U.S. Department of Labor Office of Workers' Compensation Programs
Division of Energy Employees
Occupational Illness Compensation
Washington, DC 20210

RELEASE - TRANSMISSION OF FEDERAL (EEOICPA) PROCEDURE MANUAL VERSION 2.3:

EEOICPA TRANSMITTAL NO. 18-04 July 24, 2018

EXPLANATION OF MATERIAL TRANSMITTED:

The Division of Energy Employees Occupational Illness Compensation (DEEOIC) is issuing this transmittal to notify staff of the publication of Version 2.3 of the Federal (EEOICPA) Procedure Manual (PM). Version 2.3 (v2.3) replaces Version 2.2 (v2.2), effective the date of publication of this transmittal.

Following are the content edits that make up Federal (EEOICPA) PM v2.3:

- Chapter 2 - The EEOICPA:
  - Ch. 2.4b(1) has been edited to remove reference to Secondary Claims Examiner (CE2) unit.
  - Ch. 2.4b(1)(b) has been edited to remove content relating to functions of CE2 unit. New content added to explain role of the CE while a case is undergoing review by FAB.

    PM v2.2 read:

    (b) The CE2 Unit handles DO development and adjudication required while a case is pending review at the FAB. The CE2 Unit only adjudicates issues that are outside the scope of the issue(s) being addressed by the FAB. In particular, CE2 staff:

    (i) Conduct all necessary development on outstanding claim elements not related to the RD currently in front of the FAB for review, and appropriately reflecting those actions in the Energy Compensation System (ECS) for the duration of the FAB review process;

    (ii) Prepare a memorandum for the case file explaining what development actions have

(iii) been taken and what future actions are required to address any outstanding issues;

(iv) Issue a RD whenever the case record contains enough evidence on file to support a RD on any of the outstanding claim elements.

It has been edited in PM v2.3 to read:

(b) A separation must exist between the district offices and FAB to maintain impartiality in case adjudication functions. The designated CE assigned to a case handles all necessary development on outstanding claim elements not related to the RD currently in front of the FAB for review, and may issue a RD whenever the case record contains enough evidence on file to support a RD on any of the outstanding claim elements. While the CE may concurrently work on a case assigned to FAB, the CE may not engage in any case adjudication activity relating to a claim under evaluation by FAB. Moreover, FAB may not seek CE assistance with regard to its evaluation or development of a claim under consideration for finalization.

- Ch. 2.6b has been edited to reconcile instructions on the jurisdiction and handling of Section 4 and 5 Radiation Exposure Compensation Act (RECA) claims with guidance outlined in Chapter 19 - Eligibility Requirements for Certain Uranium Workers.

  PM v2.2 read:

  Uranium Workers. Normally, all claims for uranium workers (or their survivors) who may have been awarded benefits under Section 5 of RECA are within the jurisdiction of the Denver DO. (However, if a worker filed for both RECA Section 5 and silicosis benefits, and the Nevada Test Site was the last place of employment, the case would go to the Seattle DO rather than the Denver DO).

  It has been edited in PM v2.3 to read:

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

- Chapter 8 - Case Maintenance:
  - Ch. 8.6a(2) edited to remove reference to CE2 unit
- Chapter 9 - Transfers and Loans:
  - Chapter edited to remove all references to CE2 Unit
- Chapter 13 - Establishing Covered Employment:
  - Ch. 13.10a(2) has been edited to update the fax number for the Social Security Administration (SSA)
- Chapter 14 - Establishing Special Exposure Cohort Status:
  - Chapter edited to remove all references to CE2 Unit
- Exhibit 15-4 - Exposure and Causation Presumptions with Development Guidance for Certain Conditions:
  - Exhibit 15-4, Section 5b has been edited for clarity.

    PM v2.2 read:

    b. A qualified physician has diagnosed the employee with asthma. A medical diagnosis for asthma should be made when the physician is able to identify the presence of intermittent respiratory and physiologic evidence of reversible or variable airways obstruction including positive methacholine challenge test or post-bronchocodialator reversibility. However, a physician can also rely on other clinical information to substantiate his or her diagnosis of asthma. For example, spirometry for measurement of FEV_1 and FVC is the most reliable method for assessing airway obstruction. The response to inhaled bronchodilator administration has been used as a measure of airway hyperresponsiveness. A 12% improvement in FEV_1 of at least 200 mL after inhaled bronchodilator is how the American Thoracic Society defines a significant improvement indicative of hyperresponsive airways

It has been edited in v2.3 to read:

b. A medical diagnosis for asthma should be made when the physician is able to identify the presence of intermittent respiratory and physiologic evidence of reversible or variable airways obstruction including post-bronchodilator reversibility on spirometry or a positive methacholine challenge test. However, a physician can also rely on other clinical information to substantiate his or her diagnosis of asthma, such as the findings from a detailed medical history and physical examination. Documentation of recurrent symptoms of airflow obstruction or airway hyper-responsiveness, such as episodic cough, chest tightness or shortness of breath, or symptomatic improvement following treatment for asthma (e.g., inhaled bronchodilator or steroids) supports a diagnosis of asthma. Physical examination findings such as wheezing on lung examination, nasal swelling and drainage, or use of chest muscles to breath also support a diagnosis of asthma. The response to inhaled bronchodilator administration has also been used as a measure of airway hyperresponsiveness. A 12% improvement in FEV1 of at least 200 mL after inhaled bronchodilator is how the American Thoracic Society defines a significant improvement indicative of hyperresponsive airways. However, a negative bronchodilator test does not rule out a diagnosis of asthma, especially if the patient is on medical treatment for asthma.

