current decision. These are
     the Part E reason codes available in the drop down menu:

_____

7.   FAB Decision Codes. (Continued)

          (1) CAU – 'Accept Causation' - Used when causation
          for a claimed condition is accepted for benefits and a
          portion of the claim is being denied.

          (2) CAW – 'Accept Causation and Wage Loss' - Used
          when causation and wage loss are being accepted and a
          portion of the claim is being denied.

          (3) CAI – 'Accept Causation and Impairment' - Used
          when causation and impairment are being accepted and a
          portion of the claim is being denied.

          (4) IMP – 'Accept Impairment' - Used when causation
          was previously accepted, impairment alone is currently
          being accepted, and a portion of the claim is being
          denied.

          (5) WAG – 'Accept Wage Loss' - Used when causation
          was previously accepted, wage loss alone is currently
          being accepted, and a portion of the claim is being
          denied.

          (6) IMW – 'Accept Impairment and Wage Loss' - Used
          when causation was previously accepted, impairment and
          wage loss are both currently being accepted, and a
          portion of the claim is being denied.

          (7) CIW – 'Accept Causation, Impairment, and Wage
          Loss' - Used when causation is accepted along with
          impairment and wage loss, and a portion of the claim
          is being denied (e.g., a cancer claim is pending dose
          reconstruction at NIOSH).

     The portion(s) of the claim being denied in the decision is
     identified by the secondary decision status code 'PD'
     [Partial Deny] and corresponding reason code set out in
     Paragraph 4 above.

     k.   F9 – 'Final Deny - Medical Information Insufficient To
     Support Claim/Non-Cancer Causation Denial'. This code is
     used when the CE/HR renders a final decision to deny
     benefits because there is insufficient medical evidence to
     support an acceptance; for any non-cancer causation
     denials; for when the maximum payable benefit is met; or

_____

7.   <u>FAB Decision Codes</u>. (Continued)

     for decisions that solely address impairment and/or wage
     loss claims (whose related conditions were not previously
     denied under F5). The status effective date is the date of
     the final decision.

     Upon entry of the 'F9' code, the CE/HR selects a specific
     reason code from the "reason cd" field, which is a drop-
     down box that corresponds with the 'F9' claim status code.
     The reason codes available for the 'F9' claim status code
     are listed below. The reason code 'B' [Part B] is only to
     be used in ECMS B.

     <u>Note 1</u>: In ECMS E, the 'F9' code can also be used in
     conjunction with the 'DV' code to capture partial
     deny/partial develop decisions, for which there isn't a
     single, unique primary decision status code. The CE/HR
     enters the 'F9' code with a reason code denoting what is
     being denied. The CE/HR then enters the 'DV' status code
     and appropriate associated reason code listed in Paragraph
     4 above to identify which benefits are being held for
     further development. The status effective date of both
     codes is the date of the decision.

     <u>Note 2</u>: If the decision contains findings to deny multiple
     claimed conditions, and one denial is for insufficient
     medical evidence to establish the claimed illness and
     another denial is for inability to establish causation,
     impairment or wage loss, the CE/HR should enter 'F9' with
     the reason code describing the causation/impairment/wage
     loss denial. In tandem with the 'F9' entry, the CE should
     enter 'PD' [Partial Deny] with reason code 'IN' to record
     the denial for insufficient medical to establish illness.

        (1) <u>B – 'Part B'(B only)</u> - Used when a condition is
        denied in ECMS B.

        (2) <u>DMB – 'Deny Specific Medical Benefits On Accepted
        Condition'</u> (B and/or E) - Used when a specific medical
        benefit is being denied on an accepted condition in a
        formal decision (not just a letter). (See EEOICPA PM
        3-0300.)

        (3) <u>RMB – 'Reduce Medical Benefits On Accepted
        Condition'</u> (B and/or E) - Used when a medical benefit

_____

7. <u>FAB Decision Codes</u>. (Continued)

on a previously paid item for a covered condition is reduced in a formal decision (not just a letter). (See EEOICPA PM 3-0300.)

(4) <u>IN</u> – 'Insufficient Medical To Establish Claimed Illness'(E only) - Used when a covered illness is claimed under Part E but medical evidence is insufficient to establish the illness.

(5) <u>R4C</u> – 'RECA 4 Cancer'(E only) - Used when a Part E cancer case is denied because the claimant had received benefits under RECA Section 4.

(6) <u>CAU</u> – 'Causation' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established.

(7) <u>WAG</u> – 'Wage Loss' (E only) - Used when the claim for wage loss is being denied due to lack of medical evidence to support the claimed period of wage-loss is causally related to the covered illness.

(h) <u>CAW</u> – 'Causation and Wage Loss' (E only) - Used when a covered illness is claimed under Part E, but causation cannot be established and claimed wage loss must also be denied.

(9) <u>IM0</u> – 'Impairment – 0%' (E only) - Used when the claim for impairment is being denied because the impairment rating is 0% under the AMA <u>Guides</u> or because a claim for impairment was filed, but the claimant failed to provide the necessary medical documentation.

(10) <u>IMN</u> – 'Impairment – Not Ratable' (E only) - Used when the claim for impairment is being denied because the claimed impairment is non-ratable, such as certain psychiatric conditions.

(11) <u>IMR</u> – 'Impairment – Resolved' (E only) - Used when the claim for impairment is being denied because the claimed impairment was resolved (i.e., does not exist anymore) prior to the issuance of the decision.

_____

7. <u>FAB Decision Codes</u>. (Continued)

        (12) <u>I0W</u> – 'Impairment (0%) and Wage Loss (E only) -
Used when wage loss and impairment are both being
denied. The claim for impairment is denied because it
has a 0% rating or because a claim for impairment was
filed, but the claimant failed to provide the
necessary medical documentation.

        (13) <u>INW</u> – 'Impairment (Not Ratable) and Wage Loss (E
only)</u> - Used when wage loss and impairment are both
being denied. The claim for impairment is denied
because the condition being claimed is not ratable for
impairment, such as certain psychiatric conditions.

        (14) <u>IRW</u> – 'Impairment (Resolved) and Wage Loss (E
only)</u> - Used when wage loss and impairment are both
being denied. The claim for impairment is being
denied because the impairment was resolved (i.e., does
not exist anymore) prior to the issuance of the
decision.

        (15) <u>C0W</u> – Causation, Impairment (0%) and Wage Loss
(E only)</u> - Used when claims for causation, impairment,
and wage loss are denied simultaneously. Impairment
is denied because the impairment rating is 0% or
because a claim for impairment was filed, but the
claimant failed to provide the necessary medical
documentation.

        (16) <u>CNW</u> – 'Causation, Impairment (Not Ratable), and
Wage Loss' (E only)</u> - Used when a claim is made based
on causation, wage loss, and impairment, all of which
are being denied. The impairment is being denied
because it is for a non-ratable condition.

        (17) <u>CRW</u> – 'Causation, Impairment (Resolved), and Wage
Loss' (E only)</u> - Used when claims for causation,
impairment and wage loss are being denied
simultaneously. The impairment claim is being denied
because the impairment was resolved (i.e., does not
exist anymore) prior to the issuance of the decision.