- Exhibit 15-4 Section 5c outline numbering is changed for consistency

- Exhibit 15-4, Section 6b has been updated to include a subsection (5) to add Benzidine as an agent known to be causally related to bladder cancer. The new content added with v2.3 reads:

(5) Benzidine: This substance has been used at DOE sites for activities associated with painting, predominantly used in the production of dyes. Benzidine can be absorbed into the body by inhalation, skin absorption, ingestion, and skin and/or eye contact. In 1973, OSHA regulations effectively banned

United States production of benzidine, and it has not been produced for commercial sale in the United States since 1974; however, benzidine can be imported and small amounts are still used to make benzidine-based dyes.

- Exhibit 15-4, Section 8c has been edited to add two new toxins:

  PM v2.2 read:

  c. Exposure: Evidence in the file must not only establish that the employee worked within a certain job category listed above, but that the employee was concurrently exposed to at least one of the specified organic solvents listed below:

  - *Ethyl Benzene*
  - *Methyl Ethyl Ketone*
  - *Methyl Isobutyl Ketone*
  - *Styrene*
  - *Toluene*
  - *Trichloroethylene*
  - *Xylene*

  It has been edited in PM v2.3 to read:

  c. Exposure: Evidence in the file must not only establish that the employee worked within a certain job category listed above, but that the employee was concurrently exposed to at least one of the specified organic solvents listed below:

  - *Carbon Disulfide*
  - *Ethyl Benzene*
  - *Methyl Ethyl Ketone*
  - *Methyl Isobutyl Ketone*
  - *n-Hexane*
  - *Styrene*
  - *Toluene*
  - *Trichloroethylene*
  - *Xylene*

- Exhibit 15-4 adds a new Section 12, presumptive criteria for lung cancer:

  *12. **Lung Cancer:** Part E causation can be presumed for lung cancer when all of the following criteria*

have been satisfied. If the case does not meet the causation presumption as stated below but the case involves a diagnosis of lung cancer, development is to include an IH referral if appropriate (e.g., there are no established exposure presumptions), and obtaining a medical opinion on causation.

a. Medical: The file contains a diagnosis of lung cancer.

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate workdays. This can be determined by existing asbestos exposure presumptions or an IH assessment.

c. Latency: The diagnosis of lung cancer was made at least 15 years after initial exposure to asbestos in covered employment.

- Exhibit 15-4, Section 12-18 renumbered:

12. Meningioma changes to 13. Meningioma
13. Mesothelioma changes to 14. Mesothelioma
14. Ovarian Cancer changes to 15. Ovarian Cancer
15. Parkinsonism changes to 16. Parkinsonism
16. Pleural Plaques changes to 17. Pleural Plaques
17. Radiation Induced Cataracts changes to 18. Radiation Induced Cataracts
18. Radiation Sickness (Acute) changes to 19. Radiation Sickness Acute.

- Renumbered Exhibit 15-4, Section 14c (Mesothelioma) and made changes to the exposure and latency period:

PM v2.2 (Section 13b-c) read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 250 aggregate work days. This can be determined by existing asbestos exposure presumptions or an IH assessment.

c. Latency: The diagnosis of mesothelioma was made at least 30 years after initial exposure to asbestos in covered employment.

It has been edited in PM v2.3 to read:

b. Exposure: The employee was employed in a job that would have brought the employee into contact with significant exposure to asbestos on a day-by-day basis for at least 30 or more aggregate workdays. This can be determined by existing asbestos exposure presumptions or an IH assessment.

c. Latency: The diagnosis of mesothelioma was made at least 15 years after initial exposure to asbestos in covered employment.

- Renumbered Exhibit 15-4, Section 15c (Ovarian Cancer)and made changes to the latency period:

PM v2.2 (Section 14c) read:

c. Latency: The diagnosis of ovarian cancer was made at least 20 years after initial exposure to asbestos in covered employment.

It has been edited in PM v2.3 to read:

c. Latency: The diagnosis of ovarian cancer was made at least 15 years after initial exposure to asbestos in covered employment.

- Renumbered Exhibit 15-4, Section 17c (Pleural Plaques) and made changes to the latency period.

PM v2.2 (Section 16c) read:

c. Latency: The diagnosis of pleural plaques was made at least 20 years after initial exposure to asbestos in covered employment.

It has been edited in PM v2.3 to read:

c. Latency: The diagnosis of pleural plaques was made at least 10 years after initial exposure to asbestos in covered employment.

- Chapter 18 - Eligibility Criteria for Non-Cancerous Conditions:
    - Ch. 18.15, Idiopathic Disease Diagnosis, has been added, and reads:

      15. Idiopathic Disease Diagnosis. "Idiopathic" means that the causative agent is unknown. However, in the case of pulmonary fibrosis, peripheral neuropathy/polyneuropathy, and interstitial pneumonitis, DEEOIC maintains health effect data for these commonly referenced idiopathic conditions that could allow a physician to render an opinion on the potential work-relatedness of the underlying medical condition.