        (18) <u>CA0</u> – 'Causation and Impairment (0%)' (E only) –
Used when causation and impairment are being denied
simultaneously. Impairment is denied because the

_____

7.   FAB Decision Codes. (Continued)

impairment rating is 0% or because a claim for
impairment was filed, but the claimant failed to
provide the necessary medical documentation.

(19) CAN – 'Causation and Impairment (Not Ratable)' (E
only) - Used when causation and an impairment that is
not ratable are being denied simultaneously.

(20) CAR – 'Causation and Impairment (Resolved)' (E
only) - Used when causation and impairment that is
resolved (i.e., does not exist anymore) prior to the
issuance of the decision are being denied
simultaneously.

(21) MBM – 'Maximum Payable Benefit Met' (E only) –
Used when the maximum payable benefit is already met
and a formal decision is required for an impairment
and/or wage loss claim.

l.   F10 - 'Regulatory Final Decision'. The FAB CE/HR
enters this claim status code if a case is identified as
having a "regulatory/administrative" decision based on the
"one year/365-day rule." The claim status date of the code
is different depending on whether objections are present,
or if it is a Director's Order to reopen for a new final
decision and a decision is pending for more than one year:

(1) For cases where no objection was filed, the
recommended decision becomes final 365 days from the
time the 60-day objection period expires (if no final
decision has been issued), that is, 425 days after the
recommended decision date.

(2) For cases where an objection was filed, the
recommended decision becomes final on the one-year
anniversary date that the letter of objection was
received (if no final decision has been issued.)

(3) For cases where a Director's Order was issued
reopening a case for issuance of a new final decision,
the recommended decision becomes final on the one-year
anniversary date of the Director's Order (if no new
final decision has been issued.)

_____

7.   FAB Decision Codes. (Continued)

     All of these cases must be submitted to National Office for
     reopening. See Paragraph 12 in this chapter for reopening
     coding instructions.

8.   Alternative Filing Codes. When a claimant requests an
alternative filing under Part E, the ECMS codes below are used.

     (1) XR – 'Alternative Filing Review Requested' – Used when
     a claimant requests an alternative filing. The status
     effective date is the postmark date or date stamp the
     letter is received in the office, whichever is earlier.

     (2) XC – 'Alternative Filing Review Completed' – Used when
     the CE/SrCE sends out a final response to the alternative
     filing request. The status effective date is the date of
     the written response. Depending upon the determination
     reached in the review, two findings are possible: positive
     and negative.

     The CE/SrCE selects the appropriate reason code from the
     drop-down menu to indicate whether or not a causal link was
     found to have existed. If the finding of the causal review
     is positive, the CE/SrCE selects 'P' (Positive). If the
     finding of the causal review is negative, the CE/SrCE
     selects 'N' (Negative) to show that no causal link was found
     to exist.

9.   Reconsideration Codes. When a claimant submits a request
for reconsideration, it must be appropriately coded on the
reconsideration screen (this screen is completed only for the
claimant(s) who request reconsideration).

To access the reconsideration screen, the CE/HR presses the
"Appeals/Recons" button on the claim screen, highlights a field
in the "Reconsiderations" section of the FAB screen, and clicks
insert. The following fields are completed as information on
the reconsideration becomes available:

     a.   Claimant Objections. This field is completed using
     the associated drop-down menu. The CE/HR selects the
     reason that best describes why the claimant wants
     reconsideration, e.g., "challenges law" or "non-specific".

9.   Reconsideration Codes. (Continued)

     b.   Date to HR.   This field is the date the HR is made
     aware of the reconsideration request.

     c.   Recon Req Date.   This field is completed with the date
     the reconsideration request was received in any FAB office
     only (not the DO, National Office, or a Resource Center).

     d.   Hearing Rep.   This field is completed with the
     code/name of the CE/HR assigned to the case.

     e.   Recon Status.   This field is completed by selecting
     the status of the reconsideration process, granted or
     denied, from the drop-down box associated with the recon
     status field.   Then, the date associated with the
     reconsideration status is entered in the box associated
     with the recon status date field.

     This entry reflects whether the request for reconsideration
     has been granted or denied, not the case itself.   If the
     reconsideration is granted, it will have a new, post-
     reconsideration final decision code entered [see item "g"
     below].   If the reconsideration is denied, the reason will
     be annotated in the note section [see item "f" below].

     f.   Note. This field is used to input any applicable notes
     regarding the request for reconsideration. For example, if
     the received date for reconsideration appears untimely
     because the reconsideration receipt date is more than 30
     days after the final decision, but the postmark date is
     within 30 days, the timely postmark date would be mentioned
     in the notes section.

     A note should be entered when a request for reconsideration
     is denied, because there is an untimely filing, no new
     argument or evidence is submitted, or the new argument or
     evidence does not contradict the conclusions of the final
     decision.

     g.   Post-Recon Final Decision.   This field is completed
     when FAB accepts the request for reconsideration.   A
     reconsideration code is not entered on cases where there is
     an untimely filing, no new argument or evidence is
     submitted, or the new argument or evidence does not
     contradict the conclusions of the final decision.   A note

_____

9.   Reconsideration Codes. (Continued)

        should be entered for those types of reconsideration
        denials.

        When a reconsideration decision is made, the appropriate
        post-reconsideration final decision code must be entered
        into this field for all active claimants (even though the
        reconsideration screen is only completed for the
        individual(s) who requested the reconsideration). The codes
        are listed below. The status effective date of the
        reconsideration code is the date the new final decision is
        issued. (Do not overwrite the previous final decision
        code.)

        If the post-reconsideration final decision partially denies
        or defers a claimed element on a Part E decision, the
        secondary decision codes PD and DV should be used along
        with the reconsideration code, just as they are with
        primary recommended and final decision codes. Multiple
        Post-Reconsideration codes (R_) should not be entered for
        one Part B or Part E decision, unless there is a partial
        remand. (Note: The post-reconsideration final decision
        generally parallels the related final decision unless there
        is a reversal to accept or a remand issued when the case is
        reconsidered.)

            (1) R0 - 'FAB RECON - ACCEPT'. When the
            reconsideration is granted and the post-
            reconsideration final decision is issued on an
            approved claim for benefits where there are no other
            pending elements on the claim (including additional
            medical conditions, wage loss, or impairment), the
            CE/HR enters the 'R0' code. The status effective date
            is the date the post-reconsideration final decision is
            issued. R0 should only be used if the related final
            decision that was being reconsidered was an F0.

            Upon entering the 'R0' code, the CE/HR must select a
            specific reason code from the "reason cd" field, which
            is a drop-down box corresponding to the 'R0' claim
            status code.

            The reason codes available for the 'R6' claim status
            code are listed below. The reason code should reflect

_____

9. <u>Reconsideration Codes</u>. (Continued)

everything being accepted in the current decision for
that Part of the Act.

(a) <u>B – 'Part B'</u> – Used to record any accepted
Part B component of the decision.

(b) <u>CAU – 'Causation Accepted'</u> - Used when
causation is established under Part E, which
results in medical benefits for an employee or
death benefit for an eligible survivor.

(c) <u>CAW – 'Causation and Wage Loss Accepted'</u> -
Used when causation and wage loss are being
accepted simultaneously under Part E.

(d) <u>CAI – 'Causation and Impairment Accepted'</u> -
Used when causation and impairment are being
accepted simultaneously under Part E.

(e) <u>IMP – 'Impairment Only Accepted (Causation
Previously Accepted)'</u> – Used when causation was
established on a previous decision and impairment
is all that is being accepted in this decision
under Part E.

(f) <u>WAG – 'Wage Loss Only Accepted'</u> - Used when
causation was established on a previous decision
and wage loss is all that is being accepted in
this decision under Part E.

(g) <u>IMW – 'Impairment and Wage Loss Accepted'</u> -
Used when causation was established in a previous
decision and the current decision accepts for
wage loss and impairment.

(h) <u>CIW – 'Causation, Impairment, and Wage Loss
Accepted'</u> - Used when causation, impairment, and
wage loss are all being accepted in the current
Part E decision.
To record any accepted Part E component of the
decision, the CE/HR must select one of the
following

_____

9.   Reconsideration Codes. (Continued)

          (2) R1 - 'FAB RECON – DENY, EMPLOYMENT NOT COVERED'.
          When the reconsideration is granted and the post-
          reconsideration final decision is issued to deny
          benefits due to employment that is not covered, the
          CE/HR enters the 'R1' code. The status effective date
          is the date the post-reconsideration final decision
          was issued.

          (3) R2 – 'FAB RECON – DENY, CONDITION NOT RELATED TO
          EMPLOYMENT'. When the reconsideration is granted and
          the post-reconsideration final decision is issued to
          deny benefits due to the condition not being related
          to employment, the CE/HR enters the 'R2' code. The
          status effective date is the date the post-
          reconsideration final decision was issued.

          (4) R3 – 'FAB RECON – DENY,SURVIVOR NOT ELIGIBLE'.
          When the reconsideration is granted and the post-
          reconsideration final decision is issued to deny
          benefits due to the survivor not being eligible, the
          CE/HR enters the 'R3' code. The status effective date
          is the date the post-reconsideration final decision
          was issued.

          (5) R4 – 'FAB RECON – DENY, CONDITION NOT COVERED'.
          (B only) When the reconsideration is granted and the
          post-reconsideration final decision is issued to deny
          benefits due to the condition not being covered under
          Part B, the CE/HR enters the 'R4' code. The status
          effective date is the date the post-reconsideration
          final decision was issued.

          (6) R5 – 'FAB RECON – DENY,CANCER NOT WORK-
          RELATED,POC'. When the reconsideration is granted and
          the post-reconsideration final decision is issued to
          deny benefits because the PoC result from NIOSH is
          less than 50%, the CE/HR enters the 'R5' code. If
          more than one condition is being denied in the current
          decision, but at least one of them is a cancer case
          that went to NIOSH, the F5 primary decision code must
          be selected. This code is also to be used in cases of
          CLL-cancer only, wherein the PoC is presumed to be
          zero. The status effective date is the date the post-
          reconsideration final decision is issued. This code

_____

9. Reconsideration Codes. (Continued)

            is used for BOTH Part B and Part E cancer denials if
            the above criteria for POC < 50% is met.

            Upon entry of the 'R5' code, the CE/HR selects a
            specific reason code from the "reason cd" field, which
            is a drop-down box that corresponds with the 'R5'
            claim status code.

            The reason codes available for the 'R5' claim status
            code are listed below.

                (a) B – 'Part B' (B only) - Used when cancer is
                claimed under Part B, but is being denied based
                on the NIOSH PoC.

                (b) CAU – 'Causation' (E only) - Used when cancer
                is claimed under Part E, but causation cannot be
                established (through dose reconstruction or toxic
                exposure development).

                (c) WAG – 'Wage Loss' (E only) - Used in the rare
                circumstance when a wage loss claim is received
                and adjudicated after a cancer denial.

                (d) CAW – 'Causation and Wage Loss' (E only) –
                Used when cancer and wage loss are claimed under
                Part E, but causation cannot be established
                (through dose reconstruction or toxic exposure
                development) and wage loss must also be denied.

                (e) IM0 – 'Impairment – 0%' (E only) - Used in
                the rare circumstance when an impairment claim is
                received and adjudicated after a cancer denial.
                The impairment rating may not have been completed
                because causation was not established or if one
                was provided with a 0% impairment rating.

                (f) IMN – 'Impairment – Not Ratable' (E only) –
                Used in the rare circumstance when an impairment
                claim is received and adjudicated after a cancer
                denial and the claim for impairment is for a
                non-ratable condition, such as certain
                psychiatric conditions.

_____

9.   Reconsideration Codes. (Continued)

(g)   IMR – 'Impairment – Resolved' (E only) -
Used in the rare circumstance when an impairment
claim is received and adjudicated after a cancer

denial and the claimed impairment was resolved
(i.e., does not exist anymore) prior to the
issuance of the decision.

(h)   I0W – 'Impairment (0%) and Wage Loss' (E
only) -Used when wage loss and impairment related
to a previously denied cancer are both being
denied. The claim for impairment is denied
because it has a 0% rating or because an
impairment rating was not completed due to lack
of causation.

(i)   INW – 'Impairment (Not Ratable) and Wage
Loss' (E only) - Used when wage loss and
impairment are both being denied related to a
previously denied cancer. The claim for
impairment is denied because the condition being
claimed is not ratable for impairment, such as
certain psychiatric conditions.

(j)   IRW – 'Impairment (Resolved) and Wage Loss'
(E only) - Used when wage loss and impairment are
both being denied related to a previously denied
cancer. The claim for impairment is being denied
because the impairment was resolved (i.e., does
not exist anymore) prior to the issuance of the
decision.

(k)   C0W – Causation, Impairment (0%), and Wage
Loss' (E only) - Used when claims for causation,
impairment, and wage loss are denied
simultaneously. Impairment is denied because the
impairment rating is 0% or because the claimant
failed to provide the necessary medical
documentation or because the impairment rating
was not performed because causation could not be
established.

9.   Reconsideration Codes. (Continued)

_____

(l) CNW – 'Causation, Impairment (Not Ratable), and Wage Loss' (E only) - Used when a claim is made for causation, wage loss, and impairment, all of which are being denied simultaneously.

The impairment claim is being denied because it is for a non-ratable condition.

 (m) CRW – 'Causation, Impairment (Resolved), and Wage Loss' (E only). Used when claims for causation, impairment, and wage loss are being denied simultaneously. The impairment claim is denied because the impairment was resolved (i.e., does not exist anymore) prior to issuance of the decision.

(n) CA0 – 'Causation and Impairment (0%)' (E only) -Used when causation and 0% impairment are being denied simultaneously. Impairment is denied because the impairment rating is 0% or because the claimant failed to provide the necessary medical documentation or because the impairment rating was not performed because causation could not be established.

(o) CAN – 'Causation and Impairment (not ratable)' (E only) - Used when causation and an impairment for a non-ratable condition, such as certain psychiatric conditions, are being denied simultaneously.

(p) CAR – 'Causation and Impairment (Resolved)' (E only) - Used when causation and impairment that is resolved (i.e., does not exist anymore) prior to the issuance of the decision are being denied simultaneously.