      In claims that present with medical evidence characterizing one of the above medical conditions as idiopathic, the CE is to treat those illnesses as potentially work-related and he or she is to evaluate the condition without consideration given to the idiopathic designation. With the identification of any potential exposures associated with the employee's work at a covered site, an Industrial Hygienist's referral, followed by a review of the claim by the claimant's treating physician or a Contract Medical Consultant, as appropriate, must occur.

      Regardless of whether or not DEEOIC maintains health effect data on a medical condition labeled as idiopathic, CEs may not presume that the condition is unrelated to toxic substance exposure and deny it without development. For a medical condition labeled as idiopathic, with no available health effect data relating to the underlying condition, the CE is to undertake development as outlined in Chapter 15 - Establishing Toxic Substance Exposure and Causation, including asking the claimant to submit any medical or health effect information that could associate the claimed medical condition to the employee's exposure to a toxic substance.

    - The remaining sections of Chapter 18 are renumbered:

      Section 15 Medical Conditions Associated with Asbestos Exposures changes to Section 16.

      Section 16 COPD changes to Section 17

Section 17 Parkinsonism changes to Section 18

Section 18 Other conditions changes to Section 19

- Exhibits 19-1, 19-2 and 19-4, have been updated to include the new mailing address for the U.S. Department of Justice (DOJ), RECA.

- Chapter 20 - Establishing Survivorship

  - Ch. 20.12b has been edited for clarity.

    PM v2.2 read:

    b. Death Due to Non-Covered Illness, Part E. If a covered Part E employee dies after filing a claim but before any payment is received, and if the employee's death was caused solely by a non-covered illness, the survivor (any survivor including the spouse) has the election of benefits option. The survivor may elect to receive compensation (wage-loss and/or impairment) that the employee would have received had he not died prior to payment. It is not necessary for the employee to have filed a claim specifically for wage-loss or impairment in order to have the election of benefit option available. As long as the employee filed a Part E claim, claims for impairment and wage-loss are assumed.

    It has been edited in PM v2.3 to read:

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

presumed. The earlier receipt by the employee of monetary benefits under Part E for wage-loss and/or impairment does not negate the availability of this election for any subsequent amount of monetary benefits claimed by the survivor.

- Chapter 21 - Impairment Ratings:

  - Ch. 21.16 has been updated to clarify the correct forms needed for additional filings for an increased impairment benefit and to provide new clarifying guidance regarding a waiver of the two-year waiting period on claims for increased impairment.

    PM v2.2 read:

    16. Additional Filings for Increased Impairment Benefits. An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. For such a claim, the claimant must file using Form EN-10. When a claim for increased impairment is developed but the medical evidence establishes lower whole person impairment than previously determined, the CE denies the claim for increased impairment. The CE takes no action to reopen a prior impairment determination in these circumstances because a claim filed for increased impairment after the two-year waiting period is a new claim.

    a. Timeframe. The employee may not submit a Form EN-10 for an increased impairment rating earlier than two years from the date of the last FD on impairment, except for the following reasons.

    (1) New Covered Illness. The CE waives the two-year time period requirement if the CE adjudicates an additional impairment claim based upon new covered illness not included in the previous award. A new covered illness must involve a different disease, organ, body function, illness, or injury that

was not the basis of the original impairment rating.

It has been edited in PM v2.3 to read:

16. Additional Filings for Increased Impairment Benefits. An employee previously awarded impairment benefits may file a claim for increased impairment benefits for the same covered illness included in the previous award. The DEEOIC will accept the submission of the EN-10, EN-11A or words of claim to initiate a claim for increased impairment; however, the DEEOIC must receive a completed EN-11A to allow the claimant to communicate his or her choice as the physician to perform the rating for increased impairment.

When a claim for increased impairment is developed but the medical evidence establishes lower whole person impairment than previously determined, the CE denies the claim for increased impairment. The CE takes no action to reopen a prior impairment determination in these circumstances because a claim filed for increased impairment after the two-year waiting period is a new claim.

a. Timeframe. The employee may not submit a claim form for an increased impairment rating earlier than two years from the date of the last FD on impairment.

(1) Waiver of the Two-Year Waiting Period. The CE has discretion to ascertain the circumstance warranting the waiver of the two-year waiting period. The CE may consider waivers under the following circumstances.

i. The CE accepts a new covered illness since a previous final decision awarding impairment and the condition relates to an organ system (in accordance with the AMA's Guides to the Evaluation of Permanent Impairment, 5th Edition) that was not included in a prior rating. For example, an employee was

already rated for a pulmonary condition, but now has an approval for a newly diagnosed skin cancer.

ii. *The claimant requests a waiver of the two-year rule and submits medical evidence, documenting since the last impairment rating, that the accepted condition(s) has caused a substantial detrimental effect to the claimant's living circumstances, one or more ADLs, or medical status. The effect should represent a change unlikely to improve. For example, an employee previously rated for lung cancer, who was mobile and able to perform most ADLS, has a sudden degradation of their accepted condition to the point where they are rendered bedbound. No other treatment modalities are available. Under this circumstance, the CE could grant a waiver of the two-year waiting period for a new impairment, if requested. Alternatively, an employee who has had an impairment rating performed for multiple skin cancers receives approval for two new skin cancers. There is no documented change to the employee's lifestyle or ADLs. Under this circumstance, a waiver is inappropriate because the new conditions relate to the organ system previously rated and there is no evidence of a substantial detrimental effect to the claimant's living circumstance. The CE may seek the input of a DEEOIC nurse consultant or CMC to assist in*

assessing whether a substantive basis exists for granting a waiver of the two-year rule.