(7) R6 – 'FAB RECON - REVERSED TO ACCEPT'. When the reconsideration is granted and the post-reconsideration final decision is issued to approve benefits despite the recommended decision to deny, the CE/HR enters the 'R6' code. The status effective date

9. Reconsideration Codes. (Continued)

_____

is the date the post-reconsideration final decision is issued.

Upon entering the 'R6' code, the CE/HR selects a specific reason code from the "reason cd" field, which

is a drop-down box that corresponds with the 'R6' claim status code.

The reason codes available for the 'R6' claim status code are listed below. The reason code should reflect everything being accepted in the current decision for that Part of the Act.

(a) B – 'Part B' – Used to record any accepted Part B component of the decision.

(b) CAU – 'Causation Accepted' - Used when causation is established under Part E, which results in medical benefits for an employee or death benefit for an eligible survivor.

(c) CAW – 'Causation and Wage Loss Accepted' - Used when causation and wage loss are being accepted simultaneously under Part E.

(d) CAI – 'Causation and Impairment Accepted' - Used when causation and impairment are being accepted simultaneously under Part E.

(e) IMP – 'Impairment Only Accepted (Causation Previously Accepted)' - Used when causation was established on a previous decision and impairment is all that is being accepted in this decision under Part E.

(f) WAG – 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all that is being accepted in this decision under Part E.

(g) IMW – 'Impairment and Wage Loss Accepted' - Used when causation was established in a previous

9. Reconsideration Codes. (Continued)

_____

decision and the current decision accepts for
wage loss and impairment.

(h) <u>CIW - 'Causation, Impairment, and Wage Loss
Accepted'</u> - Used when causation, impairment, and
wage loss are all being accepted in the current
Part E decision.

(8) <u>R7 - 'FAB RECON - REMANDED'</u>. When the
reconsideration is granted and the post-
reconsideration final decision is issued to remand a
decision of the DO/CE2 Unit, the CE/HR enters the 'R7'
code. The status effective date is the date the post-
reconsideration remand is issued. The CE/HR must also
select the appropriate reason code from the drop-down
menu that best describes the reason the case is being
remanded.

The reason code reflects whether the remand is based
on a DOL error (either FAB or DO) that could have been
avoided or an unavoidable reason that was not a DOL
error. The reason codes (listed below) give more
detail to the reason for the remand ("other" is the
catch-all if no other reason codes fit.)

The FAB CE/HR codes 'R7' into the appropriate system
(ECMS B for a B only remand, ECMS E for an E only
remand, and both for a Part B/E remand). If the Part
B and E decisions are remanded, an 'R7' goes into ECMS
B and E, but could have different reason codes in
each.

Do not enter multiple 'R7's and reason codes per
system to capture multiple types of errors, instead
select the reason code that captures the most
egregious error (per part type) or "other" if none
really fit. If there are multiple reasons for a
remand, some avoidable and some unavoidable, select
the avoidable reason code.

<u>DOL Error</u> - Any remand that the FAB considers to be
have been avoidable by the DO/CE2 Unit:

_____

9. Reconsideration Codes. (Continued)

            (a) ERM – 'Error – Medical (Dx, Disease,
            Causation, DMC related)' – This reason code is
            selected if the remand is based on an error in
            the medical development or conclusions, such as
            incorrect causation determinations, DMC
            referrals, and diagnoses.

            (b) ERE Error – 'Employment (Dates/Time Pd,
            Exposure, SEM Use)' – This reason code is
            selected if the remand is based on an error in

            the employment development or conclusions, such
            as incorrect employment dates/facilities,
            exposures, or SEM usage.

            (c) ERS Error – 'Survivorship' – This reason code
            is selected if the remand is based on an error in
            the survivorship development or conclusions.

            (d) ERO Error – 'Other (Error – Not Med, Emp, or
            Survivorship)' – This reason code is selected if
            the remand is based a DOL error that is not
            predominately medical, employment, or
            survivorship in nature.

        No DOL Error – Any remand that FAB considers to have
        been unavoidable by the DOL:

            (a) DEA – 'No DO Error – Death of Claimant' –
            This reason code is selected when the FAB becomes
            aware of the claimant's death prior to the end of
            the reconsideration period.

            (b) RTN – 'No DO Error – Recommended Decision
            Returned by Post Office' – This reason code is
            selected when the decision is returned by the
            post office and a new address cannot be obtained
            for re-issuance of the decision.

            (c) CLS – 'No DO Error – Administrative Closure
            (not claimant death) – This reason code is
            selected when the claim must be remanded to the
            DO/CE2 Unit for an administrative closure for a
            reason other than death or bad address.

_____

9.   Reconsideration Codes. (Continued)

             (d) OTH - 'Error - Other (Error - Not Med, Emp,
             or Survivorship)' - This code is used for remands
             that could not be avoided for a reason other than
             death of claimant, bad address, or administrative
             closure. An example of 'OTH' errors that are
             unavoidable are remands based on new evidence,
             change in law, regulation, policy or procedure,
             new SECs, and new PEPs.

     When issuing a post-reconsideration decision that is a
     partial remand, it is appropriate to use additional R_
     codes and secondary decision codes to capture any partial
     acceptance, denial, or deferral that is happening along
     with the reconsideration remand. *The R7 code should be the
     code that is entered through the reconsideration screen and
     linked to the final decision.* Any additional secondary
     codes or R_ codes related to the post-reconsideration
     decision will have the same status effective date as the
     decision.

             (a) Partial Accept/Partial Remand - 'R0' +
             reason code to show what is accepted *and* 'R7' +
             remand reason code.

             (b) Partial Reverse to Accept/Partial Remand -
             Enter 'R6' + reason code to show what is accepted
             and 'R7' + remand reason code.

             (c) Partial Deny/Partial Remand - Enter denial
             code ('R1', 'R2', 'R3', 'R4', 'R5', or 'R9') +
             reason code showing what is denied and 'R7' +
             remand reason code.

             (d) Partial Accept/Partial Deny/Partial Remand for
             Part B - Enter'R8' (FAB Recon Accept in Part/Deny
             in Part) + reason code 'B', followed by 'R7' +
             remand reason code in ECMS B.

             (e) Partial Accept/Partial Deny/Partial Remand for
             Part E - Enter 'R8' (FAB Recon Accept in Part/Deny
             in Part) + reason code that shows what is
             accepted, 'PD' + reason code to show what is
             denied, and 'R7' + remand reason code in ECMS E.

_____

(f) <u>Partial Accept/Partial Deny/Partial Develop/
Partial Remand for Part B</u> – Enter 'R8' (FAB Recon
Accept in Part/Deny in Part) + reason code 'B'
and 'R7' + remand reason in ECMS B. There is no
recon code equivalent to 'G2' (partial
accept/partial deny/partial develop), so we cover
as many elements to the decision as we can within
the coding scheme. The claimed medical
conditions that have been deferred will be
notated with an 'R' status on the medical
condition screen, which will reflect they have
not yet been adjudicated.

(g) <u>Partial Accept/Partial Deny/Partial
Develop/Partial Remand in Part E</u> – Enter 'R8'(FAB
Recon Accept in Part/Deny in Part) + reason code
to show what is accepted, 'PD' + reason code to
show what is denied, 'DV' + reason code to show
what is deferred, and 'R7' + remand reason code in
ECMS E.

(h) <u>Partial Accept/Partial Develop/ Partial
Remand for Part B</u> – There is no recon code
equivalent to 'G1' (FAB Accept in Part/Develop in
Part), so the acceptance code R0 (FAB Recon
Accept) + reason code 'B' and 'R7' + remand
reason code is entered in ECMS B. The claimed
medical conditions that have been deferred will
be notated with an 'R' status on the medical
condition screen, which will reflect they have
not yet been adjudicated.

(i) <u>Partial Accept/Partial Develop/ Partial
Remand for Part E</u> – There is no recon code
equivalent to 'G1' (FAB Accept in Part/Develop in
Part), so enter the acceptance code R0 (FAB Recon
Accept) + reason code showing what is accepted,
'DV' + reason code to show what is deferred, and
'R7' + remand reason code in ECMS E.

(9) <u>R8 – 'FAB RECON - ACCEPT IN PART/DENY IN PART'</u>.
When the reconsideration is granted and the post-
reconsideration final decision is issued where part of
the claim is approved for benefits, while another part
of the claim is denied, the CE/HR enters the 'R8'

_____

9.   Reconsideration Codes. (Continued)

code. The status effective date is the date the post-reconsideration final decision is issued.

Upon entering the 'R8' code, the CE/HR selects a specific reason code from the "reason cd" field, which is a drop-down box that corresponds with the 'R8' claim status code.

The reason codes available for the 'R8' claim status code are listed below. The reason code should reflect everything being accepted in the current decision for that Part of the Act.

(a)   B – 'Part B' – Used to record any accepted Part B component of the decision.

(b)   CAU – 'Causation Accepted' - Used when causation is established under Part E, which results in medical benefits for an employee or death benefit for an eligible survivor.

(c)   CAW – 'Causation and Wage Loss Accepted' - Used when causation and wage loss are being accepted simultaneously under Part E.

(d)   CAI – 'Causation and Impairment Accepted' - Used when causation and impairment are being accepted simultaneously under Part E.

(e)   IMP – 'Impairment Only Accepted (Causation Previously Accepted)' - Used when causation was established on a previous decision and impairment is all that is being accepted in this decision under Part E.

(f)   WAG – 'Wage Loss Only Accepted' - Used when causation was established on a previous decision and wage loss is all that is being accepted in this decision under Part E.

(g)   IMW – 'Impairment and Wage Loss Accepted' - Used when causation was established in a previous decision and the current decision accepts for wage loss and impairment.

_____

9.   <u>Reconsideration Codes</u>. (Continued)

    (h) <u>CIW – 'Causation, Impairment, and Wage Loss
Accepted'</u> - Used when causation, impairment, and
wage loss are all being accepted in the current
Part E decision.

The portion(s) of the claim being denied in the
decision is identified by the secondary decision
status code 'PD' [Partial Deny] and corresponding
reason code set out in Paragraph 4 above.

If the post-reconsideration final decision is to
accept in part, deny in part, and defer in part, the
portion(s) of the claim being denied in the decision
is identified by the secondary decision status code
'PD' [Partial Deny] and the portion of the claim being
deferred is identified by the secondary decision
status code 'DV' with the corresponding reason code
set out in Paragraph 4 above.

(10) <u>R9 – 'FAB RECON - DENY, MEDICAL INSUFFICIENT TO
SUPPORT CLAIM'</u>. When the reconsideration is granted
and the post-reconsideration final decision is issued
to deny benefits because there is insufficient medical
evidence to support an acceptance; for any non-cancer
causation denials; for when the maximum payable
benefit is met; or for decisions that solely address
impairment and/or wage loss claims (whose related
conditions were not previously denied under F5). The
status effective date is the date the post-
reconsideration final decision is issued.

Upon entry of the 'R9' code, the CE/HR selects a
specific reason code from the "reason cd" field, which
is a drop-down box that corresponds with the 'R9'
claim status code. The reason codes available for the
'R9' claim status code are listed below.

    (a) <u>B – 'Part B'(B only)</u> - Used when a condition
is denied in ECMS B.

    (b) <u>DMB – 'Deny Specific Medical Benefits On
Accepted Condition'</u> (B and/or E) - Used when a
specific medical benefit is being denied on an

_____

9.   Reconsideration Codes. (Continued)

accepted condition in a formal decision (not just
a letter). (See EEOICPA PM 3-0300.)

(c) RMB – 'Reduce Medical Benefits On Accepted
Condition' (B and/or E) - Used when a medical
benefit on a previously paid item for a covered
condition is reduced in a formal decision (not
just a letter). (See EEOICPA PM 3-0300.)

(d) IN – 'Insufficient Medical To Establish
Claimed Illness'(E only) - Used when a covered
illness is claimed under Part E but medical
evidence is insufficient to establish the
illness.

(e) R4C – 'RECA 4 Cancer'(E only) - Used when a
Part E cancer case is denied because the claimant
had received benefits under RECA Section 4.

(f) CAU – 'Causation' (E only) - Used when a
covered illness is claimed under Part E, but
causation cannot be established.

(g) WAG – 'Wage Loss' (E only) - Used when the
claim for wage loss is being denied due to lack
of medical evidence to support the claimed period
of wage-loss is causally related to the covered
illness.

(h) CAW – 'Causation and Wage Loss' (E only) -
Used when a covered illness is claimed under Part
E, but causation cannot be established and
claimed wage loss must also be denied.

(i) IM0 – 'Impairment – 0%' (E only) - Used when
the claim for impairment is being denied because
the impairment rating is 0% under the AMA Guides
or because a claim for impairment was filed, but
the claimant failed to provide the necessary
medical documentation.

(j) IMN – 'Impairment – Not Ratable' (E only) -
Used when the claim for impairment is being

_____

9.   Reconsideration Codes. (Continued)

> denied because the claimed impairment is non-
> ratable, such as certain psychiatric conditions.
>
> (k) IMR – 'Impairment – Resolved' (E only) –
> Used when the claim for impairment is being
> denied because the claimed impairment was
> resolved (i.e., does not exist anymore) prior to
> the issuance of the decision.
>
> (l) I0W – 'Impairment (0%) and Wage Loss (E
> only) – Used when wage loss and impairment are
> both being denied. The claim for impairment is
> denied because it has a 0% rating or because a
> claim for impairment was filed, but the claimant
> failed to provide the necessary medical
> documentation.
>
> (m) INW – 'Impairment (Not Ratable) and Wage
> Loss (E only) – Used when wage loss and
> impairment are both being denied. The claim for
> impairment is denied because the condition being
> claimed is not ratable for impairment, such as
> certain psychiatric conditions.
>
> (n) IRW – 'Impairment (Resolved) and Wage Loss
> (E only) – Used when wage loss and impairment are
> both being denied. The claim for impairment is
> being denied because the impairment was resolved
> (i.e., does not exist anymore) prior to the
> issuance of the decision.
>
> (o) C0W – Causation, Impairment (0%) and Wage
> Loss (E only) – Used when claims for causation,
> impairment, and wage loss are denied
> simultaneously. Impairment is denied because the
> impairment rating is 0% or because a claim for
> impairment was filed, but the claimant failed to
> provide the necessary medical documentation.
>
> (p) CNW – 'Causation, Impairment (Not Ratable),
> and Wage Loss' (E only) – Used when a claim is
> made based on causation, wage loss, and
> impairment, all of which are being denied. The

_____

9. <u>Reconsideration Codes</u>. (Continued)

            impairment is being denied because it is for a
            non-ratable condition.