- Exhibit 21-5: Title changed from "Required Medical Evidence for Specific Conditions" to "Evidence to Support Impairment Rating for Specific Conditions." Exhibit content edited to include updated guidance related to classification of voice/speech impairment, specifically referencing Table 11-8 of the AMA's Guides to the Evaluation of Permanent Impairment, 5th Edition.

- Chapter 22 - Wage-Loss Determinations:

  - Ch. 22.10a(4) has been edited to correct the fax number for resubmissions to the SSA.

- Chapter 23 - Consequential Conditions:

  - Ch. 23.12 edited for clarity.

    PM v2.2 read:

    12. SWC Claims, Lawsuits and Fraud. For each consequential injury that is to be accepted, the CE may need to obtain a newly signed Form EN-16 SWC/Tort/Fraud affidavit from the claimant.

    It has been edited in PM v2.3 to read:

    12. SWC Claims, Lawsuits and Fraud. For each consequential injury that is to be accepted, the CE must obtain a newly signed Form EN-16 SWC/Tort/Fraud affidavit from the claimant.

- Chapter 24 - Recommended Decisions:

  - All references to former CE2 Unit removed

  - Ch. 24.10.b has been updated to include reverse consequential illness acceptance by letter decision.

    PM v2.2 read:

    b. Consequential illness acceptance

PM v2.3 reads:

b. Consequential illness acceptance (including reverse consequential illness acceptance).

- Added content at Ch. 24.10.f to add new basis for issuing a letter decision:

f. Acceptance of additional cancers under Parts B and E following a NIOSH POC equal to or greater than 50% by letter decision.

- Chapter 25 - FAB Review Process:
  - Removed all content related to former CE2 Unit
  - Ch. 25.12 has been revised to outline new procedures for duties previously performed by the former CE2 Unit and clarify processing of claims with incorrect mailing addresses

PM v2.2 read:

12. CE2 Designated to the FAB. FAB offices are geographically located as noted in section 3 above. However, since DO adjudicatory functions are sometimes required while a case is at FAB, each DO assigns certain CEs to handle DO development and adjudication while the case is at FAB. This process eases the burden of file sharing and allows for case files to be maintained in one central location while RDs are pending review or FAB is addressing objections by hearing or review of the written record and further DO-level development is required.

a. Reporting and Roles. These CEs are called Co-Located Secondary CEs (CE2s) because the FAB CE (or HR) is considered the primary CE while the case is in FAB's jurisdiction. This group of CE2s is referred to as the "Co-Located Unit." The Co-Located Unit reports to either the DO or to the Policy Branch.

b. Assign CE2 Role. To enable the CE2 role, the DD or designee e-mails the Unit Chief of the Policy, Regulations and Procedures Unit, with a copy to Energy Technical Support, requesting the role

change. The e-mail contains the name of the CE and the reason for the request. The FAB manager to which the CE2 is co-located is also copied on the e-mail, so that FAB is aware of personnel changes that affect FAB workflow.

c. *Development Memorandum for Co-Located Unit. A DO CE who prepares a RD must be aware of any outstanding claims issues not addressed in the RD and requiring further development. If more development is needed concurrent with FAB's review of the case, the CE prepares a memorandum on gold-colored paper addressed to the FAB manager from the Senior CE, Supervisor, or DD who is the final reviewer of the RD. The subject line should read: "Co-Located FAB Development for File No. [file number]."*

The body of the memorandum addresses any outstanding claim issues that require development by the Co-Located Unit while the case is being reviewed by the FAB. When the RD is reviewed and signed, the memorandum is also reviewed and signed. Once this is done, the original memorandum is spindled on top of the case file documents.

d. *Receipt of Case by the FAB. The FAB CE or HR reviews any co-located development memorandum and notes any further development needed. The FAB CE or HR may also become aware of issues during their review.*

If DO development is required where no co-located memorandum exists in the case file, FAB writes a memo to the CE2 outlining the issues that must be developed and sends the file to the co-located unit. The FAB CE or HR must not assign any development actions to the CE2 regarding matters before the FAB for review. The FAB CE or HR conducts any development necessary about matters before the FAB.

e. *CE2 and FAB Coordination. The FAB CE or HR and the CE2 should coordinate their work to ensure that the file is where it is needed and the work can be completed. If both the FAB CE or HR and*

the CE2 need the actual file, the needs of the FAB CE or HR take precedence.

f. Development by CE2. When the FAB completes its initial review, the CE2 may request the case to determine whether the evidence of file is sufficient to issue a RD on an outstanding claim element. The CE2 inputs the appropriate action status in ECS. Jurisdiction should remain in the appropriate FAB office and not be changed to the DO.