            (q) <u>CRW – 'Causation, Impairment (Resolved), and
            Wage Loss' (E only)</u> - Used when claims for
            causation, impairment and wage loss are being
            denied simultaneously. The impairment claim is
            being denied because the impairment was resolved
            (i.e., does not exist anymore) prior to the
            issuance of the decision.

            (r) <u>CA0 – 'Causation and Impairment (0%)' (E
            only)</u> - Used when causation and impairment are
            being denied simultaneously. Impairment is
            denied because the impairment rating is 0% or
            because a claim for impairment was filed, but the
            claimant failed to provide the necessary medical
            documentation.

            (s) <u>CAN – 'Causation and Impairment (Not
            Ratable)' (E only)</u> - Used when causation and an
            impairment that is not ratable are being denied
            simultaneously.

            (t) <u>CAR – 'Causation and Impairment (Resolved)'
            (E only)</u> - Used when causation and impairment
            that is resolved (i.e., does not exist anymore)
            prior to the issuance of the decision are being
            denied simultaneously.

            (u) <u>MBM – 'Maximum Payable Benefit Met' (E only)</u>
            - Used when the maximum payable benefit is
            already met and a formal decision is required for
            an impairment and/or wage loss claim.

10. <u>Closure Codes</u>. The CE must enter the following ECMS closure
codes in the Claim Status History screen as appropriate.

      a. <u>C0 - 'Closed-Administrative Error'</u>. This claim status
      code is used if a claim was created in error. The status
      effective date is the date of the memo to the file
      explaining the administrative closure. This code was
      created for use by the DO prior to the claims delete

_____

10.   Closure Codes. (Continued)

capability being given to the field. Now that the field
has the ability to delete or administratively close the
claim, they need to know when to use each option. In
situations where the claim has already started to be
developed and related actions are coded into ECMS, use the
C0 code. If the claim was created in error and discovered
prior to any real development, the claim is be deleted.
The status effective date is the date of the memo to the
file explaining the administrative closure.

b.   C1 - 'Closed-Claim Withdrawn by Claimant'. This claim
status code is used if the claimant withdraws all
unadjudicated claimed conditions in a system. (A claim in
which a final decision has been issued cannot be
withdrawn.) The CE will send a letter to the claimant,
advising of the closure of the claim(s). The 'C1' is coded
with a status effective date equal to the date of the
letter to the claimant.

If there are multiple claimed conditions that have not yet
been adjudicated, and the claimant wants to withdraw only
one or some of the conditions, delete the withdrawn
condition(s) and input a case note in ECMS and a memo to
the file explaining the situation. The 'C1' is not entered
in ECMS. However, if there is only adjudication of one
illness pending or all the pending conditions are being
withdrawn (no other conditions or wage loss or impairment),
'C1' is entered in ECMS. If wage loss or impairment is
pending, wait to code 'C1' to ensure the claim remains on
reports. Be aware that if 'C1' is used to close remaining
claimed conditions after other conditions have been
accepted, medical benefits will not be affected.
Essentially, 'C1' should only be entered into ECMS B or E
if everything on the claim is adjudicated and withdrawn or
withdrawn for that Part (B or E).

c.   C2 - 'Closed-Administrative Closure'. This claim
status code is used if the claimant does not complete and
return required forms, and therefore adjudication cannot
continue. These include: tort suit or state workers'
compensation information, NIOSH smoking history, race and
skin questionnaires, and OCAS-1 (only if there is one
claimant).

_____

10. Closure Codes. (Continued)

The CE will send a letter to the claimant, advising of the closure of the claim. The 'C2' is coded with a status effective date equal to the date of the letter to the claimant.

The types of administrative closures listed above do not require a reason code. However, there are some specific circumstances that require a reason code be selected from the drop down menu associated with the 'C2' claim status code:

   FS – 'Failure To Sign Claim Form'. When a claimant files a claim telephonically with a Resource Center but then either refuses or fails to sign an actual claim form, the CE enters the 'C2' claim status code with the corresponding 'FS' (Failure to sign claim form) reason code. The status effective date is the date of the memo to the file explaining the administrative closure.

d.   C3 - 'Closed-Employee Died'. This claim status code is used when the employee dies. If the death notification (i.e., phone call, letter) is received, and the case is either pre-recommended decision or post-final decision, the CE enters the 'C3' code, with a status effective date of when the Resource Center, DO, or FAB has been notified, whichever is earlier.

If the death notification is received between the recommended and final decision, meaning FAB has yet to issue the final decision, and will in fact remand the case back to the DO due to the death of the claimant, then the 'C3' code should not be entered until the DO receives the remand. The status effective date of code 'C3' will be that of the receipt date of the remand order, which is equivalent to the transfer-in date to the DO in ECMS. This code can be used in adjudicated and unadjudicated claims.

If the first written notification of an employee's death is on a newly-filed Form EE-2 from a survivor, where the date of death is included on the form, the status effective date is that of the date stamp of receipt in the Resource Center, DO, or FAB of the Form EE-2, whichever is earlier. [The date of death should also be entered on the Case screen.]

_____

10. <u>Closure Codes</u>. (Continued)

Bills submitted for unadjudicated and denied cases will be denied for processing and payment. Bills submitted for approved cases will be accepted for processing and possible payment up to the employee's date of death.

e.   <u>C8 - 'Closed-Survivor Died Prior to Payment Being Made'</u>. This claim status code is used on a survivor claim if the survivor dies before compensation is paid. If the death notification (i.e., phone call, letter) is received, and the case is either pre- recommended decision or post-final decision, the CE enters the 'C8' code, with a status effective date of when the Resource Center, DO, or FAB has been notified, whichever is earlier.

If the death notification is received between the recommended and final decision, meaning FAB has yet to issue the final decision, and will in fact remand the case back to the DO due to the death of the claimant, then the 'C8' code should not be entered until the remand is received back at the DO.

The status effective date of the 'C8' code will be that of the receipt date of the remand order, which is equivalent to the transfer in date to the DO in ECMS.

f.   <u>C9 - 'Closed-RECA Awaiting DOJ Adjudication'</u>. This claim status code is used if a claim is filed with EEOICPA prior to adjudication by the Department of Justice (DOJ), and the claim is still pending with DOJ. The CE will send a letter to the claimant, advising of the closure of the claim. The 'C9' is coded with a status effective date equal to the date of the letter to the claimant.

<u>Note</u>: Once DOL receives a decision from DOJ that was pending, development is resumed. At that time, the CE codes 'RD' (development resumed) with a status effective date equal to the date-stamp of receipt of the DOJ decision.

g.   <u>C10 – 'Partial Claim Closure'</u>. This claim status code is used when the wage loss or impairment portion of the claim is being closed without the issuance of a recommended or final decision. (Other closure codes reflect a closure of the entire claim, but this code closes only the

_____

10.   Closure Codes. (Continued)

       individual impairment or wage loss component.) Once the
       'C10' status code is entered, the CE selects the reason
       code from the drop-down menu that corresponds with the
       reason the impairment or wage loss claim is being closed.