(1) Issuing a RD. Should the record contain enough evidence to support a RD on any of the outstanding claim elements, the CE2 issues a RD. The Senior or journey level CE in the DO (or DD designee) reviews and signs the decision before issuance. Once the decision is reviewed and approved by the appropriate individual at the DO, the CE2 returns the case to the FAB and reflects the transfer of the case in ECS. It is particularly important to issue a RD if the claim element is in posture for acceptance.

If additional elements of the claim require development, the CE2 prepares a memorandum as outlined below. There is no need to rush to issue a RD denying a claim element if alternate elements are being deferred. In such a situation, the CE2 should wait until the deferred elements are resolved before proceeding with a RD. An exception to this rule is if a hearing date has been requested or scheduled. In these cases, the CE2 proceeds with any appropriate denial prior to a hearing so that objections to all outstanding RDs can be entertained at one time, thus avoiding multiple hearings.

(2) Further Development Required. If the DO development does not permit the CE2 to issue an additional RD, he or she completes whatever development is possible and returns the case to FAB. The CE2 prepares a memorandum on gold-colored paper to the DD explaining what development actions have

been taken and what future actions are required. The memorandum is spindled on top of the case file. Throughout the time the case is in FAB, the CE2 continues development and issues RDs on approved claim elements as the requisite evidence is received and evaluated.

g. RD Returned by Postal Service. If the case file is at the FAB for review of a RD, and the Postal Service returns the RD sent to a claimant as undeliverable, the assigned FAB CE or HR should quickly ascertain whether a simple mailing mistake (e.g. typographical error) occurred that is easily rectified, or whether the claimant's mailing address is no longer valid. If the FAB CE or HR determines that the claimant's mailing address is invalid, he or she transfers the case record to a CE2 for development. Once the CE2 receives the transfer; he or she evaluates the case evidence to identify any information that could help locate the claimant. The CE2 investigation should include making a reasonable effort to obtain new information that may assist in identifying the claimant's valid mailing address. For example, the CE2 should request a forwarding address from the Post Office closest to the claimant's last known address. See Exhibit 25-8.

(1) Correct Address Not Found. If the CE2 cannot obtain the claimant's current address, the CE2 places a memorandum in the file listing the actions taken to locate the claimant, and then administratively closes the claim until receipt of the claimant's valid mailing address.

(2) Correct Address Found, Claimant Did Not Notify DO. In the event the CE2 obtains the claimant's current address, and the claimant did not notify the DEEOIC in writing of that change, the CE2 sends the claimant a copy of the RD from the file. The CE is to prepare a separate request to the claimant asking for written notice of his or her address change (See Exhibit 25-9). The letter is to

allow 30 days for the claimant to submit written confirmation of his or her address change. The CE then files a memorandum into the case describing the actions taken regarding the address problem, and transfers the case file back to the FAB. The FAB does not issue the FD until receipt of a written confirmation from the claimant of the correct mailing address. If the claimant does not submit a written confirmation of his or her address change within the 30 days requested, the FAB administratively closes the claim.

(3) Correct Address Found, Claimant Notified DO. In the event the CE2 obtains written confirmation of the claimant's proper address, and the wrong-address problem was not the claimant's fault, the CE2 coordinates with the DO to re-issue the RD to the claimant with a new issuance date. In a multiple person claim, the CE must reissue the RD to all claimants, with a brief explanation of the matter contained in the RD cover letter. The CE2 spindles a memorandum explaining the situation into the case file. The CE2 then transfers the case file back to the assigned FAB CE/HR.

(4) Multiple Claimants. If a case has multiple claimants, and the Postal Service returns one or more claimants' RDs because of an incorrect address, the CE2 undertakes development individually for each returned RD in accordance with the instruction provided above. At the conclusion of the CE2's development, he or she prepares a memorandum for the case describing the outcome of development, which could include administrative closure for claimants with an invalid address. The CE2 then returns the case to the FAB. The FAB CE or HR may then proceed to issue a FD to all claimants for which a valid and confirmed mailing address exists. Claims administratively closed due lack of correct mailing address, or failure to return written confirmation of a new

address within a 30 days, are referenced in the FD; however, the effected claimants are not party to the decision. The FAB explains in the FD that any shares of payable compensation on an administratively closed claim is held in abeyance until the claimant provides written confirmation of his or her correct mailing address.

h. *FD Returned by Postal Service. If the FAB has issued a FD and the Postal Services returns it as undeliverable, the responsible CE or CE2 staff person is to ascertain the correct mailing address for the effected claimant. If the assigned staff person obtains written confirmation of a new address from the claimant, he or she is to mail a copy of the FD to the claimant's new address. In the event that the assigned staff person is unable to obtain a written confirmation of a new address, he or she is to refer the claim to the appropriate DO contact to initiate an administrative reopening. The assigned DO staffer will draft a Director's Order for the file explaining that the mailing address of the claimant is invalid, attempts to obtain a valid address were unsuccessful, and that a reopening is necessary to allow for an administrative closure. In a multiple claimant situation, reopening and administrative closure will only apply to those claims where the DO cannot confirm an address. However, later, if the DO receives written confirmation of a valid address on an administratively closed claim, it may then become necessary to reopen the other claims to permit for a reissuance of a unified FD.*

It has been edited in PM v2.3 to read:

12. <u>Decisions Returned by Postal Service</u>. In those instances where a case file is at the FAB for review of a RD, and the Postal Service returns a RD sent to a claimant as undeliverable, the assigned FAB CE or HR should ascertain whether a simple mailing mistake (e.g., typographical error, unprocessed address change request) occurred that is easily rectified, or whether the claimant's mailing address is no longer valid. If

there was an administrative error on the part of the DO in mailing a recommended decision, FAB must coordinate with the DO to have it reissue the decision to all claimants with an effective date that corresponds with the new mailing date. Should the FAB CE or HR determine that the claimant's mailing address is not valid, he or she evaluates the case evidence to identify any information that could help locate the claimant. The investigation should include making a reasonable effort to obtain new information that may assist in identifying the claimant's valid mailing address. For example, the FAB should request a forwarding address from the Post Office closest to the claimant's last known address. See Exhibit 25-8. Once FAB has undertaken development, but is unable to obtain the claimant's current address, it places a memorandum in the file listing the actions taken to locate the claimant. It then administratively closes the effected claim. In a single claimant case, FAB returns the file to the jurisdictional office responsible for case management. For a multiple claimant case, FAB must proceed to finalize the recommendation to any remaining claimants for which a valid mailing address exists. FAB is to reference the administrative closure of any claim with an invalid mailing address. For compensable claims, FAB must also explain that the allocation of any payable compensation to a claimant for which the FAB does not have a valid address is held in abeyance until the claimant provides written confirmation of his or her correct mailing address.

a. *In the event the DO obtains information on the claimant's current address after FAB administratively closes the claim, the assigned CE must ensure that the claimant submits a written notice of his or her address change (See Exhibit 25-9). Once received, the CE resumes development of the claim.*

   (1) *In a claim with a single claimant, the CE notifies the claimant in writing that the claimant did not provide proper notification of an address change, and that for this reason, FAB administratively closed its review of a pending recommended decision. The CE explains that action on the*

claimant's file is resuming based on the status of the claim at the time of administrative closure. The CE is to reissue the previously undeliverable recommended decision with a new date. The CE then forwards the claim to FAB, for it to proceed with finalization of the recommended decision.

(2) For a claim with multiple claimants, if resumption of development occurs on an ineligible claimant, the CE is to issue a new recommendation to the claimant denying his or her claim. However, in the circumstance where resumption of development occurs involving a claimant who is eligible for compensation benefit, it is necessary to first reopen all claims to allow for a newly issued recommendation that comprehensively addresses the entitlement for all claimants with an interest in the claim.

b. FD Returned by Postal Service. If the FAB has issued a FD and the Postal Services returns it as undeliverable, the responsible FAB staff person is to ascertain the correct mailing address for the effected claimant. In such instances, the DO is to transfer the case back to FAB so that the responsible FAB staff may complete these actions. If the assigned FAB staff person obtains written confirmation of a new address from the claimant, he or she is to mail a copy of the FD to the claimant's new address. In the event that the assigned staff person is unable to obtain a written confirmation of a new address, he or she is to refer the claim to the appropriate DO contact to initiate an administrative reopening. The assigned DO staff will draft a Director's Order for the file explaining that the mailing address of the claimant is invalid, attempts to obtain a valid address were unsuccessful, and that a reopening is necessary to allow for an administrative closure. In a multiple claimant situation, reopening and administrative closure will apply only to those claims where the DO cannot confirm an address. However, later, if the DO receives written confirmation of a valid

address on an administratively closed claim, it may then become necessary to reopen the other claims to permit for a reissuance of a unified FD.

- Chapter 26 - FAB Decisions:
  - Correction to outline format. Accordingly, what was Ch. 26.3b(3)(a)(iv) has been renumbered Ch. 26.3b(4)
- Chapter 29 - Ancillary Medical Services and Related Expenses.
  - What was Ch. 29.18, Ancillary Services or Expense Authorization RD, in PM v2.2, is renumbered Ch. 29.20.
  - New Ch.29.18, Enteral Formula, incorporates content of Bulletin No. 17-02, as outlined below:

18. <u>Enteral Formula</u>. Enteral formula is a nutritional replacement for patients who are unable to get enough nutrients in their diet. Patients prescribed enteral formula consume it by mouth or through a feeding tube. The DEEOIC requires prior authorization for enteral formula.

a. Requests for the authorization of enteral formula may originate from an employee, a designated AR or a medical provider. The DEEOIC medical bill processing contractor is tasked with registering all authorization requests for enteral formula in its electronic case tracking system. If the contractor receives the authorization request directly, they will record it and forward the request, as a thread, to the appropriate DO for processing. If the DO receives the authorization request via mail or fax, it is routed through the FO to the medical bill processing contractor for record creation and thread initiation.

b. Once the assigned CE receives a thread for authorization of enteral formula, he or she must undertake a review of the evidence in the case file to make a determination as to whether or not the request is medically

necessary in the care of the covered employee's accepted work-related medical condition(s).