           (1)   NM – 'Not at MMI' – When impairment is claimed,
           but the employee has not reached Maximum Medical
           Improvement (MMI), the CE enters the 'C10' claim
           status code with the corresponding reason code 'NM'
           Not at MMI) reason code. The status effective date of
           the code is the date of the letter to the claimant
           informing him or her that an impairment rating cannot
           be made at this time due to the fact that he or she
           has not reached MMI.

           Note: Once medical evidence is received in the DO
           indicating that the claimant is at MMI, development is
           resumed and the 'RD' (Development Resumed) code will
           be entered into ECMS. The status effective date will
           be the date the DO/CE2 Unit receives such evidence of
           MMI.

           (2)   WLW – 'Wage Loss Claim Withdrawn' – Where wage
           loss had been claimed, but the claimant chooses to
           withdraw the claim for wage loss in writing, the CE
           codes the 'C10' claim status code with the 'WLW' (Wage
           Loss Claim Withdrawn) reason code. The status
           effective date is the date stamp of receipt in the
           Resource Center, DO, or FAB, whichever is earlier.

           If the claimant decides to file at a later date, enter
           a new 'WC' code.

           (3)   ICW – 'Impairment Claim Withdrawn' – Where
           impairment had been claimed, but the claimant chooses
           to withdraw the claim for impairment in writing, the
           CE codes the 'C10' claim status code with the 'ICW'
           (Impairment Claim Withdrawn) reason code. The status
           effective date is the date stamp of receipt in the
           Resource Center, DO, or FAB, whichever is earlier.

           If the claimant decides to file at a later date, enter
           a new 'IC' code.

_____

10. Closure Codes. (Continued)

> Note: If claims for wage loss and impairment are
> withdrawn simultaneously, the CE will enter two 'C10'
> claims status codes, one with the 'WLW' reason code
> and the other with the 'ICW' reason code.

11. New Claims for New Medical Conditions. When a case has a
final decision, and a current claimant submits a subsequent
claim form for a new medical condition, the new claim filing is
recorded in ECMS by entry of claim status code 'RD'-(Development
Resumed). A new claim form for new covered medical conditions
is required once a final decision is issued.

> a. Case File at DO. If the case file is at the DO, and a
> new claim form is received after a final decision has been
> issued:
>
> > (1) The CE enters the new claim in ECMS by entering
> > an 'RD'- Development Resumed in the claim status
> > history screen of ECMS. The status effective date
> > will be the new claim filing date. This is the
> > earliest of the following: postmark date or date stamp
> > of receipt on the claim form, or the initial piece of
> > evidence that instigated the claim in a DO or FAB
> > office, or Resource Center. [The envelope must be kept
> > with the claim form, and put in the case file.]
> >
> > Once the 'RD' code and status effective date are
> > entered in ECMS, the CE enters the newly claimed
> > medical condition on the Medical Condition screen.
> > The CE reviews the new condition and begins
> > development of the new medical evidence.
> >
> > (2) Development of the case will continue through new
> > recommended and final decisions (or consequential
> > acceptance letter if the newly claimed condition turns
> > out to be a consequential illness). All previously
> > entered ECMS codes in the Claim Status History are
> > still relevant for the case and will apply to the new
> > claim. They do not need to be re-entered following
> > the 'RD' code. However, all new development for the
> > claim must now be entered in ECMS, including all
> > further development claim status history codes.

_____

11.   New Claims for New Medical Conditions. (Continued)

        (3) If the new medical condition becomes an accepted condition, and the CE enters an "A" in the cond status field, then the med status effective date is determined by the following:

           (a) If the original claim was for Beryllium Sensitivity, and was accepted, and the new claim is for CBD, the med status effective date of the CBD is the same as the filing date of the Beryllium Sensitivity.

           Similarly, if the original claim was for pleural plaques, and was accepted, and the new claim is for asbestosis, the med status effective date of the asbestosis is the same as the filing date of the pleural plaques.

           (b) For all other non-consequential medical conditions, regardless of the diagnosis date, the medical status effective date is the new claim filing date for any conditions eventually accepted, prior to issuance of the final decision.

           (c) For consequential conditions, the medical status effective date is equal to the filing date for the primary condition.

    b.   Case File at FAB. If the case file is at FAB, and a new claim form or medical evidence for a new covered medical condition is received prior to a final decision:

        (1) If the case is in posture for acceptance, FAB will enter the new claim in ECMS by entering an 'RD'-Development Resumed in the claim status history screen. The entry of the 'RD' code follows the same process as in the DO/CE2 Unit, with a status effective date equal to the new claim filing date.

        Once the 'RD' code is entered into ECMS, the FAB sends a letter to the claimant, addressing the receipt of the new claim form and instructing the claimant that the DO/CE2 Unit will further develop the new condition.

_____

11. New Claims for New Medical Conditions. (Continued)

> The CE/HR then enters the newly claimed medical
> condition on the Medical Condition screen. The CE/HR
> does not begin development of the new medical
> condition. This is completed by either the CE2 or the
> CE upon case return to the DO.
>
> (2) If the case is in posture for denial, it
> is remanded back to the DO/CE2 Unit for development
> and adjudication of the new claimed condition.
>
> (3) If a new claim form or medical evidence for the
> same medical condition(s) is received after a final
> decision, regardless of its current location, and the
> claimant sends in additional medical evidence for the
> original medical condition(s) or a new claim form for
> the same medical condition(s) already adjudicated in
> the final decision, this is not considered a new
> claim.
>
> For either of these occurrences, the 'RD' –
> Development Resumed claim status code is not entered.
> Development cannot be resumed for any claims after a
> final decision without either a new claimed medical
> condition or a Director's Order. New evidence for
> previously adjudicated medical conditions must be
> properly reviewed.

12. Director's Orders. At any time after FAB has issued a
decision, the Director of the Division of Energy Employees
Occupational Illness Compensation (DEEOIC) may reopen a claim
and/or vacate FAB's decision.

For certain routine reopenings, signature authority has been
delegated to the Policy Branch Chief, the Unit Chief for Policy,
Regulations and Procedures (UPRP) or the District Director
(DD). This rule applies to all decisions issued by the FAB.

The reopening process, whether it originates with the claimant,
the DO/CE2 Unit, the FAB, or under the auspices of the
Director's own discretionary authority, requires certain ECMS
codes for identification and tracking, as follows:

> a.   'MC' - Claimant Requests Reopening. This code is used
> when the DO or FAB receives a request for reopening

_____

12. <u>Director's Orders</u>. (Continued)

directly from the claimant, or an untimely request for reconsideration containing the requisite evidence warranting further review. The DO or the FAB enters the 'MC' code into ECMS. The status effective date is the postmark date, if available, or the date the request is received in the Resource Center, DO, or FAB, whichever is earlier.