(1) Requests for enteral formula must be substantiated by a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for enteral formula based on a face-to-face examination of the patient occurring within 60 days of the date of the LMN. In addition, the physician must identify the accepted work-related medical condition (preferably with a specific diagnosis code) that is necessitating the need for enteral formula. The physician must provide a description of the type of formula he or she is prescribing, along with a discussion of the specific quantity, frequency and duration of use. The physician may also provide guidance on how the patient receives the formula (orally or via feeding tube). The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.

c. When the CE receives a request for authorization of enteral formula accompanied by an appropriate LMN, the CE prepares a decision letter to the claimant authorizing the enteral formula at the prescribed level. The CE grants authorization of enteral formula in six-month increments.

d. Upon receipt of requests for enteral formula unaccompanied by a sufficient LMN, the CE undertakes development by contacting the prescribing physician and the claimant to request evidence necessary to allow for authorization. A CE can refer requests with unclear medical support to a DEEOIC nurse consultant for review and expert advice on the proper course of action. If, after development, the CE determines that the

medical evidence is insufficient, he or she issues a letter decision denying the authorization request. The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The CE is to send a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

e. Once the CE determines to approve or deny the request, the CE sends an email to the FO, who prepares and sends a thread to the medical bill processing contractor, authorizing or denying the enteral formula request. The CE creates a correspondence entry in the Correspondence screen of ECS, documenting the decision, and bronzes the letter along with the supporting documentation into OIS.

f. An employee, a designated AR or a medical provider must request a renewal of an expiring authorization or modification of an existing authorization for enteral formula. In either of these situations, a LMN documenting the medical necessity of prescribed formula must accompany the request. A CE may authorize enteral formula in ongoing six-month increments, so long as the requestor continues to submit sufficient evidence of medical necessity.

o New Ch.29.19, Rehabilitative Therapy, incorporates content of Bulletin No. 18-01, as outlined below:

19. <u>Rehabilitative Therapy Services</u>. The DEEOIC requires prior authorization for the therapy services outlined below.

a. *Types of Therapy Requiring Prior Authorization.*

(1) *Physical Therapy is the treatment of injuries or disorders using physical methods, such as exercise and massage. The goal of physical therapy is to relieve pain and to help the patient attain his or her maximum functional motor potential.*

(2) *Occupational Therapy involves treatment that helps develop adaptive or physical skills that will help the claimant to return to the ordinary tasks of daily living. Occupational therapy focuses on the use of hands and fingers, coordination of movement, fine motor skills and self-help skills such as preparing meals and dressing.*

(3) *Speech Therapy is the treatment of defects and disorders of speech and swallowing.*

(4) *Other rehabilitative therapy services is defined as a therapeutic service for which a provider charges a fee to render care outside of the scope of routine and customary medical care generally provided by a qualified physician.*

b. *The recommended other therapeutic service must be considered safe and effective by the medical community and intended to improve the health of the patient.*

An appropriately licensed (in accordance with relevant state requirements) or credentialed specialist must perform the prescribed rehabilitative therapy.

c. *Requests for the authorization of rehabilitative therapy, including physical therapy, occupational therapy, speech therapy*

or other rehabilitative therapy, may originate from an employee, a designated authorized representative or a medical provider.

The DEEOIC Bill Processing Agent (BPA) must register all authorization requests for rehabilitative therapy services in its electronic case tracking system. The BPA will record authorization requests it receives and then forward the request, as a thread, to the Workers' Compensation Assistant (WCA)/FO for processing. Authorization requests received at the DO via mail or facsimile must be routed through the WCA/FO to the BPA for record creation and thread initiation.

d. *Once the assigned CE/MBE receives a thread for authorization of a rehabilitative therapy, he or she must undertake a review of the evidence in the case to make a determination as to whether or not the request is medically necessary in the care of the covered employee's accepted work-related medical condition(s).*

e. *The CE/MBE must approve requests for a rehabilitative therapy initial assessment as long as the employee's treating physician prescribes it. The CE/MBE approves the request and sends an email to the WCA who then notifies the BPA to authorize an initial therapy assessment. The CE/MBE sends a letter authorizing the initial assessment to the requestor with a copy to the employee. If the CE/MBE receives a request for an initial rehabilitative therapy assessment without a physician's prescription, he or she sends a letter to the employee (with a copy to the therapy provider) requesting a signed prescription for the initial assessment. In the letter, the CE/MBE advises that the employee has 30 days within which to submit a signed physician's prescription for an initial therapeutic evaluation.*

If medical documentation or a signed physician's prescription is not received within 30 days, the CE/MBE must deny the request. The CE/MBE sends an email to the WCA who then notifies the BPA to deny the request. The CE/MBE sends a letter to the requestor with a copy to the employee denying the request and providing instruction to resubmit the request once the treating physician submits a signed prescription.

f. *Requests for rehabilitative therapy must be substantiated by the results of the initial evaluation by the applicable therapy specialist and a LMN from the employee's treating physician. The LMN must provide a description of the employee's medical need for the requested rehabilitative therapy based on the results of the initial evaluation and the physician's face-to-face examination of the employee occurring within sixty days of the date of the LMN.*

   The physician must provide a description of the type of rehabilitative therapy he or she is prescribing, along with a discussion of the specific quantity, frequency and duration of the therapeutic service. DEEOIC considers rehabilitative therapy services medically appropriate only if a qualified physician describes, with appropriate medical rationale, how the prescribed rehabilitative therapy will lead to an expected measurable improvement in one or more activities of daily living within a reasonable period. The LMN signed by the treating physician must include his or her official practice address, telephone and fax number.

g. *When the CE/MBE receives a request for authorization of rehabilitative therapy accompanied by an appropriate LMN, the CE/MBE prepares a decision letter to the employee authorizing the requested therapy. The initial authorization period may be fewer than, but must not exceed 3 months (90 days). The assigned CE/MBE may approve up to 3*

visits per week by therapy discipline. Each visit is equal to a maximum of 1.5 hours (6 units). PT, OT, or ST services are limited to one hour (4 billable units) when the provider bills with combined codes. The CE/MBE may not authorize therapy for any one discipline more than 60 visits per calendar year. The approval letter must contain the following information:

(1) Covered medical condition(s) for the rehabilitative therapy.

(2) Number and frequency of visits approved (e.g., 3 visits per week for 12 weeks).

(3) Authorized billing code(s) relevant to the approval.

(4) Dates for the authorized period.

(5) Statement to indicate that corresponding medical notes must be provided for each service date.

(6) Statement advising that fees are subject to the OWCP fee schedule.

h. *Upon receipt of requests for rehabilitative therapy unaccompanied by a sufficient LMN, the CE/MBE undertakes development by contacting the prescribing physician and the employee to request evidence necessary to allow for authorization.*

(1) After 30 days has passed with no satisfactory response from the treating physician, or no response from the employee, the CE/MBE prepares a second letter to the employee(accompanied by a copy of the initial letter), advising that following the previous letter, no additional information has been received from the treating physician. The CE/MBE advises that an additional period of 30 days will be granted for the submission of necessary evidence,

and if the information is not received in that time, the request for rehabilitative therapy may be denied by the DEEOIC.

(2) *If the employee or the physician does not provide a response to the second request for information within the 30-day period allowed, the CE/MBE issues a letter decision to the employee denying the claim for rehabilitative therapy. The CE/MBE further sends an email to the FO, who sends a thread to the BPA for system update.*

A CE/MBE can refer requests with unclear medical documentation to a DEEOIC nurse consultant or CMC for review to obtain expert advice on the recommended course of action. Once the CE/MBE has undertaken development, including allowance for the treating physician to provide further support for an unsubstantiated request for rehabilitative therapy, he or she can issue a letter decision denying the authorization if sufficient medical justification has not been forthcoming.

The letter decision is to include a narrative as to why the evidence is insufficient to warrant authorization. The CE/MBE is to send a letter to the employee along with a copy of the letter decision to the provider, if applicable. The letter decision is to include the following language:

If you disagree with this decision and wish to request a formal decision, please immediately advise this office, in writing, that you wish to have a Recommended Decision issued in this case, providing you with your rights of action.

i. Once the CE/MBE decides to approve or deny the request, he/she sends an electronic mail message to the WCA/FO, who prepares and sends a thread to the BPA, authorizing or denying the rehabilitative therapy request. The CE/MBE creates a correspondence entry on the correspondence screen of ECS, documenting the decision and bronzes the letter along with the supporting documentation into OIS.

j. An employee, an authorized representative, treating physician, or rehabilitative therapy provider must request a renewal of an expiring authorization or modification of an existing authorization for rehabilitative therapy and should do so prior to the expiration date of the existing authorization, to allow care to continue uninterrupted. In either of these situations, the requestor must submit a LMN documenting the continuing medical necessity of the request. Requests for rehabilitative therapy outside of this guidance must be evaluated on a case-by-case basis, including possible consultation with the DEEOIC Medical Director. The employee, or his or her AR, has final responsibility regarding the amount or type of rehabilitative therapy sought.

k. Rehabilitative therapy providers must conduct services in an appropriate setting; (i.e., in a clinic, professional office, or other similar location). If the CE/MBE receives a request for in-home professional therapy, the employee must be homebound to receive such authorization. Medical evidence from the treating physician must demonstrate that the employee is medically unable to travel to obtain the therapy outside the home. Once the CE/MBE receives convincing medical evidence that the employee is not able to travel for therapy, and sufficient documentation exists regarding the medical necessity for care, the CE/MBE may authorize in-home rehabilitative therapy. Provider

travel to and from an employee's residence is not a billable service.

l. *Rehabilitative therapy providers must submit appropriate clinical notes to the BPA, along with their bill, describing in detail the particular therapeutic care provided during each visit, and the time spent providing that care. The therapy notes must document compliance with the LMN. The notes should describe the effect of the rehabilitative therapy specific to unique features of the employee, including any specific improvements in functionality or in achieving relief from the symptoms of a compensable illness. The CE/MBE may refer claims to the Program Integrity Unit for investigation of those situations where an applicable therapy provider does not provide an employee specific description of the services provided, lists vague or non-descriptive services or conducts therapy services that do not comply with the prescribing physicians LMN.*

- Appendix 3 - Index of Archived Bulletins and Circulars, has been updated to include the following items which have been incorporated into the PM:

  - Bulletin No. 17-02, Prior Authorization Required for Enteral Formula

  - Bulletin No. 18-01, Rehabilitative Therapy

  - Circular No. 18-01, Idiopathic Disease Diagnosis

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