For cases with multiple claimants, this code is entered in the claim status history only for the claimant(s) who submitted the request. (This is the only code related to Director's Orders for which this is true. All other codes for Director's Orders are entered for all active claimants.)

<u>'MI' – District Director (DD) Requests Reopening</u>. When the DD or FAB manager asks the Director of DEEOIC (or designee) to review a claim for possible reopening, a memo outlining the DD or FAB manager's concerns must be submitted. The DO or FAB will enter the 'MI' code prior to forwarding the file to the National Office (NO). This code is used whether a reopening request is based on a claimant's request or the DD or FAB manager's, except in the case of a FAB remand order sent to NO for a possible Director's Order (i.e., remand challenge). The status effective date is the date of the DD or FAB manager's memo to the Director of DEEOIC.

This code can also be entered by the CE, senior, or supervisor when a memo is drafted to the DD/ADD requesting a case be reopened, possibly because of SEM database changes or new residual contamination information.

c.   <u>'M7' – DO Submits FAB Remand for Possible Vacate Order</u>. When the DD disagrees with a FAB remand order, the DD will prepare a memo outlining his or her concerns and forward the memo and case file to the NO for review by the Director of DEEOIC. The DO will enter the 'M7' code into ECMS prior to sending the case file to NO. The status effective date is the date of the DD's memo to the Director of DEEOIC.

d.   'MQ' - Reopening Request Received in NO. NO staff enter this code. When a reopening request is received in

_____

12.   Director's Orders. (Continued)

     NO from the DO, or the FAB, this code is required to denote
     receipt of the request and to indicate that the case file
     is physically present at the NO. The status effective date
     is the date of receipt of the request for a reopening in
     the NO.

     This code is also entered when the DD disagrees with a FAB
     remand order and submits a challenge to the remand order to
     the NO for review by the Director of DEEOIC. In this
     circumstance, the status effective date of the 'MQ' is the
     date the NO received the case file.

     e.   'MN' – NO Initiates Review for Reopening. NO staff
     (and DO staff when appropriate) enter this code. When the
     Director reviews a claim under the Director's own
     initiative for either administrative purposes, a change in
     the law, or for reasons within the sole discretion of the
     Director, the NO staff (or DO staff when authority has been
     delegated) enter the 'MN' code to denote that the Director
     has identified the case as one necessitating a review for
     possible reopening and/or vacating of a FAB decision. The
     status effective date is the date the NO received the case
     file unless there is other specific guidance for this date,
     such as in new SEC or PEP bulletins.

     f.   'MX' – Reopening Request Denied. After the DD, the
     Director of the DEEOIC, the Policy Branch Chief, or Unit
     Chief for UPRP has reviewed the request for reopening and
     has determined that the request must be denied, the 'MX'
     code is entered to denote the status of the review.

     DO staff enters the 'MX' code if the DD is denying the
     reopening. NO staff enters the 'MX' code if the Director
     of the DEEOIC, Policy Branch Chief, or Unit Chief for UPRP
     is denying the reopening. The status effective date is the
     date of the letter denying the request for reopening.

     This code is also used by NO staff for remands that were
     submitted to the Director of the DEEOIC for review, where
     the remand is found to be correct. In this circumstance,
     the status effective date is the date of the memo to the DD
     explaining that the remand order stands.

_____

12.   Director's Orders. (Continued)

      g.   'MF' – Claim Reopened, File Returned to FAB. After
      the Director has determined a claim must be reopened and a
      new FAB final decision must be issued, NO staff enters the
      'MF' code to denote that a reopening has been granted and
      that the file has been returned to the FAB for a new final
      decision. This 'MF' code is not used when a remand order
      has been vacated and requires a new final decision by FAB.
      The status effective date is the date of the order granting
      the reopening.

      h.   'MD' - Claim Reopened, File Returned to DO. NO staff
      enter this code into ECMS to denote that the Director of
      the DEEOIC, Policy Branch Chief, or Unit Chief for UPRP has
      granted the reopening request and the file is being
      returned to the DO for further action and the issuance of a
      new recommended decision. The status effective date of the
      'MD' code is the date of the Director's Order vacating the
      final decision and granting the reopening.

      In situations where reopening authority has been delegated
      to the DDs, the DO will enter the 'MD' code with a status
      effective date of the date of the Director's Order.

      i.   'MV' – FAB Remand Order Vacated, Requires New Final
      Decision. This code is used when the Director of the
      DEEOIC has determined that the remand order was improper
      and must be set aside, and a new final decision must be
      issued. NO staff enters this code into ECMS when the
      Director's Order vacating the Remand Order is issued. The
      status effective date is the date of the order vacating the
      FAB remand order.

      j.   'MZ' – Receipt of Director's Order in DO or FAB. Once
      the Director's Order and accompanying case file is received
      from NO in the DO/FAB, the DO/FAB staff will enter the 'MZ'
      code to denote date of receipt. The status effective date
      is the date the DO/FAB receives the Director's Order.

      This code is required for the return of every requested
      Director's Order, regardless of whether the order was
      granted or denied. This code is also to be used where a
      remand order was submitted to the Director for review and
      the file was returned with a memo to the DD explaining that

_____

12. Director's Orders. (Continued)

     the remand order stands or returned with a Director's Order
     to FAB vacating the remand order.

     In cases where the DD reopens the case, there is no need to
     enter the 'MZ' code.

     k.   'MA' – Residual Contamination Reopening. This code is
     used to denote that a reopening has been granted based on
     residual contamination. Authority has been delegated to
     the DDs to handle these types of reopenings, so this code
     is entered by the DD with a status effective date of the
     Director's Order vacating the final decision and granting
     the reopening.

     l.   'MB' – Reopening Based on Change to SEM Database. This
     code is used when the DD, Director, or anyone else
     delegated reopening authority, reopens a case based on
     updated information to the SEM database. The status
     effective date is the date of the Director's Order vacating
     the final decision and granting the reopening.

Note: If a decision awarding medical benefits is vacated, the
'A' medical condition status must be set back to 'R' and the
condition "unlinked" from the final decision, until a new
decision is rendered. This will require coordination with
Energy Tech Support, but must be done to stop medical bills from
being paid on ineligible claims.

13. 'CA' – Consequential Acceptances. When a consequential
illness is being accepted, the medical condition status must be
updated to an 'A' (Accepted) status on the medical condition
screen. When the consequential acceptance letter is issued, the
CE enters the 'CA' (Consequential Acceptance) code in the claim
status history with a status effective date equal to the
acceptance letter's date of issuance. When the CA code is
entered, the CE will be prompted to link the accepted condition
to the consequential acceptance in ECMS.

When the CE enters the CA code, the system will also force the
entry of one of the following reason codes:

                    a. 'ACP' – Additional Conditions Pending. If
                       there is at least one additional condition

_____

12. <u>Director's Orders</u>. (Continued)

(regular or consequential) that requires a decision (either a new CA code or new Recommended & Final Decision), the CE selects the 'ACP' reason code.

b. <u>'CCR' – Consequential Conditions Resolved</u>. If there are no other medical conditions (regular or consequential) currently pending a decision (either a new CA code or new Recommended & Final Decision), the CE selects the 'CCR' reason code. This will essentially close out any newly claimed conditions entered with an 'RD' (Resume Development) code.